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CASE STUDIES

Escape from Alcatraz: Finding Safety and Peace

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We'll call her Amy. Amy first came to see me because her previous therapist had discontinued practice after they had worked together for about six years. She was on Social Security Disability due to a chronic mental illness that had been first diagnosed at age 19, shortly after she began college. Amy had been in treatment more or less continuously in the intervening 16 years and was currently taking several psychotropic medications. She wanted continuing psychotherapy and referral to a psychiatrist for medication management. She hoped to reduce the current level of medication that she was taking as well.

Amy had recently moved back into her childhood home with her parents, who were now in their sixties. Her father had a long history of alcohol abuse and was showing progressive dementia; he soon was diagnosed with Alzheimer's disease. Amy's mother, a one-time Peace Corps volunteer, functioned as the primary bread-winner and head of the household. An accountant, mother was described as emotionally aloof and critical. Further, Amy complained that both parents favored her younger brother. She felt like she was unwanted and an inconvenience to them at times.

To complicate her situation, about two and one half years prior to our initial contact she had fallen from the roof of the house while attempting to install Christmas lights. She landed on her face on the concrete below. The fall resulted in a fractured occipital orb and required reconstructive surgery. The facial injuries had healed, but there was a possibility of a continuing organic brain syndrome secondary to the fall. Consequently, early in treatment I referred

her for a neuropsychological evaluation from a colleague.

Results of the neuropsychological exam supported my initial diagnosis of depression and PTSD. Amy's current intellectual functioning was in the high average range with a Full Scale WAIS-III score of 115. However, there was evidence of significant impairment in working memory. This was attributed to emotional interference due to her mental disorder rather than traumatic brain injury, which was tentatively ruled out. The neuropsychologist also reported that she had a history of sexual abuse and suggested that there were signs of poor relationship boundaries; he cautioned that she might be seductive. These data supported our tentative plans to work on psycho-social functioning, so we agreed to move ahead in this direction.

In considering my work with Amy I will provide an overview of her psychosocial assessment, case conceptualization, and some examples of my therapeutic approach and the process of treatment as it unfolded.

Psychosocial Assessment

Presenting Problem: Depression, hopelessness, and anxiety related to sexual abuse trauma. Amy stated that she wished to reduce her medications.

Appearance and Presentation: Very casually dressed with minimal attention to grooming and self-care. Amy had a "deer in the headlights" look about her that suggested intense vigilance and tension. She requested that the lights be turned off and kept her eyes closed or looked away most of the time. Eye contact was almost entirely absent.

Mental Status: Amy was fully oriented. She showed no apparent signs of hallucinations, delusions, or other serious cognitive distortions. Mood was markedly anxious and depressed.

History of problem/prior mental health treatment: Mental health treatment began at about 12-13 years of age, following sexual abuse by a paternal uncle. Amy experienced her first episode of severe emotional distress as a college freshman about 16 years ago. In the interim she has been hospitalized at least three

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times, including at least two serious suicidal episodes in which she took overdoses of medications. She had qualified for Social Security Disability due to her chronic mental illness. Diagnoses included Bipolar Disorder with a possibility of schizoaffective disorder, and anorexia. More recently Attention Deficit Disorder had been added. Amy reported that she had overdosed at one time, done some cutting on herself in the past, and had intentionally hit herself on the head and given herself a concussion.

Medical History: Amy fell from the roof of her house in December, two and a half years prior to our treatment, suffering significant injuries to the left side of her face that included fracture and displacement of the left occipital orb and injury to the left frontal cortex. Amy reported a history of asthma and chronic ear, nose and throat problems from early childhood. Due to ear infections, she reported, both eardrums had ruptured and she had undergone bilateral tympanoplasties. She reported loss of auditory acuity in her left ear. Bilateral bunionectomies had also been performed, and Amy has experienced problems with a knee as well.

Family and Interpersonal History: Amy's ancestry is Native American on her father's side and European American on her mother's side. Dad was reportedly a chronic alcoholic during much of her childhood, although he reportedly has discontinued alcohol abuse in the past few years. Dad apparently has worked little since Amy was about 10 years old and now has significant dementia due to Alzheimer disease. Mother has been the primary bread winner since Amy's early childhood. The family has had credit card debt problems and some domestic violence is reported between the parents. Amy also has a history of anger outbursts. She reported one episode of domestic violence with her brother and one with her former husband. Amy was married for eight years. The marriage was stormy, with several separations prior to divorce. At least some of the marital conflict was about sexual concerns.

History of Physical and Sexual Abuse: At intake Amy reported that she had been sexually abused by a paternal uncle at about 12-13 years of age. Much later I learned that there had also been domestic violence in the home, and Amy had experienced verbal abuse, rejection, and possibly some neglect.

Alcohol and Drug Use History: Amy reported some consumption of caffeinated beverages,

mostly cherry Coke. She denied use of any other substances.

Educational History: Amy reported significant academic success through High School and seemed proud of her academic accomplishments up to this point. She had withdrawn from college during her freshman year, however, following her first mental health hospitalization.

Patient's Goals: Improve mood and functioning and reduce medication.

Symptoms: At intake, symptoms included depression, anxiety, and relationship conflict with Amy's parents. She had resumed living with them when she separated from her husband. Amy reported that she was depressed, lonely, had problems with self-esteem, was restless, bored, and distractible, had lapses in attention, concentration and memory, had seasonal mood changes, lacked motivation, tended to withdraw into isolation, and had begun to have difficulties with sleep. She reported flashbacks and agoraphobia. Other concerns included eating problems, relationship problems, and anxiety related to sexual intimacy.

Diagnostic Impression:

Axis I: 300.4 Dysthymic Disorder, early onset
309.89 PTSD, chronic

296.35 Major Depression, recurrent, in partial remission (with episodic psychotic features)

307.50 Eating Disorder NOS by history
R/O 296.89 Bipolar Disorder II

Axis II: 799.9 Diagnosis deferred

Axis III: History of head injury
Asthma and chronic ear infections with bilateral ruptures of the eardrums and tympanoplasties
Bilateral bunionectomies
Problems with her left knee

Axis IV: Psychosocial Stressors

Problems with primary support group:	<i>recent divorce of abusive relationship</i>
Problems related to social environment:	<i>isolated</i>
Educational problems:	<i>college drop-out due to mental disorder</i>
Occupational problems:	<i>disabled</i>
Housing Problems:	<i>living with parents</i>
Economic problems	<i>limited funds</i>

Axis V: GAF = 53 Time Frame: current

Medications: At the time of her intake, Amy was taking seven psychotropic medications. She expressed the desire to reduce her medications or eliminate some. A psychiatric consultation was arranged. For the first few months we monitored Amy's functioning and further tested our

working hypotheses. In consultation with her psychiatrist we agreed to a trial reduction of Concerta and it was gradually phased out with no apparent harmful effects. Amy then proposed a reduction in Seroquel. It was lowered in two steps to 400 milligrams a day and she continued at that level for several months. However, during her hospitalization a decision was made to increase the Seroquel once more to 600 milligrams a day as well as to increase her Cymbalta from 60 to 80 milligrams per day. Ambien was also prescribed as a sleep aid at that time. She currently continues at those levels.

Medications at intake

Lamictal, 300 mg

Seroquel, 600 mg

Methylphenidate (Concerta),
30 + 10 mg

Cymbalta, 60 mg

Carbamazepine (Tegretol),
600 mg

Clonazepam,
.5 mg/qam, 1 mg//qhs

Benzotropine (Cogentin),
.5 mg/bid

Current

Lamictal, 200 mg/qam,
100 mg/qhs

Seroquel, 600 mg

–

Cymbalta, 80 mg

Tegretol, 200 mg/qam,
100 mg/qh

Benzotropine .5 mg/bid
Ambien, 10 mg/qhs

Case Conceptualization

My approach to case conceptualization includes a working hypothesis, five-axis DSM-IV diagnosis, problem statement, general treatment goal, interventions, objective outcomes, and consideration of assets, challenges, and religion/spirituality.

Working Hypothesis

Amy presented with a working diagnosis of Bipolar II disorder with a rule out for Schizoaffective Disorder from her prior psychiatrist. She was also taking stimulants for a presumed Attention Deficit Disorder. A review of her history led me to a somewhat different perspective. My working hypothesis was that she had experienced abuse and trauma which resulted in hyper vigilance that simulated both manic and attention problems. In addition, trauma and PTSD had resulted in chronic depression that at times became exacerbated to the point of major depression with psychotic features. My initial estimate was that her intelligence was average to high average, but that emotional interference had disrupted her cognitive functioning. A recent fall and brain injury had been superimposed on this

underlying problem and had possibly exacerbated her symptoms.

Problem Statement

For our work together I described Amy's problems simply. I stated that she had sought treatment for chronic anxiety, depression, and PTSD and relationship problems. With minor editing, these have remained the focus of treatment throughout, although the specific goals have been revised about once each six months, thus a total of five times now. While Bipolar Disorder and Schizoaffective Disorder cannot be firmly ruled out, the current symptom picture seems more consistent with depression and PTSD. PTSD can masquerade as Bipolar disorder, especially when it causes sleep difficulties.

Therapeutic Approach

My approach with Amy reflected my integrative approach to psychotherapy that has strong roots in behavioral and cognitive-behavioral psychotherapy, along with elements of object-relational and experiential approaches. In many ways my approach to therapy is similar to McMinn and Campbell's *Interpersonal Psychology* (2007), but it is also subtly different in several respects. Simply stated, my approach seeks to balance emphases on behaviors, thoughts, feelings, relationships, and worldview/meaning-making. Somewhat paralleling McMinn and Campbell (2007) I term these as *functional*, *structural*, and *relational*, plus *developmental* and *hermeneutical* levels of analysis. I view relationships as profoundly and inherently spiritual; thus relationship to God is included in this five-dimensional psychotherapy model. In some respects this approach draws on and extends the approach I have previously described as consecrated counseling (Bufford, 1997).

The Beginning

From the outset, Amy would come into my office and abruptly flip off the overhead light. If it was daytime she would put off the lamp as well. She then reclined on the love seat, removed her glasses, and at times closed her eyes. It gradually became apparent that she did these things to avoid the distraction of observing my facial expressions and postural changes. At any slight change in the volume or intonation of my voice she would respond with a sharp "What?" Gradually I came to realize that this was a part of her PTSD. She was sufficiently aware of her hyper vigilance that she sought to avoid troubling social cues from me as much as possible.

Initially, a bit put off by Amy's sharp inquiries, I would ponder silently, and then respond with a "good enough" account of what was going on for me. I might identify the bits of information she had reported that I was pondering, tell her I was considering how to ask my next question, or report the relationship I had just noted. These mostly matter-of-fact responses seemed to enable her to gradually relax in my presence.

We began to work on several fronts, more or less simultaneously and interchangeably. Among these were increasing her emotional regulation, behavioral self-control, and social skills. We also worked on improving her relationships with her parents, her brother, her former husband, and another male friend with whom she developed a romantic interest. I also sought to address her history of abuse and trauma, and to explore her cognitive functioning further with the aim of discovering whether she might be able to recover some of her lost cognitive capabilities.

Unusual Behaviors

Beginning with her earliest sessions, a number of unusual behaviors were noted in addition to Amy's putting off the lights, as noted above. Amy was very observant of the details of my office. She often asked rather blunt questions about them. For example, she asked when I was going to replace or repair a defective lamp. Because my office is shared, occasionally she would discover objects left by other counselors or their clients and ask about them. Usually I responded matter-of-factly, and removed the object.

One day Amy found a marble, presumably left by a child client. "Where did this come from?" she asked. Consistent with my pattern, I began to tell her that someone else had left it there. In the middle of my response she tossed it at me, narrowly missing my face. I informed her "that was not acceptable behavior" and we continued with our conversation. About six weeks later she inquired what had happened to the marble. I told her it likely was still where she had thrown it, and located it under my desk. I deposited it in a drawer and we continued on with the day's topic. Several weeks later she once again inquired about the marble; I confirmed that it was still in my drawer. The topic has not arisen since at her initiative.

On another occasion we were discussing the need for Amy to become better at respecting social boundaries. As part of the conversation we talked about things I had observed in our times together and how I had responded to them, most-

ly by ignoring them. The marble episode was again discussed. At the time Amy was sitting on top of my two-drawer file cabinet, as she had done a half dozen times in the past few months as she gradually became more comfortable in my presence. She hypothesized that most of my clients did not sit on the file cabinet, and I confirmed her hypothesis.

Sometime in the second year of our work together, early in the day's session, Amy pulled out her camera phone and asked me if she could take my picture. My initial impulse was to just say no. Mind racing, I weighed the pros and cons. I suddenly remembered that she was aware of my affiliation with George Fox University and had clearly visited the GFU web-site on a prior occasion. I also remembered that my photograph was posted there. I quickly concluded that she could readily obtain a photograph of me whether or not I gave her my permission. Though the request felt a bit like a boundary crossing on her part, I concluded that there was likely to be little tangible harm in saying yes, and little benefit in saying no. I agreed. Recently we had occasion to refer to this event again and Amy confirmed that the photograph is a transitional object for her. This conversation further confirmed my hypothesis that she had developed a significant degree of father transference toward me. Perhaps not coincidentally, I am about her parent's age.

Family

In referring to her father, Amy consistently used his first name. When I referred to him as her father she informed that she had ceased to think of him as a father around fourth grade. By her report he had seldom worked since then and was often drunk.

As signs of dementia progressed for her father and family conflicts about his behavior increased, Amy urged her mother to seek counseling for them regarding dealing with him. They found a counselor and all three often went together initially. Gradually her father ceased to participate and Amy and her mother saw the counselor together. Amy began to complain about these sessions; she said that her mother and the counselor tended to gang up on and criticize her. I talked with the counselor on a couple of occasions with her permission and gained the same impression. We explored ways that Amy might deal with this. Eventually she chose to discontinue participation, though she encouraged her mother to continue. Mom soon quit as well.

Amy and I continued to work together on improving her relationship with both parents, especially her mother because of her father's dementia. Amy invited her mother to participate in a few sessions with us. We used these to identify concerns her mother had about things like clutter about the home, Amy's eating, neglect of responsibilities around the house, and problems in caring for her father. These provided insight into their relationship and enabled me to work more effectively in assisting Amy to develop skill in dealing with her mother.

Though I cannot identify all the crucial elements that contributed, her relationship with her mother gradually improved. They began to take walks together regularly on Sundays before her recent move to campus housing at her new college. Now that they are apart, Amy reports that they talk by phone two or three times daily. It appears that Amy has become a primary social contact for her mother and their relationship has become much more satisfying to both of them.

Abuse History

I made several attempts to further explore the childhood sexual abuse and reported flashbacks. Each time Amy asked if we could change the subject or stated that she did not want to talk about it any more. Since one of my treatment goals was to affirm her decision-making and encourage her to set boundaries in socially appropriate ways, I acceded to these requests.

About the fourth or fifth time Amy declined to talk about abuse I decided to focus on something else. We began to examine ways that she had been affected by the abuse and seek to remedy them insofar as was possible. This led to our work on social skills, an area in which Amy was at that point clearly underdeveloped.

About a month or two after the above change in directions, Amy entered my office one day and thrust a handful of pages at me. She told me to read them. What I found was 15 or so pages in large pencil writing that chronicled her abuse history from her earliest childhood memories up to the recent past. The chronicle began with an account of Amy cowering in the closet in terror while her father ranted in the hall. He apparently was drunk. He called her a misbegotten she-devil. Further discussion suggested that this was a common theme in his angry outbursts at her.

As I digested her hand-written notes, it became apparent that the sexual abuse around

12 years old was merely a vivid event in a much longer saga. Amy felt invalidated and devalued by her family. Her brother, though younger, was blatantly preferred by both parents in her judgment. Throughout childhood he had been more privileged than she. The family counselor had echoed this perception back to Amy: her brother was the "crown prince," she the "ugly step-sister."

At his request, Amy's brother visited with me during one of her sessions that occurred while he was in town. He wanted to know how she was going to be able to make it through life with her (to him obvious) disabilities. It also became apparent that he wanted little to do with her and considered her dangerous. In part he referred to a physical brawl between them that had occurred around the time of her first hospitalization—over 16 years ago. By her account, her brother had blackened both her eyes in that fight. Still, the violence between Amy and her husband lent some credence to her brother's concerns that she was "dangerous."

Return to School

After reviewing the results of Amy's neuropsychological evaluation, I decided to explore her ability to remember things she read. Results of the neuropsychological evaluation had suggested that her working memory was at that time about three standard deviations below her general intellectual functioning. Emotional interference was the suggested cause. I encouraged her to read and to watch the news. We began for a time to talk about what she remembered. On a couple of occasions she asked me why I wanted her to take an interest in the news. Once she got the idea that it was to exercise her memory she proposed to begin reading books and promptly began doing so.

Several months later Amy began to talk about her wish to return to college. We discussed it and agreed she might make a trial of taking a course or two. She began at the community college with a psychology course and a music class. She requested and got adaptive accommodations due to her disability and the neuropsychological report. She succeeded!

For the next two quarters Amy added slightly to her schedule and continued to take classes. It was stressful, and she was uncomfortable practicing her music at home while her parents were present. Distractibility continued to be a problem. However, winter quarter went well.

Crisis

About the middle of the spring quarter, several events converged to cause a crisis. First, it had been a month or so prior to this time that Amy had delivered her notes about her memories of childhood trauma. Remembering the trauma, living with her parents, academic challenges, falling behind in her school work, unexpected contact with her abuser-uncle, daily rehearsals for a solo musical performance of the Bohemian Rhapsody (a suicidal ode), and the growing realization that she had reached an impasse with her brother in the spring of this year combined to produce a suicidal crisis. These parts I knew at the time, but likely underestimated. Only later, did I fully realize that yet another stressor at this time was a deteriorating relationship with the choral director with whom she was working at the college.

Amy had met with her counselor at the college and was so despondent that it just slipped out—she was seriously contemplating suicide. Together they called me and I was able to fit her into a vacant hour at the end of the day. She said that she had been hoping to contain the secret until she was able to see me. “I knew you could handle it,” she declared, voicing more confidence in me than I felt at the time.

The school counselor stayed with Amy until I met her in the waiting room. For about an hour I did my best to help her resolve her despair. It was to no avail. We called her mother to come and transport her to the Emergency Room. I called the ER and informed the attending personnel that she was coming and briefed them on her history and crisis. She was admitted and remained for 14 days. She was released to meet with me again on the fourteenth day. With the intensive work done at the hospital, increases in a couple of her medications, and follow-up with me, Amy was able to resume her classes. She made up missed work, and achieved a B+ gpa for the quarter. She was both disappointed and relieved.

Soon after the suicidal episode Amy informed me that she had decided to seek transfer to a private college for the fall semester rather than wait an additional year as she had previously proposed. She worked diligently to complete admission, submit financial aid applications, and request support from her family. Initially the obstacles seemed insurmountable, at least to me. She was admitted. In the end the finances came together and Amy made the move.

One of the recommendations from her hospital stay was that Amy seek another residence to

reduce the stresses related to living with her family, especially her father. We began work on planning this, but we shelved the project temporarily while she sought to change colleges. In the end, she moved to college housing.

Assets and Strengths

Perhaps Amy's biggest asset is her own persistence and determination to make a better life for herself. A surprise for Amy was the degree of support that she has received from her classmates and friends. Several visited her while she was in the hospital. They have also helped her to become more resourceful in dealing with anxiety and PTSD.

Challenges and Obstacles

Amy continues to face a number of challenges. First, her mental illness has been chronic. In my judgment her depression and PTSD probably extend back to her early childhood. She also has the complications related to her head injury. These include a permanent displacement of her left eye, and some degree of cognitive impairment from the trauma that she describes, I believe accurately, as dyslexia; she states that it was not present prior to the injury. Her relationship with her family of origin continues to be fragile and difficult at times although much improved.

Religion and Spirituality

A Catholic, Amy's involvement in the church has been both an asset and a challenge. At times she talked about her distress with the priest who headed her local parish. The choir was one of her most important support systems. Many of the people have known her for years and are among her most important supporters. Her religious faith has also been a source of hope in the midst of the challenges she has faced in the past couple years. However, conflict with the parish priest was at times a source of distress for Amy; she was relieved when he left the parish a few months ago.

Concluding Thoughts

In the past two and one half years Amy has come a long ways. Amy has successfully returned to college after dropping out over fifteen years earlier. She also made the initial transition to her new college. She reports that each hour still brings new challenges. It is possible that her present success is just a “good” period in an otherwise dismal life. However, I am optimistic that significant and perhaps lasting gains have been made.

As I reflect on Amy's progress I find it a challenge to explain it and to have an appropriate perspective on my role. Amy has said on more than one occasion "you're the best." I delight to hear these words, but also need to keep them in perspective. I am reminded that my role is that of a steward. In the spirit of consecrated counseling, I use the knowledge and skills that I have to the best of my ability and leave the outcome to God.

Several threads have contributed to Amy's progress. Among these are the family counseling that was received with her parents, the support of her friends and members of the choir at her church, guidance by her academic counselors, her psychiatrist/medication manager, the staff at the hospital, and Amy's faith in God.

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