

## **Individualizing Exposure Therapy for PTSD: The Case Of Caroline**

**UELI KRAMER**<sup>a,b,c</sup>

<sup>a</sup> Institute for Psychotherapy, University of Lausanne, Switzerland

<sup>b</sup> Correspondence concerning this article should be addressed to Ueli Kramer, Clinical Psychotherapist FSP, Institute of Psychotherapy, Dept. of Psychiatry-CHUV, University of Lausanne, Cèdres-Site de Cery, CH-1008 Prilly-Lausanne, Switzerland

<sup>c</sup> Note: I thank Caroline for being so kind as to let me use this clinical material. I would also like to thank Edna Foa for her inspiring training on her Prolonged Exposure therapy, and Franz Caspar for his support with regard to his Plan Analysis model. Finally, many thanks to Hansruedi Ambühl and Claude Haldimann for clinical supervision of the case.

E-mail: [ueli.kramer@chuv.ch](mailto:ueli.kramer@chuv.ch)

---

### **ABSTRACT**

In therapy for chronic posttraumatic stress disorder (PTSD), prolonged exposure (PE) to stimuli associated with an original trauma experience is considered a state-of-the-art treatment method. The present case report outlines the use of Foa and Rothbaum's (1998) manual for this type of treatment in the year-long, 40-session treatment of Caroline, an adult female victim of child sexual abuse. The manual was supplemented by Caspar's (1995, 2007) Plan Analysis technique for individualized case formulation and treatment planning, along with Caspar's concept of the Motive-Oriented Therapeutic Relationship (MOTR). As indicated by standardized, quantitative measures, by changes in the client's behavior patterns, and by the client's subjective report, the treatment was very effective. An analysis of the therapy process illustrates the importance of a combination of manual-based procedures with individualized case formulations and interventions. The case is discussed in the context of enhancing the cognitive-behavioral treatment of PTSD.

*Key words:* posttraumatic stress disorder (PTSD); prolonged exposure (PE); therapeutic relationship; Plan Analysis; imaginative relaxation

---

## **1. CASE CONTEXT AND METHOD**

### ***A. Rationale for Selecting This Particular Client for Study.***

At the time of treatment, the client "Caroline"<sup>1</sup> was 26 years old and was referred to me by a colleague. She presented with complaints of depression and reported that she had a history of posttraumatic stress disorder (PTSD) symptoms resulting from sexual abuse by her maternal grandfather, when she was between 12 and 14. Based upon my training and the outcome research on PTSD, I decided to use prolonged exposure (PE) therapy (e.g., Foa, 2001; Foa, Rothbaum, Riggs, & Murdock, 1991; Foa et al., 1999; Maercker, 2003; Rothbaum, Foa, & Hembree, 2003).

---

<sup>1</sup> The client's name and her temporal and demographic details have been changed to protect her privacy. Writing up this case and its use for this publication was authorized by the client's explicit written consent

However, in this type of case, my clinical experience has been that additional techniques are needed, e.g., supportive counseling and imaginative relaxation (Reddemann, 2001; described below). In addition, I have found that Caspar's (1995) "Plan Analysis" assessment technique is an important, additional approach in understanding and conceptualizing a case like Caroline's. I selected this client for write-up to illustrate the ways in which exposure therapy and Plan Analysis can work together in treating PTSD.

### ***B. The Methodological Strategies Employed for Enhancing the Rigor of The Study***

As a quality control for the treatment, three regular case supervision sessions were undertaken: one session was used for reviewing the case formulation (after session 3); one session for consultation on crisis management for the sudden emergence of disturbing eating problems (after session 16); and one session for reviewing the exposure therapy procedures (after session 21). Also, over the therapy, while no tape recordings were made, I took detailed notes, in order to be able to reflect upon the process, either in supervision or on my own in between sessions.

Standardized self-report measures were used for symptom assessment, monitoring and outcome measures. They were administered at the end of sessions 1, 29 (during a switch in the therapy from explicit exposure to indirect exposure treatment), and 40 (the last session), as well as at 3-month and 6-month follow-up. The specific measures will be described in section 4 below on assessment.

### ***C. The Clinical Setting in Which the Case Took Place***

The therapy took place at a public psychiatric clinic and charges were paid by the client's public health insurance, according to the Swiss Federal Law.

## **2. THE CLIENT**

As mentioned above, when treatment began, Caroline was 26 years old and experiencing clinically significant depression. She reported that she was sexually abused by her maternal grandfather, from age 12 to 14. As a result, she had a history of major PTSD-related problems in maintaining romantic relationships. At the time she entered therapy, she had been living for four years in an abusive intimate relationship with "Sylvia," a 40-year-old bi-sexual. Caroline was working as a secretary for a small local company.

She entered therapy with ambivalence, not sure it was the right choice for her.

## **3. GUIDING CONCEPTION WITH RESEARCH AND CLINICAL EXPERIENCE SUPPORT**

### ***Prolonged Exposure Therapy***

Foa and Rothbaum (1998) developed a manualized treatment for PTSD, organized around prolonged exposure (PE) to the original trauma. Subsequently, PE has been found to have

high effectiveness for this problem (Foa, 2001; Foa et al., 1991, 1999; Maercker, 2003; Rothbaum et al., 2003), and it is considered the treatment of choice for PTSD.

Housed within the cognitive-behavior therapy (CBT) model, PE interventions are specifically based on the principles of classical and operant conditioning. PE therapy explains PTSD as stemming from a neutral stimulus being associated with fear, thus becoming a conditioned stimulus. As a consequence, this conditioned stimulus discriminatively produces fear in similar situations in the life of the subject. Operant conditioning generally explains avoidance tendencies in PTSD: negative reinforcement, by means of avoidance of the aversive conditioned stimulus, contributes to maintain and consolidate the fear (and other PTSD-symptoms). To change this process, prolonged exposure breaks the negative reinforcement of avoidance by preventing the avoidance response. PE also has effect on classical conditioning: it leads thus to an extinction of the connection between the conditioned stimulus and a fear reaction, as no fearful consequences follow from exposure to the conditioned stimulus during the exposure period. More recent findings (e.g. LeDoux, 2002) have suggested that the connections within the synaptic “fear circuit” in the human brain, i.e. the amygdala-hippocampus, remain intact even after CBT, and rather that this therapy helps to develop an inhibitory control from the medial prefrontal cortex on this fear circuit. This control mechanism yields a decrease in PTSD-symptoms.

The formal PE therapy program (Foa & Rothbaum, 1998) consists of three components: psychoeducation about common reactions to trauma and the cause of chronic post-trauma difficulties; *in sensu* or imaginal exposure, involving a repeated recounting of the traumatic memory (emotional reliving); and *in vivo* or real world exposure to trauma reminders (e.g., situations, objects) that, despite being safe, are feared and avoided.

The specific application of these principles to Caroline’s case is described in the Formulation section below.

### ***Imaginative Relaxation***

Without doubting the effectiveness of prolonged exposure when applied correctly, my clinical experience has been that the client’s personal and interpersonal desires and goals are not always sufficiently taken into account in the PE protocol. Certain individuals with PTSD, as reported by Rothbaum et al. (2003) and more fully by Reddemann (2001), do not respond to PE, do not wish to undergo PE, or wish to undergo PE in a different way. For such clients, it would seem that supportive counseling and other therapeutic options are necessary.

One such option is “imaginative relaxation” (Reddemann, 2001), which may enhance the level of integration of the trauma narrative. It consists of pairing individualized positive imagery underlining the subject’s strengths and assets in coping with a problem and the negative images of the trauma. It has particular clinical relevance in the treatment of PTSD.

### ***Plan Analysis and the Development of “Motive-Oriented Therapeutic Relationships”(MOTRs)***

A method for individualizing the PE treatment of PTSD is Caspar’s (1995, 1997, 2007) “Plan Analysis,” an approach for developing specific psychotherapy case conceptualizations independent of any school of psychotherapy. Since this model falls outside the CBT tradition in the strict sense, and thus has not yet been described in the PE research literature, it will be presented in some detail below.

In the mid 70s, Grawe and Dzewas (e.g., Grawe, 1980) developed “Vertical Behavior Analysis,” the predecessor of Plan Analysis (Caspar, 2007). Its “behavior analytic” function can be seen in Caspar’s description of it:

[In Plan Analysis,] clinically relevant information about an individual’s behavior and experience is gathered through careful observation and synthesized into a meaningful whole. The fundamental question that guides Plan Analysis is as follows: Which purpose, conscious or unconscious, underlies an individual’s behaviors and experiences? (1997, p. 260). ...

The components of a Plan Analysis formulation are interrelated and hierarchically organized Plans, each of which has a goal and an “operations” component. The goal is a statement of the patient’s intention, hope, wish, or some other “end state” that the individual consciously or unconsciously strives to achieve. The operations element indicates the means to reach this goal. (1997, p. 262).

Caspar, Grossmann, Unmüssig and Schramm (2005) present an example of a Plan structure, which is shown in Figure 1. They point out that most particular Plans, like “acquire appreciation” in Figure 1, can be viewed from two perspectives: a *means* for accomplishing a superordinate goal like “acquire affection,” or as a *goal* in itself for the Subplan of “achieve professionally.” Likewise, “achieve professionally” can be a goal for the behavior of “does everything to get a contract.”

Overall, a Plan Analysis provides “a picture of patients' needs and possibilities in the therapeutic relationship as well as patients' problems and resources they can use to solve them and have a happier life” (Caspar et al., 2005, p. 92). Caspar et al. describe how Plan Analysis can then guide therapists in developing a Motive-Oriented Therapeutic Relationship (MOTR; originally called a “Complementary Therapeutic Relationship”), that is, offering each patient “an individually custom-tailored relationship that suits his or her most important needs and goals” (2005, p. 91), facilitating better therapy outcomes.

Caspar et al. (2005) present a schematic example of how a MOTR process can work, reproduced in Figure 2. As shown, the client’s main goals are to “avoid being overstrained” and to “make sure that the therapist commits himself fully.” If left to the client’s own cognitive and behavioral dynamics, as one goes down the hierarchy it can be seen that the client ends up primarily whining and complaining, making sure the therapist will eventually show pity on the patient. Even if the therapist does this only intermittently, it would still increasingly entrench the client’s undesired whining.

On the other hand, going from the bottom to the top of the hierarchy, from the whining it may be inferred that the patient wants to ensure that the therapist takes the problem seriously (Figure 2). This appears to be in itself an non-problematic motive, but is not yet high enough in the hierarchy, as higher again problematic Plans can be found. Thus, if we keep asking, for what this ensuring may serve, we may hypothetically infer the motives of preventing the therapist from asking him, the patient, to be active, and of causing the therapist to be active beyond his/her professional role. These are still problematic in the sense of limiting the therapist if he wants to comply with them. We need thus—following the rule of going higher in the hierarchy until we reach motives which are no more problematic—to infer further up. We may then infer the Plans of avoiding being overstrained (the patient trying to be on the safe side by preventing the therapist from demanding anything) and of making sure that the therapist commits himself fully (the patient trying to cause action beyond the professional role as a sign of being on the safe side).

The motives of avoiding to be overstrained and of getting the therapist's full commitment seem unproblematic in the sense of not limiting the therapist in an undue manner. The therapist can thus satisfy these motives, that is, make clear to the patient by his/her behavior and possibly meta-communication, that s/he will take care of these motives. The patient knows then that a continued use of the problematic means (whining) is unnecessary, because s/he has already what s/he needs. The therapist should take an active stance and satisfy the motives whenever possible, independent of an occasional re-occurrence of the whining, in order to avoid a contingency in time with this reinforcement.

Concretely, the therapist can develop a positive therapeutic relationship (a) by showing that he fully commits to the client, and (b) by convincing the client that he or she will not be over-demanding. These are the "construction Plans" for the concrete therapist behavior which takes the possibilities and constraints of the concrete situation into account and is concretely developed on a moment-to-moment basis.

In a related clinical example, Caspar (1997) illustrates the development of a MOTR in the case of Mr. W., who has a presenting problem of social phobia.

[Mr. W.] is handicapped by his strong Plans of maintaining control, by his conflictual wish that the therapist structure the therapy and take responsibility for it, and by the persistent criticism of others. The fear of rejection and of threats to his positive self-concept also need to be considered. The fear of disappointment in close relationships may lead the patient to test the therapist before he lets himself enter into a closer therapeutic relationship. Consistent with the goal of achieving a complementary relationship, the therapist should encourage the patient to maintain control and should ask for permission when he wants to restrict the patient's control. The therapist should actively and positively enhance the patient's self-esteem, emphasizing the patient's equal position. The therapist should acknowledge the patient's abilities whenever he can, mentioning the patient's expertise in his work; and openly and assertively admit his or her (the therapist's) insecurity when it occurs. The general strategy is to make the patient's problematic control and defense strategies superfluous as far as possible, to obviate their use rather than react to them contingently later on. (1997, p. 282).

Based on MOTR, Caspar et al. (2005) used a group design to empirically test the hypothesis that treatments in which therapists develop a MOTR with their patients lead to better outcomes. The researchers found support for their hypothesis based on ratings of success by patients, although not based on ratings of success by others. (For more on the conceptual background of Plan Analysis and MOTR, see Caspar, 1995, 1997, 2007.)

The results of my specific application of Plan Analysis in Caroline's case are described below in the Assessment section; and my use of these results in planning for a MOTR in the therapy are described below in the Formulation and Treatment Plan section.

#### **4. ASSESSMENT OF THE CLIENT'S PROBLEMS, GOALS, STRENGTHS, AND HISTORY**

##### *History*

Caroline's parents divorced when she was 9 years old; they both remarried and had more children. Caroline was sexually abused by her maternal grandfather, from age 12 to 14. Caroline concealed her abuse for two years, until the day she opened up and told her father (at age 14). With no hesitation, he believed in the veracity of the narration, whereas even now, her mother still refuses to accept the facts about her own father. The alleged abuser was brought to justice and convicted by the court; but then, only a few months later, he died of a heart attack. The traumatized adolescent received psychological counseling, an intervention that Caroline reports was not beneficial to her. =

After her compulsory education, Caroline trained as a secretary and worked for a small local company. Between the age of 17 and 22, she suffered from intermittent depressive episodes, which necessitated antidepressant medication. Apparently, no psychotherapeutic treatment was undertaken during this period. At 19, Caroline had her first erotic relationship with a man, which turned out to be extremely conflictual for her. Her erotic feelings and sexuality were affected by recurrent flashbacks: she had the sensation of seeing her grandfather's eyes in front of her every time she was physically close and attracted to her boyfriend. These disturbing, PTSD-related symptoms made her, after several painful attempts, abandon intimacy and sexuality with her boyfriend, and led to them later splitting up. At the age of 22, Caroline met Sylvia, a 40-year-old bi-sexual, and started an abusive intimate relationship with her. Sylvia regularly forced Caroline to have sexual intercourse with her, after heavy alcohol drinking. This conflictual relationship lasted 4 years, until the first months of Caroline's psychotherapy.

At the beginning of treatment, Caroline had a positive relationship with her father, but a conflictual one with her mother. Caroline's brother was himself in treatment for depression. Caroline came in complaining of PTSD symptoms, including flashbacks, recurrent nightmares, and manifest avoidance behaviors, along with co-morbid, recurrent depression. Caroline reported that she was aware of her symptoms as problems and suffered from them.

##### *Plan Analysis*

Plan Analysis was done according to Caspar's (1995, 2007) manual, and in line with the conceptual model presented in the Guiding Conception section above. Specifically, in the first

three sessions of therapy, I collected relevant instrumental information on Caroline's history and present behaviors and experiences, including both those that represented negative, self-defeating and those that represented positive, strength-based aspects of Caroline's functioning. This information was put in a free-form manner on paper and was analyzed and then hierarchically rearranged according to the apparent and inferred purpose of the observed behaviors and experiences. Hypotheses were written out and several drafts were necessary, in order to construct the final Plan Analysis, shown in Figure 3. In this process, specific case supervision on the conceptualization of Caroline's case was especially helpful. No psychometric reliability checks were applied for the resulting Plan structure in Figure 3, but this structure was reviewed with and approved by the case's clinical supervisor. (See supervisor's comment in the Appendix.)

In Figure 3, all the Plan items are numbered, from 1-41, for reference. Generally, they are numbered in sequential rows, starting in the upper lefthand part of the page, and reading across each row as one would read text. Conveniently, Plans, needs, and motives are formulated as imperatives (e.g., "1-Search for recognition" and "7-Avoid being hurt"); and specific behaviors are listed in descriptive format (e.g., "17-Does babysitting" and "35-Changes [romantic] partner frequently"). Specific Plans may be in conflict with others, for example, between the Plans "8-Avoid obligating relationships" and "20-Search for understanding in close relationships," and also between the Plans "11-Avoid conflicts" and "15-Assert yourself."

Figure 3 provides a clinically rich picture of the different components and dynamics of Caroline's functioning. It does this in terms of Caroline's strengths and positive, "approach" aspirations—e.g., "1-Search for recognition," "14-Search for other's compassion," "15-Assert yourself," and "20-Search for understanding in close relationships." It also does this in terms of reflecting how her traumatic experience caused by the abuse led to her PTSD via (a) with its associated underlying schema (e.g., "7-Avoid being hurt," "8-Avoid obligating relationships," "16-Avoid being [physically] attractive," and "19-Show yourself as a victim;" and (b) with its related symptoms (e.g., "27-Wears man-like clothes," "28-Has lesbian relationship," "29-Avoids being close to men," "31-Talks about her fragile body," and "36-Insists having destroyed her family."

The Plan structure as depicted in Figure 3 was not discussed with the client, nor were the direct results shared with her in any other form. Rather, as discussed below, in my therapist role I used these results to guide me in creating a Motive-Oriented Therapeutic Relationship with Caroline.

### *Self-Report Measure Used*

The measures used for assessment were the General Symptom Index (GSI) of the SCL-90-R, the Posttraumatic Symptom Scale-Self-Report (PSS-SR), the Beck Depression Inventory (BDI), and the Spielberger Stait-Trait Anxiety Inventory (STAI). The results are presented in Table 1.

The SCL-90-R (Derogatis, 1994) assesses the level of general symptomatology and is composed of 10 subscales, but only the General Symptomatic Index (GSI, score ranging from 0 to 4) is reported here, which is a mean rated over all symptoms. A validation study with French

speakers has been carried out by Pariente & Guelfi (1990) and has yielded satisfactory coefficients. The cut-off score for clinical subjects is at .80.

PSS-SR assesses the severity of PTSD symptoms (Foa, Riggs, Dancu, & Rothbaum, 1993). Satisfactory internal consistency, high test-retest reliability and good concurrent validity was found. Cut-off score for clinical subjects is at 1 (sum score).

The 13-item version of the BDI (Beck, & Beck, 1972) was used, with 0 to 4 indicating no or minimal depression, 5 to 7 mild depression, 8 to 15 moderate depression, and over 16 severe depression. Validation studies yield satisfactory correlation coefficients for the original, longer version of the BDI (Beck, Rial, & Rickels, 1974; Seggar, Lambert, & Hansen, 2002).

Finally, the STAI (State and Trait) was used (Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983). The state subscale (20 items) measures transient aspects of anxiety, and the trait subscale (20 items) measures stable aspects of anxiety. Summary scores vary between 20 to 80. Normative data with French speakers show a mean of 35.73 (SD = 10.89) for the STAI-S, and a mean of 41.89 (SD = 10.40) for the STAI-T (Vautier, & Jmel, 2003). Assuming a clinical cut-off score of one standard deviation above the norm, this yields clinical cut-off scores of 46 and 52, respectively.

All scales were administered after three sessions: the intake session, session 29, and the last session (session 40), along with 3-month and 6-month follow-up measures. It was not possible to anticipate in detail the total length of the therapy process, and thus mid-treatment assessment was not exactly half-way through the therapy. The follow-up sessions each also included a clinical interview, from which additional, qualitative follow-up information was collected.

Table 1 summarizes the results at intake, along with the other four assessment points. The results indicate that at intake Caroline was suffering from clinically significant scores on overall symptom severity (GSI), post traumatic stress disorder (PSS-SR), depression (BDI), and trait anxiety (STAI-T).

### *Diagnosis*

At the beginning of therapy, Caroline's DSM-IV (American Psychiatric Association, 1994) diagnosis was as follows:

Axis I: 296.32, Major Depressive Disorder, Recurrent  
309.81, Post-Traumatic Stress Disorder

Axis II: none

Axis III: none

Axis IV: unemployment

Axis V: GAF = 58 (toward the top of the range of "moderate symptoms or moderate difficulty in social, occupation, or school functioning")

### *Strengths*

The resources that Caroline brought to therapy were mainly her motivation to tackle difficult themes within the therapy and her capacity to reflect on interpersonal issues related to her situation. She was quite clear about objectives for therapy and formulated them to the therapist early in the process: (1) to separate from Sylvia, as this relationship was becoming abusive, and, furthermore, to gain distance from her mother; (2) to be able to live “less nervously,” without depressive and posttraumatic symptoms, such as irritation and disturbed sleep patterns; and (3) to find an intimate relationship with a man that was satisfying to her.

## **5. FORMULATION AND TREATMENT PLAN**

### *Cognitive-Behavioral Formulation and Treatment Plan*

Above in the Guiding Conception section, I mentioned that the mechanism of classical conditioning is employed to explain how previously neutral or positive stimuli become associated with anxiety-producing stimuli connected to a traumatic experience, like exposure to an improvised explosive device for a soldier (Cigrang, Peterson, & Schobitz, 2005), or rape for a female adolescent or adult (Calhoun & Resick, 1993; Foa & Rothbaum, 1998). In Caroline’s case it appears that her PTSD-symptoms (e.g., flashbacks) were produced by the association between the neutral stimulus of her erotic encounter with her boyfriend (at age 19) and the conditioned stimulus of the memory of the incestuous relationship with the maternal grandfather (see Foa & Kosak, 1986). Erotic encounters are thus avoided by Caroline, resulting in the maintenance of the above-mentioned association by negative reinforcement.

Caroline’s current depressive state seemed to be maintained by her low self-efficacy and low perceived self-control. These in turn were being maintained by Caroline’s problematic attempts to avoid anxiety-arousing interactions with men that were motivated by the dynamics of her original traumatic sexual experience, a pattern reflected in such Figure 3 items as “7-Avoid being hurt,” “16-Avoid being attractive,” “27-Wears man-like clothes,” and “29-Avoids being close to men.” Also contributing to the maintenance of her depressive symptoms was Caroline’s recurrent devaluation of herself in the relationship with Sylvia, making self-statements like, “I have to accept everything from other people in order to maintain the relationship,” and, “I have to do everything for other people in order to be happy.” Two potential origins of the devaluation may be assumed. First, the memory of the abuse led her to self-blame about her own involvement in the process and made her feel like a bad person needing constant and unconditional love from others in order to feel acceptable. Second, her mother’s constant blaming of Caroline for all the negativity in the family in the past and present had been internalized within Caroline’s psychological functioning. Probably both hypotheses held true, giving rise to a long-standing, multi-determined pattern of self-devaluation. Finally, Caroline’s pattern of social avoidance and retreat, generalizing from her response to the rape, also contributed to the maintenance of depressive symptoms by greatly limiting her social relationships.

Based on the cognitive-behavioral formulation of the case, Foa and Rothbaum’s (1998) Prolonged Exposure (PE) manual was employed to address Caroline’s PTSD symptoms.

### ***Using the Plan Analysis Results to Design a Strategy for Creating A Motive-Oriented Therapeutic Relationship***

In developing a strategy to create a Motive-Oriented Therapeutic Relationship (MOTR) with her, I first identified at least two Plans from Figure 3 that might have been potentially problematic in her behaviors within therapy: “19-Show yourself as a victim” and “8-Avoid obligating relationships.” In response to Plan 19, if apparent in a repetitive way, I might have naturally reacted in an angry or annoyed manner. The Plans, “7-Avoid being hurt” and “8-Avoid obligating relationships,” might become an obstacle to Caroline engaging fully in a positive therapeutic relationship.

As mentioned in the Case Formulation section above, the theory of MOTR prescribes that the therapist not react directly to the problematic Plan items. Rather, the therapist is guided to react in a way that focuses on those Plan items—among related, hierarchically superior Plans and motives—that are at least non-problematic for the therapeutic relationship, and at best positive for it. In line with this concept, for Caroline’s Plan of “19-Show yourself as a victim,” I responded by focusing on her higher-order Plans and motives of “1-Search for recognition” and “14-Search for other’s compassion.” For Caroline’s Plans of “7-Avoid being hurt” and “8-Avoid obligating relationships,” I responded by focusing on her higher-order Plans and motives of “4-Maintain your autonomy” and “5-Maintain your integrity.”

In summary, my approach for creating a Motive-Oriented Therapeutic Relationship involved a response to Caroline’s Plan of “19-Show yourself a victim” by my Plans, “Show the patient that you care for her,” “Express how much the patient is welcomed in the session,” and “Convey to the patient that she is doing so much herself already in order to cope with the difficult situation.” Likewise, I responded to Caroline’s Plans of “7-Avoid being hurt” and “8-Avoid obligating relationships” with my Plans of “Be particularly sensitive to the client’s perception of the therapist being critical and harsh,” and “Convey to the client that it is important to maintain her integrity and autonomy.”

### ***Treatment Goals***

Caroline mentioned the reduction of depressive symptoms and the separation from Sylvia and Caroline’s mother as her first treatment goals. Based on these goals, the aims of the therapy were to shore up interpersonal boundaries in intimate areas by learning to say “no” to excessive demands on her. This seemed particularly urgent in the current relationships with Sylvia and Caroline’s mother. I explained this to Caroline and emphasized that the therapy needed to be carried further after the shoring up of interpersonal boundaries, in order for her to acquire appropriate social skills (e.g., assertiveness) to satisfy her need for proximity and close relationships (see items 3 and 20 in Figure 3), while at the same time creating more distance from Sylvia and her mother. This initial focus on depression is consistent with Foa (2001), who recommends that working with Prolonged Exposure for PTSD-symptoms should only be carried out after the reduction of depressive symptoms.

After Caroline's first treatment goal was met, I planned to proceed to her next two stated goals: to address her PTSD symptoms, and to help her work towards finding an intimate relationship that was satisfying to her.

## **6. COURSE OF THERAPY**

Forty weekly psychotherapeutic sessions took place over a year. The phases of the therapy are described below.

### ***Sessions 1-10: Establishing a Working Alliance***

The first ten sessions were devoted to establishing a functional working alliance and enhancing Caroline's motivation for treatment. A therapy contract was established focusing on treatment of the above-mentioned initial goals, excluding at first the work on the sexual trauma and its consequences. A positive working alliance was established by taking very seriously the patient's problems and adopting the MOTR model described above. More specifically, Caroline's afore-mentioned strengths (her motivation to tackle difficult themes within the therapy and her capacity to reflect clearly on interpersonal issues) were spelled out to the patient. Moreover, in line with these strengths, I underlined several of her positive, approach Plans, such as "9-Be a good mother," "14-Search for other's compassion," and "15-Assert yourself" (see Figure 3). Regarding #9, I pointed out that Sylvia had children Caroline liked to care for, and I asked if she also had other girlfriends with young children for whom she could imagine offering some help. This was acknowledged by Caroline, but even if there were not any girlfriends around, this comment aimed at raising the awareness about her Plan "9-Be a good mother" and about its possible satisfaction, for which she could enjoy caring about children other than Sylvia's. =

### ***Sessions 11-15: Separating from Sylvia***

The following five sessions focused on the lack of boundaries within the relationship with Sylvia. The client collaborated well in working on this problem. After one session, as a homework assignment, I asked Caroline to draft a letter to Sylvia, which was neither sent nor disclosed to the therapist. In this letter, Caroline was to write everything she wanted to express concerning the four-year-long relationship with Sylvia. In the following session, Caroline came with a big smile and said she wrote the letter, and while writing it, she gained so much insight about the relationship that she decided to call Sylvia. On the phone, Caroline was able to summarize the content of the letter and to ask for more distance. Sylvia was astonished by Caroline's behavior and did not oppose it. Two weeks later Caroline was able to physically and emotionally distance herself from Sylvia and then, another two weeks later, break away completely from her.

### ***Sessions 16-20: A Crisis with Disturbing Eating Problems***

The end of the relationship with Sylvia led Caroline into a crisis with the onset of disturbing eating problems, involving refusal of food, with regular vomiting. As mentioned in the Case Formulation section above, I anticipated the possibility of an increase in depressive mood due to a decrease in social contact from Sylvia, who represented a close—albeit conflictual and

self-defeating—relationship. However, the Case Formulation did not predict disturbing eating behaviors. From the history I had not uncovered any evidence of an eating disorder in the past, and the various criteria of a formal diagnosis of an eating disorder were not present, e.g., there was no fear of gaining weight or becoming fat. Rather, it seemed that intense anxiety raised when one of Caroline’s main goals (see “3-Search for proximity” in Figure 3) was frustrated, and that this anxiety was expressed by a loss of appetite and nausea. As a result, the treatment plan needed adjusting. In the short-term, intervention for Caroline’s emergent and intense anxiety became the main treatment focus. Since Caroline and I had by then established an excellent therapeutic relationship, at this point I focused on further developing the therapeutic relationship to compensate for the loss of the relationship with Sylvia, that is, by having the therapeutic relationship link more directly to Caroline’s goal of “3-Search for proximity.”

More specifically, the eating problems were addressed in Sessions 16-20 by cognitive crisis intervention and imaginative relaxation (see Reddemann, 2001). Cognitive crisis intervention involved the establishment of an eating program paralleled by an eating diary to be completed every day after every meal. This self-observation diary technique encompassed cognitive, emotional and behavioral elements; and it enabled the therapist to monitor the evolution of the eating disturbance and the client to become aware of the day-by-day links between the eating disturbance and her inner affective life. The imaginative relaxation that was introduced in this phase involved having the client develop a visualization of an inner “safe place” for herself. According to Reddemann’s (2001) manual, the use of the imagined safe place may be used in conjunction with trauma-related material. Since I used imaginative relaxation as crisis intervention and not to address past trauma experiences, no further visualization besides the safe place was employed at this point. The creation of the imagined safe place was helpful to the client in being able to relax and in strengthening her access to her inner resources.

The above interventions were successful in eliminating the eating problem symptoms, and Caroline was then willing to undertake, from session 21 onward, as much exposure therapy for PTSD as would be necessary in her situation. In accordance with Foa and Rothbaum (1998), the exposure was planned in two phases: *in vivo* exposure to men in group settings, followed by *in sensu* (imaginative) exposure to the events associated with Caroline’s sexual traumatic experiences from age 12 to 14. *In vivo* exposure precedes *in sensu* exposure, as the former involves exposure to the behavioral consequences of the trauma, not the traumatic memory itself. The *in vivo* exposure, guided by the therapist, aims first at an habituation to the anxiety-producing situation and second, at enhancing the client’s perceived self-efficacy, which is an important factor, probably even a condition, for the subsequent *in sensu* exposure to the trauma-memory.

### ***Sessions 21-23: In Vivo Exposure to Men in Group Settings***

Following the Foa and Rothbaum (1998) manual, I socialized Caroline into the cognitive-behavioral model of PTSD before starting *in-vivo* exposure to treat her behavioral avoidance patterns. In particular, I discussed with her the role and negative consequences of the avoidance of specific, trauma-related stimuli. Furthermore, I summarized the nature of PTSD symptomatology, and then worked to enhance Caroline’s motivation for change by having her visualize her life without these symptoms.

Caroline went every morning before work to a snack bar for coffee, to expose herself to a social situation where she was likely to meet men in a safe environment, a situation she characterized as causing mild anxiety. As shown in Table 2, on a Subjective Units of Distress, or “SUD” scale, ranging from “0-no distress” to “100-highest possible distress,” Caroline rated this situation as a 65. As the *in vivo* exposure progressed (Session 23), Caroline was able to face up to social situations that she characterized as causing high anxiety, such as being in front of a disco with a girlfriend (practiced twice a week), which was associated with a SUDs rating of 80.

This part of therapy went remarkably smoothly. Even though Caroline had been avoiding these situations prior to the therapy exercises, the exercises did not provoke major problems for Caroline. This might be explained partly by the clear rationale that I gave at the outset of the PE sessions, and partly by the strong, trusting therapeutic relationship between Caroline and myself. As a consequence, after only a few sessions of *in vivo* PE, Caroline was able to comfortably experience the previously mentioned situations that she had originally rated quite high on her SUD scale.

#### ***Sessions 24-26: In Sensu (Imaginative) Exposure to Abuse-Related Events***

The next step was to prepare Caroline for *in sensu* (imaginative) exposure to the abuse-related events that had taken place during her adolescence and their sequelae. In Caroline’s case this would have involved making an audio tape while she was talking about the past abusive situation in the therapy and then re-listening to it at home as homework, according to the principle of habituation of feared stimuli (Foa & Rothbaum, 1998). At this point, around session 24 and in anticipation of this process, Caroline began vomiting again, and the same specific supportive strategies were necessary to deal with this problem as were used during sessions 16-20 as described above.

As recommended by Foa and Rothbaum (1998), Caroline had to talk about the past abusive situation in therapy and then re-listen to the audio tape of the session as homework. In line with this, I began to regularly tape-record the sessions in anticipation of Caroline talking about the past abuse, starting in session 25, and to have Caroline re-listen to them. =

Caroline had major distress in reaction to this arrangement, and the whole 26th session was devoted to the problems she encountered with re-listening to the tape of the 25<sup>th</sup> session. In the 26<sup>th</sup> session, Caroline mentioned that while listening to the tape at home, she thought of herself as being a 12-year-old child, dangerously vulnerable and helpless, and at the mercy of adults. This upsetting feeling was explored more fully and was linked to the presumed feelings she had towards her abusive grandfather, as well as to the assumed underlying interpersonal Plan or schema of hurt avoidance (e.g., in Figure 3 see items “7-Avoid being hurt” and “12-Avoid being sexually abused”). Following my MOTR described above in the Treatment Plan section, I spelled out these links to the patient and also underlined explicitly that for me it was very important that Caroline was not being hurt at the present moment in therapy (see the therapist Plans).

Once Caroline fully calmed down and agreed to focus on the hurt avoidance theme within therapy, I began raising questions about thoughts of herself as being a 12-year-old child,

dangerously vulnerable and helpless, and at the mercy of adults. Very rapidly, she acknowledged the absurdity in the thought, especially with regard to me, the current therapist. In order to test her insight, I played the devil's advocate and said that based on her abuse experience, it is fully understandable to have these thoughts and it is fully understandable to mistrust even the most caring therapist—also reminding her that her grandfather was most caring in the beginning. Carolyn responded, with some humor, by countering my argument and declaring that things are very different now and she felt much different—much better—now at the end of this session (session 26).

Based on Caroline's upset anticipation of the *in sensu* exposure, we then agreed not to proceed with it as previously planned, but to maintain tape-recording of at least the next 10 sessions and, as homework, to have Caroline listen at home to each session in the days following it. Caroline also agreed to report in the following sessions all thoughts she had while listening to the previous session's tape at home, since these thoughts were important information, as was shown in session 26. I praised Caroline for sharing and exploring her challenging reactions in response to listening to the tape.

### ***Sessions 27-40: Switch from In Sensu Exposure to Enhancement of Social Competence***

The remaining sessions of the psychotherapy (i.e., sessions 27-39, except session 40 which was the last session) were all tape-recorded, and the client's reactions while listening to the tapes monitored, reframed, and restructured, if necessary. Crucially, the therapeutic focus then shifted from specific symptom reduction to work on the therapeutic relationship and related social relationships. This included relevant, underlying interpersonal schemas (see Figure 3) that were activated by the therapeutic relationship and were linked to her traumatic sexual experience in adolescence, without elaborating explicitly the narrative of that experience. In this context, there was a focus on Caroline's experience in recent social situations that had been difficult for her.

Thus, according to the client's explicit wish, instead of *in sensu* exposure, sessions 27 to 40 were devoted to enhancement of her social competence in interpersonal relationships, e.g., with her mother and with men, whom she had previously avoided. Situations were practiced in role plays and were consequently enhanced by rapid transfer of competence into reality. For example, for a family party, Caroline's mother tried to insist her daughter buy a specific dress and go accompanied by a man she hardly knew, instead of coming in jeans and alone. The client used the session for practicing her assertive response to the mother's request and managed to tell her (after the practice) very calmly that she would wear what she liked and would certainly not be accompanied by a person she barely knew. The mother, surprised by her daughter's reaction, accepted and only commented in a puzzled way, "You're not the same person anymore." Caroline's refusal of the *in sensu* exposure may be understood as a first trial of assertiveness, this time within the therapeutic relationship. It may also be understood as an interpersonal "test" (Weiss, Sampson et al., 1986), where Caroline was checking to see if the relationship to the therapist was safe, i.e., respecting her motives and needs, in particular the need for integrity (cf. item 5 in Figure 1) and the Plan of avoiding being hurt (cf. item 7 in Figure 1). At this point my awareness of the Motive-Oriented Therapeutic Relationship I had planned was particularly important. Also, the relationship model provided by myself as the therapist, a man but in a

supportive, empathetic, non-demanding role, seemed to have helped the client to become more self-confident in interpersonal relationships, as shown both with her mother, and also later on with men. For example, at the party mentioned above, the client approached the man who, later, became her stable boyfriend.

After one year of treatment, Caroline's personal and interpersonal functioning showed clear improvement: she found that she was effective and assertive with regards to her wishes for herself, the therapist, and intimate relationships. Moreover, there was no resurgence of eating problems. Therefore, the therapy was terminated by common decision in a highly positive climate.

## **7. THERAPY MONITORING AND USE OF FEEDBACK INFORMATION**

Qualitative assessments were carried out on a monitoring basis over the course of therapy, and quantitative assessments were made at three points: the first session, the 29th session (an estimate of the mid-point of the therapy), and (3) the last session, along with follow-ups at three and six months.

There were three points at which the feedback from these assessments was particularly important in revising and guiding the treatment. The first occurred when eating disorder symptoms were occasioned by Caroline's rupture with Sylvia. The second happened when these symptoms were stimulated again by the initiation of *in sensu* prolonged exposure for Caroline's sexual trauma. At each of these two time points, the treatment moved to supportive procedures for addressing the eating problems.

Third, quantitative assessment of symptoms after session 29 was the basis for further treatment focus mostly on depressive and anxiety symptoms. Specifically, as shown in Table 1, at Session 29 the GSI and STAI-T scores were still at clinical levels and her BDI was close to clinical levels, while PTSD-symptoms, as indicated by the PSS-SR, had clearly dropped under the clinical cut-off level. Overall, at Session 29, I determined that a moderate, interpersonally determined depression along with some elevated anxiety necessitated another ten sessions of treatment that focused on developing new social approach skills, to facilitate Caroline's expansion of her social network and to increase her chance of finding a satisfying, intimate relationship.

## **8. CONCLUDING EVALUATION OF THE THERAPY'S PROCESS AND OUTCOME**

### *Quantitative and Qualitative Indicators of Outcome*

Table 1 lists the five measures that were employed to assess Caroline's intake status and change over the course of therapy and follow-up. In the table, Reliable Change Index (RCI; Jacobson & Truax, 1991) values are listed in parentheses. Each RCI value provides an indication of the degree of change on a particular post-intake variable as compared with intake status. RCI values equal to or greater than 1.96 show a statistically significant increase over intake at the .05 level.

Table 1 also shows the clinical cut-off score on each variable, that is, the score above which a client's symptoms and/or functioning enter the clinical range of psychopathology. Jacobson and Truax (1991) define "clinically significant change" on a particular measure over time as involving both a statistically significant improvement on the measure along with a change on the measure from a value that was above the clinical cutting point initially to one that is below the clinical cutting point afterwards.

From Table 1 it can be seen that overall, the various measures indicate a dramatic decrease in general and specific symptomatology between Session 1 and later assessments. Specifically, on the General Symptom Index (GSI), post-traumatic stress disorder (PSS-SR), and depression (BDI) scales, all but one of the changes measured—at session 29, session 40, 3-month follow-up, and 6-month follow-up—were all in the clinically significant range. This was also true of trait anxiety (STAI-T) at session 40 and at 3-month and 6-month follow-up. There were no changes on the state anxiety (STAI-S) scale.

In terms of related, qualitative indicators of success, at 3-month follow-up, Caroline said that she was in a satisfying intimate relationship with a man whom she had met at the aforementioned friend's wedding. Caroline was able to have sexual intercourse with this partner without any problems, reporting that she was completely satisfied by the experience. Contacts with Sylvia and with her mother were far more distant than before therapy, and the client was more assertive in these relationships. These qualitative results remained stable at 6-month follow-up. Caroline was asked about the course of therapy and what remained in her mind. She said that at the beginning of therapy she had been hesitant to come in, but she felt encouraged by the therapist and fundamentally knew, if she wanted to have a better life, she had to do this therapy. She also said that if she is doing less well again, she would definitely come back, since she had confidence in me. In fact, Caroline called me two years after therapy ended for a question related to her professional life. I saw her for one session and learned she now planned to marry her boyfriend and wished to have children. No further therapy was indicated at that time.

### *Discussion*

According to Foa and Rothbaum's (1998) clinical recommendations, prolonged exposure therapy should be carried out systematically for not more than 10 therapy sessions. The format of the therapy with Caroline was four times this length, since additional sessions were needed to deal with other symptoms and problems, e.g., depression, emergent eating difficulties, and the need to develop improved skills in handling close social relationships.

The first 10 sessions focused on establishing a working alliance, and the next 10, on crisis management. Increase in motivation to work specifically on trauma symptoms was another main focus of this initial period. At the end of this preparation, the client was willing to start on prolonged exposure.

After only a few sessions, in which *in vivo*, social exposure was effectively carried out, the client expressed the wish that the *in sensu* prolonged exposure procedure involving her adolescent sexual trauma should be abandoned, as it was leading to the resurgence of eating problems. At this point, a detailed analysis of interpersonal schemas from the Plan Analysis

revealed that it was important for the client to experience a relationship that was responsive to her needs. At the time of the rape, her grandfather ignored her pleas to stop hurting her, and subsequently, the client protected herself by means of Plans of hurt avoidance (e.g., see Figure 3, items 7, 8, 11, and 12). To create a Motive-Oriented Therapeutic Relationship, I fully respected her interpersonal needs and motives and agreed not to proceed with the *in sensu* exposure, while at the same time addressing these needs and motives in other ways, e.g., by continuing the distressing tape-recording and working on it in session.

Specifically, at the point when Caroline resisted continuing with the prolonged exposure procedure—and this is somewhat unusual for cognitive-behavioral therapists—the therapeutic relationship and the client’s ideas, worries and wishes in this regard became the focus of the treatment; and the client’s relationship-avoidance tendencies were explicitly discussed. In Caroline’s case, making a tape recording of each therapy session and having the client systematically re-listen to it and reprocess it in the next session might well have had a similar function as prolonged *in sensu* exposure to the difficult emotion associated with the avoidance schema. The client’s fear of abuse expressed during the current therapeutic relationship, by cognitions such as, “I feel like a 12-year-old child, helpless when alone with a man,” was activated (Foa & Kozak, 1987). This time the activation was within the therapeutic relationship, and a new, positive and supportive emotional experience could be created, replacing the hitherto dysfunctional relationship patterns. In the words of some psychodynamic therapists, the client was able to have a “corrective emotional experience” in the therapy. One might hypothesize that this process was facilitated by Caroline having a therapist who was male, the same gender as previously avoided due to the traumatic experiences. Gender might have been an important aspect also for the competence-related aspect of assertiveness described above. The therapeutic relationship as a model, provided by a man, the therapist, might have facilitated the client’s assertiveness with her mother and in particular towards men. On the contrary, I personally would not want to over-valuate the gender factor, since my clinical experience is that gender, even if important as such, is very seldom a real obstacle for therapeutic change. This would mean that I ultimately believe that a female therapist would have yielded similar therapeutic results with this client as I did.

Working in such a way on relationship experiences seems particularly important in the treatment of chronic psychopathological states, such as PTSD and personality disorders. In the context of the posttraumatic stress disorder literature, systematic, individualized case conceptualizations are rather rare, since prolonged exposure for PTSD is a manual-based procedure that does not explicitly take into account the nature of the therapeutic relationship. In this regard, the present case report is intended to add to the body of research on Prolonged Exposure and to underline the necessity for adapting the procedure to the client’s specific needs, interpersonal schemas, and patterns, as assessed by a procedure like Plan Analysis. The Plan Analysis model is particularly interesting in this case, since rape victims, in addition to their PTSD symptomatology, may suffer from interpersonal difficulties that increase the level of their suffering (Thelen, Sherman, & Borst, 1998).

In conclusion, adult PTSD after child sexual abuse, along with other traumatic experiences such as interpersonal violence, very often involves the entrenchment of maladaptive interpersonal schemas. The extremely demanding procedure of prolonged exposure, the state-of-

the-art CBT method of treatment in this domain, is prone to activate such patterns within the therapeutic relationship. Not addressing them or maintaining focus solely on the reduction of PTSD-symptoms might jeopardize the quality of the therapeutic relationship or the effectiveness of the entire treatment. The flexible and individualized use of exposure therapy, along with a clear case formulation including relationship patterns, seems indispensable for the successful psychotherapeutic treatment of PTSD-related psychopathology. In the case of Caroline, I found the model of Plan Analysis and its use in developing a Motive-Oriented Therapeutic Relationship particularly helpful in such individualization of the therapy.

## 9. REFERENCES

- Beck, A. T., & Beck, W. (1972). Screening depressed patients practice: A rapid technique. *Postgraduate Medicine*, 52, 81-85.
- Beck, A. T., Rial, W., Rickels, K. (1974). Short form of Depression inventory: Cross-validation. *Psychological Reports*, 34, 1184-1186.
- Calhoun, K.S., & Resick, P.A. (1993). Post-traumatic stress disorder. In D.H. Barlow (Ed.), *Clinical handbook of psychological disorders*, 2<sup>nd</sup> Edition. New York: Guilford.
- Caspar, F. (1995). *Plan Analysis. Towards optimizing psychotherapy*. Seattle: Hogrefe.
- Caspar, F. (1997). Plan Analysis. In T. D. Eells (Ed.), *Handbook of psychotherapy case formulation* (pp. 260-288). New York: Guilford Press.
- Caspar, F. (2007). Plan Analysis. In T. D. Eells (Ed.), *Handbook of psychotherapy case formulation* (2<sup>nd</sup> edition)(pp. 251-289). New York: Guilford Press.
- Caspar, F., Grossmann, C., Unmüssig, C., & Schramm, E. (2005). Complementary therapeutic relationship: Therapist behavior, interpersonal patterns, and therapeutic effects. *Psychotherapy Research*, 15, 91-102.
- Cigrang, J.A., Peterson, A.L. & Schobitz, R.P. (2005). Evaluation of a brief exposure therapy treatment for the secondary prevention of combat-related PTSD. *Pragmatic Case Studies in Psychotherapy* [Online], Vol. 1(2), Article 1. Available: [http://hdl.rutgers.edu/1782.1/pcsp\\_journal](http://hdl.rutgers.edu/1782.1/pcsp_journal)
- Derogatis, L. R. (1994). *Symptom Checklist-90-Revised : Administration scoring and procedures Manual (3rd Edition)*. Minneapolis MN: National Computers Systems.
- Foa, E. B. (2001). A comparison of prolonged exposure and prolonged exposure plus cognitive restructuring in female assault victims with PTSD: Preliminary findings. *Paper presented at World Congress of Cognitive and Behavior Therapy*, Vancouver, B.C.
- Foa, E. B., Dancu, C. V., Hembree, E. \*A., Jaycox, L. H., Meadows, E. A., & Street, G. P. (1999). A comparison of Exposure Therapy, Stress Inoculation Training, and their combination for reducing Posttraumatic Stress Disorder in female assault victims. *Journal of Consulting and Clinical Psychology*, 67(2), 194-200.
- Foa, E. B., & Kosak, M. J. (1986). Emotional processing of fear: exposure to corrective information. *Psychological Bulletin*, 99, 20-35.
- Foa, E. B., Riggs, D. S., Dancu, C. V., & Rothbaum, B. O. (1993). Reliability and Validity of a Brief Instrument for Assessing Post-Traumatic Stress Disorder. *Journal of Traumatic Stress*, 6, 459-473.
- Foa, E. B., Rothbaum, B. O., Riggs, D. S., & Murdock, T. B. (1991). Treatment of Posttraumatic Stress Disorder in Rape Victims: A comparison between Cognitive-Behavioral

- procedures and Counseling. *Journal of Consulting and Clinical Psychology*, 59(5), 715-723.
- Foa, E. B., & Rothbaum, B. O. (1998). *Treating the trauma of rape : Cognitive behavioral therapy for PTSD*. New York : Guilford Press.
- Grawe, K. (1980). Die diagnostisch-therapeutische Funktion der Gruppeninteraktion in verhaltenstherapeutischen Gruppen[The diagnostic-therapeutic function of group interaction in behavioral treatment groups]. In K. Grawe (Ed.), *Verhaltenstherapie in Gruppen* (pp. 88-223). München: Urban & Schwarzenberg.
- Grossmann, C. (2001). *Die Auswirkung der Komplementären Beziehungsgestaltung auf die Ergebnisqualität [The effects of a complementary relationship offer upon therapy outcomes]*. Unpublished Master's Thesis. University of Freiburg i.B.
- Jacobson, N. S., & Truax, P. (1991). Clinical Significance : A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology*, 59, 12-19.
- LeDoux, J. (2002). *Synaptic Self. How our Brains become who we are*. New York: Viking.
- Maercker, A. (Ed.)(2003). *Therapie der Posttraumatischen Belastungsstörungen[Therapy of Post-Traumatic Stress Disorder]*. Göttingen: Hogrefe.
- Meichenbaum, D. (1994). *A Clinical Handbook/Practical therapist manual for assessing and treating Adults with Post-Traumatic Stress Disorder*. Waterloo : University of Waterloo.
- Pariente, P., & Guelfi, J. D. (1990). Inventaires d'auto-évaluation de la psychopathologie chez l'adulte. 1<sup>ère</sup> partie : Inventaires multidimensionnels. *Psychiatrie Psychobiologique*, 5, 49-63.
- Reddemann, L. (2001). *Imagination als heilsame Kraft. Zur Behandlung von Traumafolgen mit ressourcenorientierten Verfahren[Imagination as healing force. On the treatment of trauma sequelae by means of resource-oriented interventions]*. Stuttgart : Pfeiffer bei Klett-Cotta.
- Rothbaum, B. O., Foa, E. B., Hembree, E. A. (2003). Kognitive Verhaltenstherapie bei posttraumatischen Belastungsstörungen. Formen und Wirksamkeit. In A. Maercker (Ed.), *Therapie der posttraumatischen Belastungsstörungen[Therapy of the Post-Traumatic Stress Disorders]*. 2., überarbeitete Auflage (pp. 75-90). Berlin : Springer.
- Seggar, L., Lambert, M., Hansen, N. (2002). Assessing Clinical Significance: Application to Beck Depression Inventory. *Behavior Therapy*, 33, 253-269.
- Spielberger, C. D., Gorsuch, R. L., Lushene, R., Vagg, P. R., Jacobs, G. A. (1983). *State-Trait Anxiety Inventory*. Palo Alto: Consulting Psychologists Press.
- Thelen, M. H., Sherman, M. D., & Borst, T. S. (1998). Fear of Intimacy and Attachment among rape survivors. *Behavior Modification*, 22(1), 108-116.
- Vautier, S., Jmel, S. (2003). Transient error or specificity? An alternative to the staggered equivalent split-half procedure. *Psychological Methods*, 8, 225-238.
- Weiss, J., Sampson, H. & Mount Zion Psychotherapy Research Group (1986). *The psychoanalytic process: Theory, clinical observations, and empirical research*. New York: Guilford.

**Table 1. Outcome of Caroline’s Psychotherapy**

<b>Scale</b>	<b>Clinical Cut-Off Score<sup>b</sup></b>	<b>Session 1 score</b>	<b>Session 29 score</b>	<b>Session 40 score</b>	<b>3-Months Follow-up Score</b>	<b>6-Months Follow-up score</b>
GSI <sup>a</sup>	.8	2.4	1.5 (8.89 <sup>c*</sup> )	.4 (19.76*#)	.3 (20.75*#)	.4 (19.76*#)
PSS-SR	1.0	1.46	.78 (4.57*#)	.26 (8.06*#)	.39 (7.19*#)	.31 (7.73*#)
BDI	16	26	15 (5.43*#)	2 (11.85*#)	5 (10.37*#)	3 (11.36*#)
STAI-S	46	41	42 (-.24)	45 (-.98)	43 (-.49)	45 (-.98)
STAI-T	52	71	68 (.73)	38 (8.07*#)	44 (6.60*#)	42 (7.09*#)

<sup>a</sup> GSI: General Symptom Index of Symptom Checklist 90-Revised (SCL-90-R)

PSS-SR: Posttraumatic Stress Symptoms Self-Report

BDI: Beck Depression Inventory

STAI-S: Spielberger Anxiety Inventory – State

STAI-T: Spielberger Anxiety Inventory – Trait

<sup>b</sup> Score at or below which a client’s functioning is in the normal, non-pathological range.

<sup>c</sup> Reliable Change Index (RCI; Jacobson & Truax, 1991) values compared to intake session are in parentheses.

\*  $p < .05$ , for RCI values greater than 1.96

# “Clinically significant change” by Jacobson and Truax’s (1991) standard, i.e., a statistically significant change on a scale in which the client begins above the clinical cut-off score and has an end state at or below the clinical cut-off score, thus in the normal range of functioning.

Table 2. Caroline's SUD Hierarchy

SUD-level	Item
0	To have a beer with a good friend
20	To visit a bar the patient knows with a good friend (afternoon)
40	To visit a bar the patient barely knows with a good friend (evening)
50	To visit her best friend (B.) and the patient knows that there are unknown men at this private party
60	To propose to her friend to go together to a disco
65	To go alone in the morning to a full Cafe to have a coffee
70	To be alone with a man, when the patient has erotic feelings
80	To be in front of the disco with a girlfriend
100	To be in the disco, with many unknown men and to have momentarily lost her accompanying girlfriend

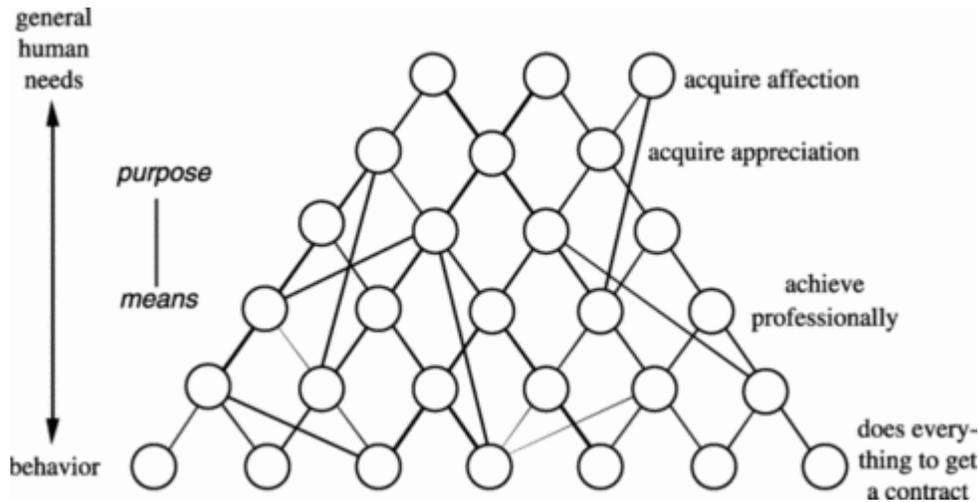


Figure 1. Schematic 2-Dimensional Representation of a Plan Structure: Nonclinical Example (reprinted from Caspar et al. (2005) by permission of *Psychotherapy Research*)

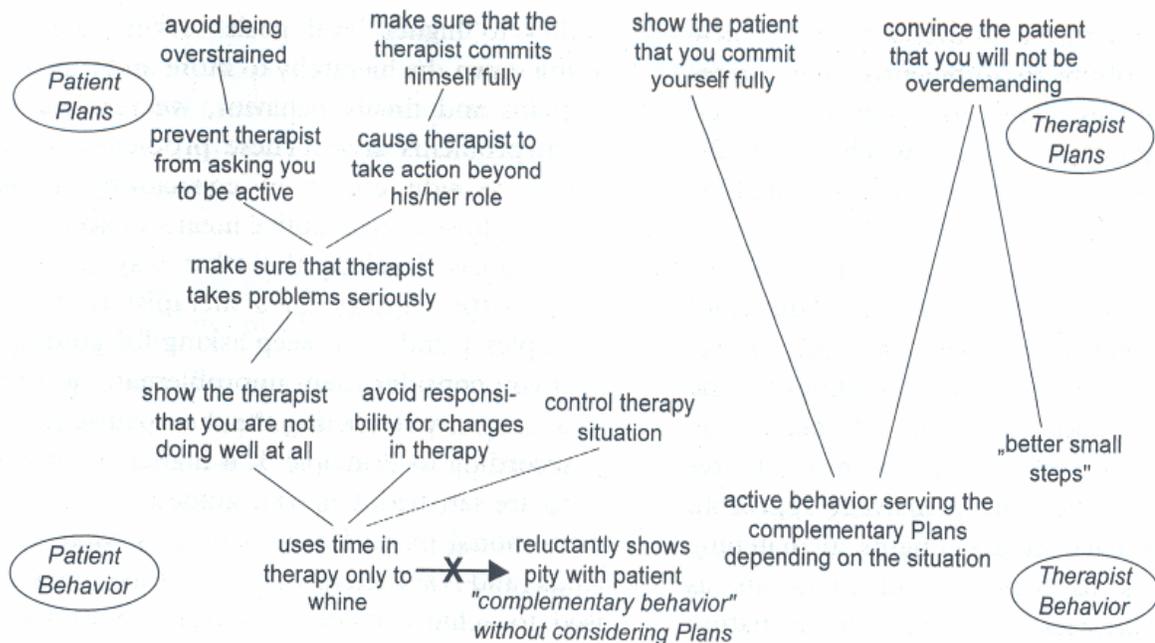


Figure 2. Complementary Therapeutic Relationship: Schema and Example (reprinted from Caspar et al. (2005) by permission of *Psychotherapy Research*)



## **APPENDIX: COMMENTARY ON THE CASE OF CAROLINE BY SUPERVISOR CLAUDE HALDIMANN-BALLI**

Editor's Note: Claude Haldimann-Balli, Lic. Phil., conducts a Psychological and Psychotherapeutic Practice at Bahnhofstrasse 7, CH-3072 Ostermundigen, Switzerland. His email is: [cn.haldimann@swissonline.ch](mailto:cn.haldimann@swissonline.ch). Mr. Haldimann-Balli is a co-founder of the Program in Cognitive-Behavioral Supervision, sponsored by the Clinical Psychology Department at the University of Zurich and the Swiss Association of Cognitive-Behavioral Therapy.

As indicated by therapist Kramer, I was consulted as supervisor three times during the course of his cognitive-behavior therapy treatment with Caroline. In addition, I received short updates on the progress of the therapy during the first year of the treatment because, at the time, Kramer participated in one of my supervision groups. In light of my thus following the complexities of this case, I am particularly impressed with Kramer's description of how the cognitive-behavior therapy of Caroline was successfully brought to a close.

Carolyn's basic attitudes and motives, roughly sketched out in the first supervision session during treatment planning as the most important foundation for a complementary therapeutic relationship, have now (see Figure 3) been integrated into a detailed Plan Analysis (Caspar, 2007). It was on the basis of these core motives that I was able to guide Kramer during the crisis with Caroline's eating problems in offering Caroline more support and connection in the therapeutic relationship so as to temporarily compensate the fears triggered by the separation from Sylvia.

After the detachment from Sylvia and the corresponding phase of stabilization and assurance, it was very important that Kramer encouraged Caroline to take active and constructive steps in her life outside of therapy. She had to confront situations that she had previously avoided due to her traumatization in the past; and in the process she adapted to a more psychologically healthy life style again. With his well-practiced motivation techniques, Kramer was able to support Caroline in crossing this Rubicon.

Another aspect of the therapy I would emphasize is how effective it was for Kramer to share with Caroline tape recordings of her therapy sessions. Just as is often pointed out in the literature (e.g., Boos 2005), this technique can help enable traumatized patients, most of whom display some form of avoidance behavior, to further face their trauma in between sessions and to support them in applying the results in their daily lives.

### References

- Boos, Anne (2005). *Cognitive behavior therapy of chronic traumatization*. Göttingen, Germany: Hogrefe.
- Caspar, F. (2007). Plan Analysis. In T. D. Eells (Ed.), *Handbook of psychotherapy case formulation* (2<sup>nd</sup> edition)(pp. 251-289). New York: Guilford Press.