‘‘I Want to Punish Him’’: A Case Study of Systemic Family Therapy in Zimbabwe

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Abstract

This case study presents the therapy journey of a 26-year-old Zimbabwean woman with self-diagnosed post-traumatic stress disorder (PTSD) rooted in childhood exposure to domestic violence. Clinical assessment using the PTSD Checklist for DSM-5 (PCL-5) and the Beck Depression Inventory-II (BDI-II) confirmed symptoms of trauma, depression, and suicidal ideation. The client’s unresolved emotional pain was compounded by substance use, academic failure abroad, unemployment, and estrangement from her abusive father. Therapy employed an integrative systemic approach drawing on family therapy, narrative trauma processing, and culturally sensitive adaptations such as a no-harm contract tailored to Zimbabwean realities. Collaboration with psychiatric services ensured medication support and risk management. The therapy explored maternal triangulation, intergenerational patterns of vilification, and cultural attributions of witchcraft within the family. This paper highlights how a contextualised family systems therapy, grounded in systemic thinking and supported by multidisciplinary input, can foster healing in clients with complex trauma, especially in African cultural settings.

Keywords: PTSD, family therapy, triangulation, Zimbabwe, no-harm contract

Case Context and Method

The therapy was done at a counselling clinic in Harare, Zimbabwe. The client was referred by a family friend after expressing patricidal ideation towards her estranged father. The presenting issues were complex, deeply rooted in family trauma, and compounded by socioeconomic challenges. A systems thinking approach was employed, informed by contextual family therapy that acknowledge the importance of culture, power, and narrative in therapeutic work. The client gave full consent to participate in therapy and for her anonymised story to be used in academic writing. A collaborative approach to treatment, safety planning, and confidentiality were among the ethical procedures that were followed. Clear documentation of risk levels and interventions was included in the no-harm contract, which was created and evaluated on a regular basis. The duty of care and confidentiality were carefully weighed, especially when the

client made it clear that she intended to hurt her father. In order to guarantee cultural competency and ethical clarity, supervision was sought. A multidisciplinary strategy was used, which included psychiatric assessment for trauma-related distress and depression symptoms. Over the course of four months, weekly therapy sessions were conducted. Because of its applicability to current issues in Zimbabwean mental health care such as violence, triangulated family structures, intergenerational trauma, suicidal and homicidal thoughts, and the relationship between culture and mental health, this case was chosen for publishing. To improve contextual understanding, visual components (genogram and family dynamics diagrams) and chosen client quotes are included

Client Demographic Information

Table 1*: Client demographic information*

Name	Tapiwa Jacks*
Gender	Female
Date of Birth	15/03/1998
Date of Initial Session	17/09/2024
Nationality	Zimbabwean
Marital Status	Single
Occupation	Unemployed
Academic Level	Advanced Level

Tapiwa Jacks*(Pseudonym)

Case Summary

Tapiwa, a 26-year-old Zimbabwean woman, sought therapy after expressing a detailed plan to harm her estranged father. She presented with symptoms of post-traumatic stress disorder (PTSD), chronic depression, and unresolved grief. Growing up in one of the high-density suburbs of Harare, Tapiwa witnessed her father's frequent and brutal abuse of her mother, leading to deep-seated feelings of anger, betrayal, and helplessness. Her father's intermittent presence and aggression, coupled with her mother's emotional reliance on her as a confidante, blurred familial boundaries and intensified her psychological distress. Those early experiences fostered a profound resentment towards both parents and contributed to the mental health challenges she was facing when she sought therapy.

Tapiwa’s attempt to escape her traumatic past by studying in Europe was ruined by financial constraints, leading to substance abuse and a premature return to Zimbabwe. Back home, she faced unemployment, familial conflict, and a sense of alienation. Her relationship with her elder sister was strained, marked by hostility and mistrust, as she perceived her sister to be

dismissive of her suffering and aligned with their father. This belief was reinforced by her mother who alleged that her father had "bewitched" the family. This added a spiritual dimension to her trauma, and further portrayed her father as malevolent and dangerous. These compounded factors necessitated urgent psychiatric intervention due to her expressed intent to harm her father.

In therapy, Tapiwa exhibited a flat affect, episodes of dissociation, and emotional flooding, oscillating between hopelessness and rage. Despite these challenges, she demonstrated articulateness and insight into the impact of her childhood experiences on her current state. Her engagement in therapy was consistent and; over time, she developed trust in the therapeutic relationship. Initially, her desire to "heal" was intertwined with a need for revenge, but her openness to therapy indicated a potential shift towards processing her trauma and seeking genuine recovery.

Assessment of the Client's Problems, Goals, Strengths, and History

Tapiwa (pseudonym), a 26-year-old Zimbabwean woman, presented with symptoms of PTSD and depression, confirmed by the PTSD Checklist for DSM-5 (PCL-5) and the Beck Depression Inventory-II (Blevins et al., 2015; Beck et al., 1996). Her difficulties were rooted in childhood exposure to domestic violence, emotional neglect, and intergenerational trauma (Freyd, 1996). Raised in an enmeshed family system, she was parented by her overwhelmed mother, who was burdened with adult emotional responsibilities (Minuchin, 1974). Cultural beliefs about witchcraft framed her father as spiritually dangerous, reinforcing her traumatic narrative (Chavunduka, 1999).

During her time in Europe, cultural isolation and academic struggles led to substance abuse, reflecting the self-medication hypothesis (Khantzian, 1997). Upon returning to Zimbabwe, Tapiwa faced chronic unemployment and emotional isolation. Notably, she disclosed patricidal thoughts toward her father and such thoughts were interpreted systemically as expressions of disempowerment and unresolved grief (Maguen & Litz, 2012). A safety plan, adapted to Zimbabwean communal values, was co-created (Mpofu, 2011).

Therapy addressed complex family dynamics, including triangulation, blurred boundaries, and loyalty binds (Bowen, 1978). Broader socio-cultural stressors, such as patriarchal norms, economic dependency, and limited mental health access, compounded her struggles

(Mupedziswa, 2001). The therapeutic goal focused on restoring her autonomy, creating emotional safety, and supporting trauma recovery within her cultural context.

Therapeutic Goals

The therapy offered to Tapiwa combined family systems, narrative, and trauma-informed approaches, addressing both her symptoms and relational patterns. Initial goals focused on stabilising PTSD symptoms through grounding techniques, psychoeducation, and trauma narrative work (van der Kolk, 2014). The "window of tolerance" framework supported emotional regulation (Siegel, 1999), while dialectical behaviour therapy (DBT) skills and family role exploration helped replace substance use with healthier coping (Linehan, 1993).

Given her patricidal thoughts, the therapy prioritised a culturally respectful safety plan and provided space to process rage and betrayal. These thoughts were reframed as signs of unresolved family power dynamics and moral injury, encouraging reflection on loyalty, gender roles, and intergenerational silencing.

Emotional and economic differentiation was promoted through boundary-setting and vocational goals, balancing family duty with personal autonomy (Nichols, 2013). Finally, narrative therapy (White & Epston, 1990) and internal family systems work (Schwartz, 2001) supported the reconstruction of a coherent self-narrative. Through this, Tapiwa externalised shame, found meaning in her suffering, and re-authored her life story with resilience and agency.

Strengths and Resources

Despite her challenges, Tapiwa brought considerable strengths to the therapeutic space. Her intellectual capacity and reflective insight supported deep engagement during therapy. She showed high emotional intelligence, and was able to articulate complex feelings and family dynamics with clarity. Her spiritual and cultural openness enabled meaningful dialogue around beliefs in witchcraft, ancestors, and generational curses, creating a space for cultural integration rather than conflict.

Tapiwa's emerging self-efficacy was visible in her increased assertiveness, commitment to therapy, and ability to act on insights. These strengths served as leverage points for transformation and sustained healing. Her willingness to explore difficult truths, challenge internalised family roles, and embrace change suggested a readiness for long-term growth.

Formulation and Treatment Plan

Formulation (using the 4Ps model)

Tapiwa's distress is best understood through a systemic and trauma-informed lens, drawing on structural family therapy (Minuchin, 1974), narrative therapy (White & Epston, 1990), and trauma theory (van der Kolk, 2014). This integrative approach aligns with this research emphasising multi-theoretical formulation in complex trauma cases (Wolpert et al., 2023).

Predisposing factors

- Exposure to chronic domestic violence and emotional neglect during formative years disrupted Tapiwa's attachment patterns and sense of safety (Briere & Scott, 2015).
- Parentification and enmeshment, particularly with her mother, led to role confusion and psychological burden, placing her in a pseudo-adult position within the family (Hooper et al., 2022).
- Cultural beliefs about witchcraft and ancestral harm contributed to chronic fear and symbolic representations of evil in her family system (Chavunduka, 1999; Musindo & Mhembere, 2021).

Precipitating factors

- Academic failure and cultural isolation while abroad heightened her sense of shame and abandonment.
- The return to Zimbabwe and unemployment reactivated feelings of worthlessness and helplessness.
- Recurrent contact with family, especially her father, and an emotionally dependent mother, exacerbated trauma symptoms and triggered patricidal ideation as a symbolic cry for justice and agency (Maguen & Litz, 2012).

Perpetuating factors

- Triangulation and blurred generational boundaries maintained emotional confusion and guilt (Bowen, 1978).
- Substance abuse (alcohol and cannabis) functioned as a maladaptive coping strategy, sustaining emotional numbing and avoidance (Khantzian, 1997).
- Silence around family trauma, sibling rivalry, and lack of differentiated roles further entrenched dysfunction and isolation.

Protective factors

- High intellectual insight, verbal expression, and motivation for change.
- Therapeutic alliance, cultural openness, and increasing self-efficacy emerged as key assets during therapy (Norcross & Lambert, 2019).
- Willingness to explore emotional, relational, and cultural material allowed for integrative intervention.

Theoretical Frameworks Used

1) **Structural family therapy (SFT):** To address systemic patterns of enmeshment, triangulation, and generational boundary violations (Minuchin, 1974; Nichols, 2022).
2) **Narrative therapy:** To help Tapiwa externalise her trauma, reconstruct her identity, and shift from a passive to an empowered self-narrative (White & Epston, 1990; Batrouney, 2019).
3) **Trauma-informed care:** Recognising the neurobiological and relational impacts of early trauma and grounding therapy in safety, regulation, and empowerment (van der Kolk, 2014; Substance Abuse and Mental Health Services Administration [SAMHSA], 2023)

Treatment Plan

Safety and risk management

Due to Tapiwa's patricidal thoughts, a culturally adapted no-harm contract was co-created, emphasising shared responsibility and family safety (Mpofu, 2011). Psychiatric support included SSRI treatment and regular risk monitoring, with interdisciplinary collaboration ensuring continuity of care (National Institute for Health and Care Excellence [NICE], 2023).

Family systems work

Using structural family therapy (Minuchin, 1974), the therapist helped clarify family roles through psychoeducation, genograms, and family sculpting. A joint session with Tapiwa's mother gently explored boundaries, respecting cultural hierarchies and family honour (Tew, 2022).

Narrative and trauma work

Narrative techniques helped Tapiwa externalise her trauma, naming it, "The Shadow", to reduce shame (White & Epston, 1990). Letter-writing and re-authoring conversations helped

her shift from a story of victimhood to one of survival (Denborough, 2021). Trauma processing was paced within her "window of tolerance" (Siegel, 2020), using mindfulness, grounding, and parts work (Schwartz & Sweezy, 2020).

Cultural and economic empowerment

Tapiwa's spiritual beliefs about witchcraft were explored respectfully, helping her reframe these as symbolic of her pain, not pathology (Makhubele & Matlakala, 2022). Social work input supported vocational goals, promoting financial independence and reducing family enmeshment.

Course of the Therapy

Therapy with Tapiwa took place over 14 sessions across five months, using family therapy, narrative, and trauma-informed approaches. The work followed three practical phases: stabilization, family and story work, and healing and moving forward. Cultural values of respect (*rukudzo*), family duty (*mhuri*), and spirituality were respected throughout.

Phase 1: Stabilising and building trust (Sessions 1–4)

The priority was to create a safe and trusting space where Tapiwa could open up about her pain. She shared feelings of deep anger, sadness, and thoughts of harming her father. A no-harm agreement (*chibvumirano chekusarwadzisa vamwe kana iwe pachako*) was created, that is, a culturally adapted tool used in Zimbabwe to help people reflect on their responsibilities toward family and community safety (Mpofu, 2011). She also received medication support from a psychiatrist.

The therapist used simple explanations about trauma, helping Tapiwa understand her symptoms as normal reactions to past hurt, not signs of weakness. This phase also helped her see her sleeping patterns as emotional avoidance, not laziness.

Phase 2: Family and story work (Sessions 5–11)

This was the focal point of therapy. The therapist worked with Tapiwa to map out family relationships using a genogram, showing patterns of pain, silence, and role confusion over generations. Together, they explored how Tapiwa was caught between protecting her mother and hating her father: a common struggle in families where domestic violence has occurred (Minuchin, 1974).

Through narrative therapy, Tapiwa named her trauma "The Shadow," helping her externalise the pain. Writing letters (without sending them) helped her express deep feelings of anger and sadness toward her father. She also began imagining a new life story as a survivor with purpose, not just a victim. Vocational interests (e.g., enrolling in a short skills course) were supported, involving informal help from a local social worker.

Phase 3: Healing and moving forward (Sessions 12–14)

The final sessions focused on strengthening Tapiwa's progress. The sessions focused on reviewing what she had learned and further practised strategies like journaling and mindfulness, which helped her manage difficult emotions. Tapiwa reported fewer nightmares and less anger.

Tapiwa wrote a symbolic goodbye letter to "The Shadow", marking closure with her trauma. A brief family-focused session helped her begin repairing the relationship with her younger sibling. Throughout the sessions, her cultural and spiritual beliefs were respected and gently reframed for healing (Makhubele & Matlakala, 2022).

Therapy Outcomes and Reflections

Tapiwa's story demonstrates how systemic family therapy can be powerful even when not all family members are present. Though life challenges remain (e.g., financial struggles), she developed:

- Fewer PTSD symptoms and disturbing thoughts,
- A shift away from harmful thoughts,
- Better emotional control,
- Hope and new life goals.

This case illustrates that family-informed and trauma-sensitive approaches that respect Zimbabwean culture can help people reclaim their dignity and heal from deep family wounds.

Recommendations

i. **Enhance trauma-informed training for therapists in Zimbabwe:** Therapists should receive specialised training in trauma-informed care, including risk management for homicidal and suicidal ideation (SAMHSA, 2023).

ii. **Promote systemic and culturally competent family therapy models:** Systemic family therapy should be adapted for Zimbabwean socio-cultural contexts, addressing triangulation, generational role reversal, and patriarchal systems (Tew, 2022).

iii. **Integration with psychiatric services:** Therapists and psychiatrists should collaborate closely in complex trauma cases to improve safety and treatment outcomes (NICE, 2023).

iv. **Strengthen access to support services for women affected by domestic violence:** Policy reforms and community initiatives are urgently needed to provide protection, psychosocial services, and economic empowerment for women and children facing gender-based violence.

v. **Explore group therapy and peer support models:** Following individual therapy, survivors may benefit from peer support and group therapy to process shared experiences of trauma and healing.

vi. **Conduct further research on family therapy in African contexts:** More case studies and empirical research are needed to document culturally adapted family therapy practices in Africa, thereby enriching local mental health models.

References

Batrouney, T. (2019). *Narrative therapy in action: The power of stories in clinical practice*. Routledge. https://doi.org/10.4324/9780429024934.

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Manual for the Beck Depression Inventory-II*. Psychological Corporation.

Blevins, C. A., Weathers, F. W., Davis, M. T., Witte, T. K., & Domino, J. L. (2015). The Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5): Development and initial psychometric evaluation. *Journal of Traumatic Stress*, *28*(6), 489–498. https://doi.org/10.1002/jts.22059

Bowen, M. (1978). *Family therapy in clinical practice*. Jason Aronson.

Briere, J., & Scott, C. (2015). *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment* (2nd ed.). SAGE.

Chavunduka, G. L. (1999). *Traditional medicine in modern Zimbabwe*. University of Zimbabwe Publications.

Courtois, C. A., & Ford, J. D. (2020). *Treating complex traumatic stress disorders: Scientific foundations and therapeutic models* (2nd ed.). Guilford Press.

Denborough, D. (2021). *Retelling the stories of our lives: Everyday narrative therapy to draw inspiration and transform experience*. Norton.

Evans, J., & Parry, S. (2022). Systemic and trauma-informed practice: Integrating frameworks for complex cases. *Journal of Family Therapy*, *44*(1), 112–130. https://doi.org/10.1111/1467-6427.12345

Freyd, J. J. (1996). *Betrayal trauma: The logic of forgetting childhood abuse*. Harvard University Press.

Hooper, L. M., Doehler, K., Jankowski, P. J., & Tomek, S. (2022). Parentification, mental health, and resilience: A meta-analytic review. *Journal of Child and Family Studies, 31*(2), 405–421. https://doi.org/10.1007/s10826-021-02158-0

Khantzian, E. J. (1997). The self-medication hypothesis of substance use disorders: A reconsideration and recent applications. *Harvard Review of Psychiatry*, *4*(5), 231–244. https://doi.org/10.3109/10673229709030550

Maguen, S., & Litz, B. T. (2012). Moral injury in veterans of war. *PTSD Research Quarterly*, *23*(1), 1–6.

Makhubele, J., & Matlakala, F. K. (2022). African spirituality and mental health: Integrative approaches for helping professions. *African Journal of Social Work, 12*(1), 13–24.

Minuchin, S. (1974). *Families and family therapy*. Harvard University Press.

Mpofu, E. (2011). Counseling people of African ancestry. In E. Mpofu (Ed.), *Counseling people of African ancestry: A cultural perspective* (pp. 3–24). Cambridge University Press.

Musindo, B., & Mhembere, W. (2021). Witchcraft beliefs and mental health in Zimbabwe: A qualitative exploration. *African Journal of Social Work, 11*(1), 50–60.

Mupedziswa, R. (2001). The challenges of social work training in Africa: Towards indigenization. *International Social Work, 44*(3), 285–297. https://doi.org/10.1177/002087280104400303.

National Institute for Health and Care Excellence. (2023). *Depression in adults: Treatment and management (NICE Guideline NG222)*. https://www.nice.org.uk/guidance/ng222.

Nichols, M. P. (2013). *Family therapy: Concepts and methods* (10th ed.). Pearson.

Nichols, M. P. (2022). *Family therapy: Concepts and methods* (12th ed.). Pearson.

Norcross, J. C., & Lambert, M. J. (2019). Psychotherapy relationships that work III. *Psychotherapy, 56*(4), 423–430. https://doi.org/10.1037/pst0000233.

SAMHSA. (2023). *Trauma-informed care in behavioral health services* (Treatment Improvement Protocol Series 57). U.S. Department of Health and Human Services. https://www.samhsa.gov/

Schwartz, R. C. (2001). *Introduction to the Internal Family Systems Model*. Trailheads Publications.

Schwartz, R. C., & Sweezy, M. (2020). *Internal family systems therapy* (2nd ed.). Guilford Press.

Siegel, D. J. (1999). *The developing mind: How relationships and the brain interact to shape who we are*. Guilford Press.

Siegel, D. J. (2020). *The developing mind: How relationships and the brain interact to shape who we are* (3rd ed.). Guilford Press.

Tew, J. (2022). *Social approaches to mental distress*. Red Globe Press.

Van der Kolk, B. A. (2014). *The body keeps the score: Brain, mind, and body in the healing of trauma*. Viking.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. Norton.

Wolpert, M., Pote, H., Seal, K., Fleming, I., & Hill, C. (2023). Developing multi-theoretical formulations in trauma-focused therapy: A guide for practitioners. *Clinical Child Psychology and Psychiatry, 28*(1), 24–39. https://doi.org/10.1177/13591045221120257.

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Tawanda Karise is a registered Systemic Family Counsellor affiliated with Connect – Zimbabwe Institute of Systemic Therapy. He holds a Bachelor of Arts in Philosophy from Arrupe Jesuit University and a Diploma in Systemic Family Counselling. He is currently pursuing further training in advanced family therapy. Tawanda works with individuals, couples, and families, helping them navigate relational and emotional challenges. His background in philosophy informs his reflective and thoughtful approach to therapy. He has an interest in exploring intergenerational patterns and the role of belief systems in shaping family life and mental wellbeing.