

Treating Complex Trauma: Relational Healing for Relational Injury

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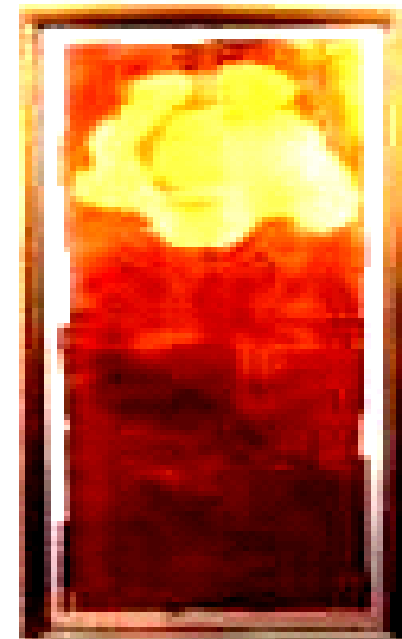


HEALING THE
INCEST WOUND

SECOND EDITION

ADULT SURVIVORS IN THERAPY

CHRISTINE A. COURTOIS



HEALING THE

And Survivors in Therapy

INCEST WOUND

CHRISTINE A. COURTOIS



Treating Complex Traumatic Stress Disorders

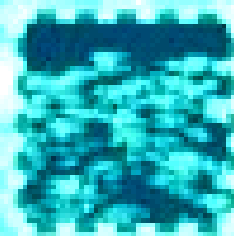
An Evidence-Based Guide

Christine A. Courtois
Julian D. Ford

Recollections

— of —

Sexual Abuse



TREATMENT PRINCIPLES
and
GUIDELINES

Christine A. Courtois

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Relational Approaches to Healing Attachment-Based Complex Trauma

- I. Introduction: Complex Trauma, CPTSD/DESNOS, and Dissociation
 - ▼ types of traumatic stressors
 - ▼ criteria of diagnostic conceptualizations
 - ▼ co-morbidity
 - ▼ distinction from/resemblance to BPD
 - ▼ inclusion of dissociation

Relational Approaches to Healing Attachment-Based Complex Trauma

- II. Treatment: The Clinical Consensus/Evidence-Based Meta-Model
 - ▼ The (evolving) standard of care
 - ▼ Philosophy, principles and goals of practice
 - ▼ General structure and sequence
 - ▼ Integrated, multimodal and individualized
 - ▼ Attachment/relationship issues
 - relationship as BOTH container and catalyst
 - learning laboratory for other relationships
 - “earned security” of attachment

Relational Approaches to Healing Attachment-Based Complex Trauma

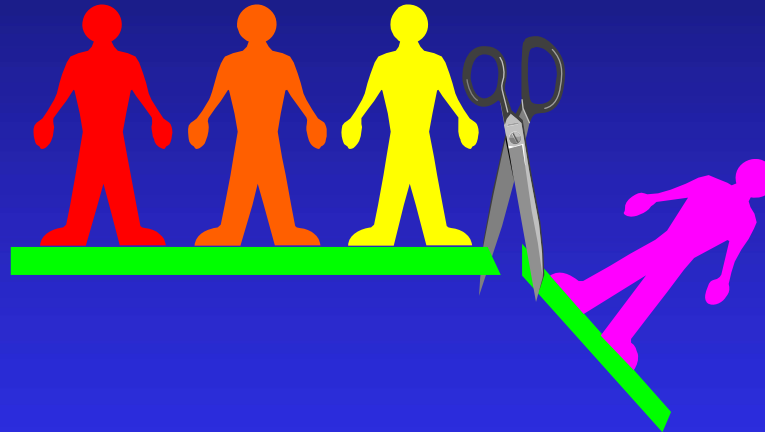
● III. Relational Issues

- ▼ The self of the therapist
- ▼ Relational approach: RICH model
- ▼ Treatment relationship defined and delimited
- ▼ Boundary issues
- ▼ Attachment-based understanding & approaches
- ▼ Use of relationship to understand the client
- ▼ VT
- ▼ Therapist self-care, support, & consultation

Interpersonal Trauma:

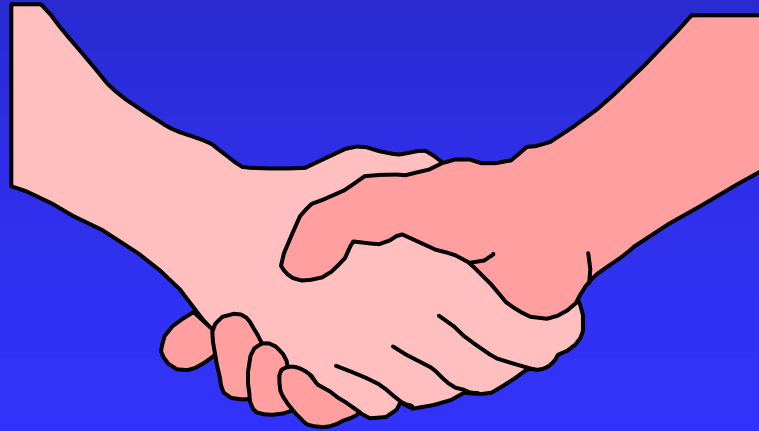
“A break in the human lifeline”

Robert Lifton



Self and interpersonal effects
brought to treatment

Relational Healing for Interpersonal Attachment (Relational) Trauma



Trauma Defined

“...the *unique individual experience*, associated with an event or enduring conditions, in which the individual’s ability to integrate affective experience is overwhelmed or the individual experiences a threat to life or bodily integrity...”

(Pearlman & Saakvitne, 1990)

Trauma Defined

- “An experience of **unbearable affect**”

(Krystal, 1978)

- “The sudden uncontrollable loss of **affiliative bonds.**”

(Lindemann, 1944)

Types of Traumatic *Stressors*

Emotional Trauma

“It is the essence of emotional trauma that it shatters...absolutisms, a catastrophic loss of innocence that permanently alters one’s sense of being-in-the-world.”

(Heidegger, quoted in Stolorow, 2007)

Types of Traumatic *Stressors*

● Attachment/Relational Trauma

- ▼ occurs in attachment relationships with primary caregivers
 - insecurity of response and availability
 - mis-attunement, non-response
 - lack of caring and reflection of self-worth
 - caregiver as the source of *both* fear and comfort
- ▼ includes DV and child abuse of all types
 - often “on top of”/in context of attachment insecurity
 - neglect, abandonment, non-protection, non-response, sexual and physical abuse and violence, verbal assault

Types of *Traumatic Stressors*

● Relational trauma

- ▼ disruptions in the sense of safety, security, loyalty, and trust that may block connections and communication in the family of origin and that extend to other relationships

● Betrayal trauma

- ▼ involves betrayal of a role or relationship

● Second injury

- ▼ involves lack of assistance and/or insensitivity on the part of those who are supposed to help or intervene

Types of Traumatic *Stressors*

● Developmental Trauma

- ▼ “originates within a formative inter-subjective context whose central feature is mal-attunement to painful affect--a breakdown of the child-caregiver system of mutual regulation”
- ▼ It cannot be overemphasized that **injurious childhood experiences in and of themselves need not be traumatic** (or at least not lastingly so) or pathogenic, provided that they occur within a responsive milieu. ***Pain is not pathology.*** It is the *absence of adequate attunement and responsiveness to the child’s painful emotional reaction* that renders them *unendurable and thus a source of traumatic states and psychopathology.*

Stolorow, 2007

Types of Traumatic *Stressors*

● Complex Trauma

- ▼ Attachment/relational/developmental trauma &/or
- ▼ Other forms of chronic trauma
 - Domestic violence
 - Community violence
 - Combat trauma: warrior or civilian, POW
 - Political trauma: refugee status, displacement, political persecution, “ethnic cleansing”
 - Slavery/forced servitude
 - Chronic illness w/ invasive treatment
 - Bullying
 - Sexual harassment
 - Other...

Types of Post-trauma *Responses*

- **Complex Developmental/Dissociative Trauma**

- ▼ Associated with chronic, pervasive, cumulative trauma **in childhood**, often on a **foundation of attachment/relational trauma**
 - insecure attachment, *especially disorganized*
 - all forms of abuse and neglect, exposure
 - severely impacts the developing child
 - neurophysiology
 - psychophysiology
 - bio-psycho-social maturation & development, including attachment capacity/style



Post-trauma *Responses and Disorders*

- Peritraumatic **Reactions**
- Posttraumatic **Reactions**
 - ▼ immediate (may resolve, continue, or return)
 - ▼ delayed
 - ▼ chronic
- Acute Stress **Disorder**
 - ▼ 4 weeks' duration or less
- “Simple” or Classic Posttraumatic Stress **Disorder**
 - ▼ immediate
 - ▼ delayed
 - ▼ *chronic*
 - ▼ often/usually co-morbid (depression, anxiety, ED/SA/OCD; Axis I, II, & III)

PTSD: Diagnostic Criteria

(DSM-IV, American Psychiatric Association, 1994)

- A. Exposure to a traumatic event
 - ▼ 1. objective seriousness (**limited definition**)
 - ▼ 2. subjective response: fear, horror, helplessness
- B. Traumatic event is persistently *re-experienced*
- C. Persistent *avoidance* of stimuli associated with the trauma
- D. Persistent symptoms of *increased arousal*
- E. Duration of B, C, & D > 1month
- F. Clinically significant distress or impairment

PTSD in Children

- No available childhood PTSD or DD diagnosis in the *DSM*
- *Children respond as children, not as little adults*
 - ▼ work of Terr, Putnam, Pynoos, Perry has been instrumental to early understanding of childhood trauma
- Children are very vulnerable, yet resilient
 - ▼ on average, takes less to traumatize them

(Proposed) Developmental Trauma Disorder

(van der Kolk, 2005)

- Domains of impairment in children exposed to complex trauma:
 - ▼ Attachment/relationship capacity
 - ▼ Biology
 - ▼ Affect regulation
 - ▼ Dissociation
 - ▼ Behavioral control
 - ▼ Cognition
 - ▼ Self-concept

The Significance of Labels

“To attribute the affective chaos or schizoid withdrawal of patients who were abused as children to ‘fantasy’ or to ‘borderline personality organization’ is tantamount to blaming the victim and, in doing so, reproduces features of the original trauma”.

(Stolorow, 2007)

Post-trauma *Responses and Disorders*

- **Complex Posttraumatic Stress Disorder/ (DESNOS) “PTSD plus”**
 - ▼ related to severe chronic abuse, usually in childhood, and attachment disturbance
 - ▼ usually highly co-morbid
 - ▼ often involves a high degree of dissociation
- **Dissociative Disorders**
 - ▼ associated with disorganized attachment and/or abuse in childhood
 - ▼ can develop in the aftermath of trauma that occurs any time in the lifespan
 - ▼ DDNOS may be the most common DD (as currently defined in the *DSM*)

Complex PTSD/DESNOS

(Disorders of Extreme Stress Not Otherwise Specified)

- Designed to account for developmental issues, co-morbidity, memory variability and to reduce stigma
- Co-morbid/co-occurring diagnoses:
 - ▼ *distinct from or co-morbid with PTSD*
 - ▼ other Axis I, mainly:
 - depressive and anxiety disorders
 - substance abuse/other addictions
 - impulse control/compulsive disorders
 - ▼ Axes II (**BPD**) and III

Symptom Categories and Diagnostic Criteria for Complex PTSD/DESNOS

(Spitzer, 1990)

- 1. Alterations in regulation of affect and impulses
 - ▼ a. Affect regulation
 - ▼ b. Modulation of anger
 - ▼ c. Self-destructiveness
 - ▼ d. Suicidal preoccupation
 - ▼ e. Difficulty modulating sexual involvement
 - ▼ f. Excessive risk taking
- 2. Alterations in attention or consciousness
 - ▼ a. Amnesia
 - ▼ b. Transient dissociative episodes and depersonalization

Symptom Categories and Diagnostic Criteria for Complex PTSD/DESNOS

(Spitzer, 1990)

- 3. Alterations in self-perception
 - ▼ a. Ineffectiveness
 - ▼ b. Permanent damage
 - ▼ c. Guilt and responsibility
 - ▼ d. Shame
 - ▼ e. Nobody can understand
 - ▼ f. Minimizing
- 4. Alterations in perception of the perpetrator
 - ▼ a. Adopting distorted beliefs
 - ▼ b. Idealization of the perpetrator
 - ▼ c. Preoccupation with hurting the perpetrator

Symptom Categories and Diagnostic Criteria for Complex PTSD/DESNOS

(Spitzer, 1990)

- 5. Alterations in relations with others
 - ▼ a. Inability to trust
 - ▼ b. Revictimization
 - ▼ c. Victimizing others
- 6. Somatization
 - ▼ a. Digestive system
 - ▼ b. Chronic pain
 - ▼ c. Cardiopulmonary symptoms
 - ▼ d. Conversion symptoms
 - ▼ e. Sexual symptoms
- 7. Alterations in systems of meaning
 - ▼ a. Despair and hopelessness
 - ▼ b. Loss of previously sustaining beliefs

Comorbidity

PTSD

Complex PTSD (DESNOS)

Dissociative Disorders

Anxiety Disorders

Substance Abuse

Depression

Eating Disorders

Somatization

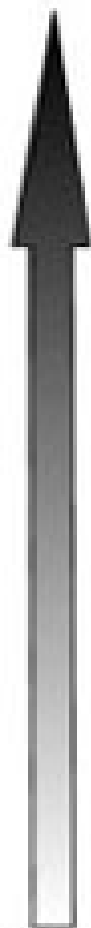
Obsessive-Compulsive

Other affective disorders (bipolar, etc.)

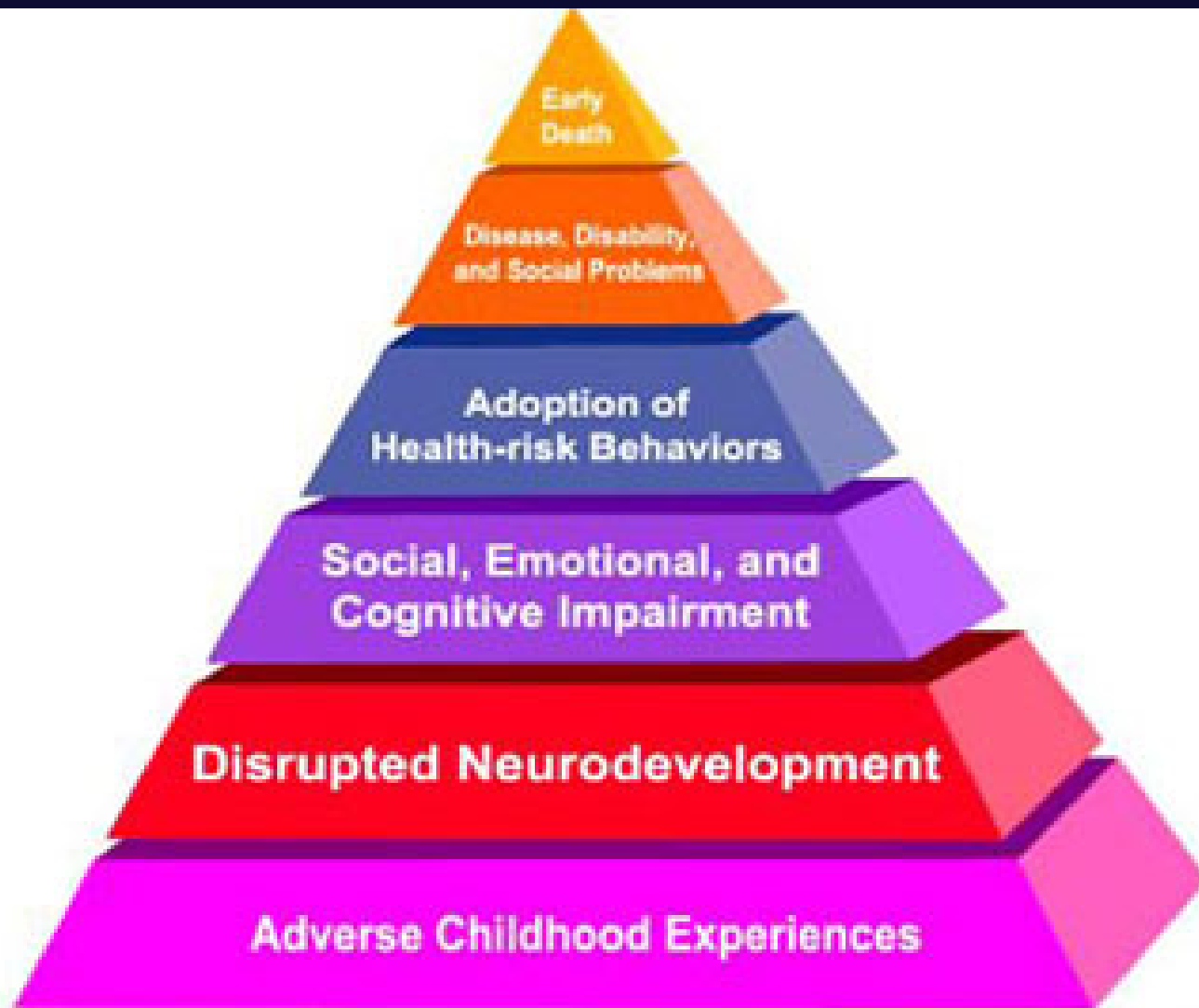
Brief reactive psychosis

Sleep disorders

Death



Conception



Mechanisms by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

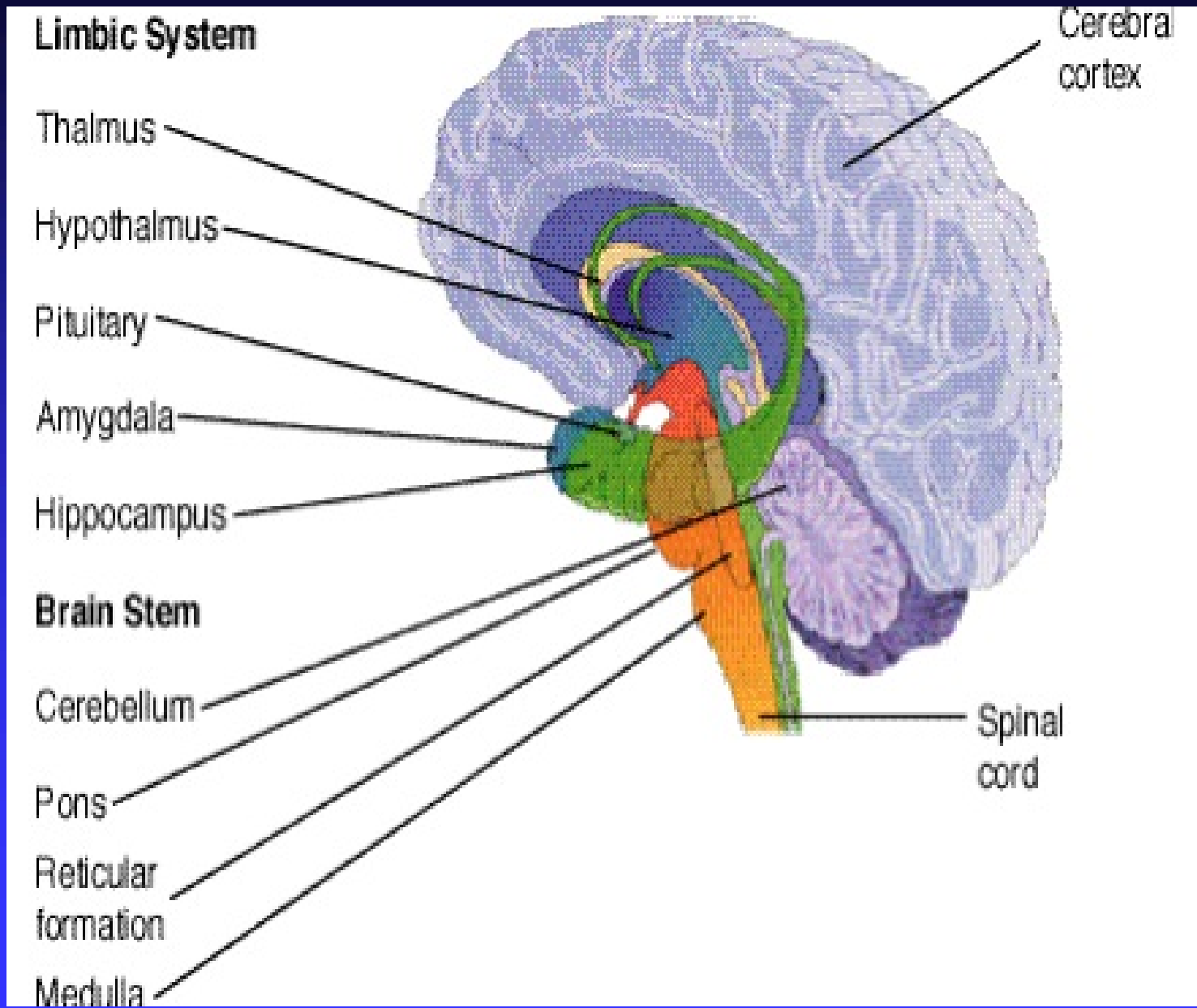
Personality Disorders in Survivors

- Avoidant (76%)
- Self-defeating (68%)
- Borderline (53%)
- Passive-aggressive (45%)
- Narcissistic
- Obsessive Compulsive
- Hysterical
- Histrionic
- Schizoid
- Antisocial
- Many survivors have features of several personality disorders
- Personality disorders reflect insecure attachment patterns, and emotional and impulse dysregulation (Dell, 2002)

Chronically Traumatized Individuals

- *Are too rigid and closed instead of flexible*: fixed in particular and narrow ways of being, especially defense and avoidance; overly closed to learning from the present; respond with conditioned reactions
- *Are too unstable and open*: overly open to the influence of internal experiences and perceptual distortions, and sometimes to other people; overly open to the influence of the past
- *Are reflexive instead of reflective*: have great difficulty being reflective or staying in a reflective mode; are impulsive and reactive

(Steele, 2009)



Complex PTSD/DESNOS

- Controversial
- Not a formal *DSM* diagnosis YET:
Currently an associated feature of PTSD
- Nevertheless, a useful way of organizing symptoms and treatment
- A less pejorative way of understanding and approaching the treatment of those who often look and behave like BPD
- Empirical investigation underway

Defining Dissociation

Dissociation is:

a **psycho-physiological process** with psychodynamic triggers which produces an alteration in ongoing consciousness.

“escape where there is no escape”

Putnam, 1985

Defining Dissociation

- A state of **fragmented consciousness** involving amnesia, a sense of unreality, and feelings of being disconnected from oneself or one's environment (**subjective experience**)
- An unlinking; de-contextualizing; “not-me”
- A standard human response to trauma, a near universal reaction to a life-threatening event

Defining Dissociation

- Dissociation not invariably linked to *overt* trauma
 - ▼ recent studies of attachment, family dynamics
- Yet, often develops in dire circumstance
- A segregation of states of mind, a skill and a defense
 - ▼ BASK-M or FAST model of separation
- Mechanism not available to all
 - ▼ a predisposition to dissociate is a necessity
 - ▼ more available to children
- May be lifesaving at one time but its overuse can be crippling and dangerous

Attachment Relationships

- “...are crucial to the process of integration. The difficulties that bring patients to treatment usually involve unintegrated and undeveloped capacities to feel, think, and relate to others (and to themselves) in ways that ‘work’”
- Paraphrasing Bowlby, “The therapy relationship involves sanctioning patients to think thoughts, experience feelings and consider actions that parents have forbidden.” (Wallin, 2007)

Attachment Organization

(Ainsworth, 1978; Liotti, 1992; Main, 1986, Siegel, 1999)

● Child style

- ▼ secure
- ▼ insecure-avoidant
- ▼ insecure-dismissing/
resistant/ambivalent
- ▼ insecure-disorganized/
disoriented/**dissociated**

● Adult style

- ▼ autonomous
- ▼ dismissive/detached
("teflon")
- ▼ preoccupied/anxious
("velcro")
- ▼ fearful/anxious
unresolved/**dissociative**







Implications for Treatment

- Attachment abuse including **ongoing neglect and failure to respond and soothe a child** (neglect) or antipathy is implicated in the development of the DD's
 - ▼ a wider base beyond overt physical and sexual abuse from which to understand DD's
- The emphasis in treatment is shifted back toward education and the **intrapsychic** and **interpersonal patterns** started early in life and away from solely working through the other forms of childhood and adult trauma

II. Treatment: The Clinical Consensus Evidence-Based Meta-Model

- The (evolving) standard of care
- Philosophy, principles and goals of practice
- General structure and sequence
- Integrated, multimodal and individualized
- Attachment/relationship issues
 - ▼ relationship as BOTH container and catalyst
 - ▼ learning laboratory for other relationships
 - ▼ “earned security” of attachment
- Therapist self-monitoring/self-care
- Different treatment trajectories

II. Treatment: The Clinical Consensus Evidence-Based Meta-Model

- Ethics and risk management
- Relational challenges
- Treatment of:
 - ▼ posttraumatic symptoms
 - ▼ dissociative symptoms
 - ▼ self-impairment/self disorder
 - affect dysregulation
 - cognitive distortions & beliefs/misattributions
 - attachment style and capacity
 - ▼ relational impairment
 - ▼ associated/co-morbid conditions

Treatment

Variable Adaptations

**Variable and Multi-modal
Treatments**

Evidence-Based Practice

- Best research evidence
- Clinical expertise
- Patient values, identity, context

*American Psychological
Association Council of
Representatives Statement,
August 2005*



Note:

EBT (Evidence-Based Therapy)

is *NOT* the same as

EST (Empirically-Supported
Therapy)

Expert Consensus Guidelines for “Classic” PTSD

- ISTSS Guidelines (Foa, Friedman, & Keane, 2000, 2008)
- Journal of Clinical Psychiatry (2000)
- American Psychiatric Association (2003)
- Clinical Efficiency Support Team (CREST, Northern Ireland, 2003)
- Veterans’ Administration/DoD (US, 2004)
- National Institute of Clinical Excellence (NICE, UK, 2005)
- Australian Centre for Posttraumatic Mental Health (2007)

Effective Treatments for PTSD*

- Psychopharmacology
 - Psychotherapy (CBT, especially)
 - Psych-education
- Other supportive interventions

*Few studies have evaluated using a combination of these approaches although combination treatment commonly used and may have advantages

Other Expert Consensus Guidelines

● Dissociative Disorders

- ▼ Adult (ISSD, 1994, 1997, 2005, **in revision**)
- ▼ Children (ISSD, 2001)

● Delayed memory issues

- ▼ Courtois (1999; Mollon, 2004)

● Complex trauma (under development)

- ▼ (Courtois, 1999; **CREST, 2003**; Courtois & Ford, 2009; ISTSS complex trauma expert consensus survey, in process)

Treatment: Chronic/Complex PTSD

- Ongoing assessment
- Longer term treatment (ongoing or episodic)
 - ▼ co-morbidity/dual diagnosis/co-occurring diagnoses
- **Sequenced treatment**
 - ▼ more initial emphasis on stabilization, self-management, affect regulation, safety, relapse planning
- Psychopharmacology
- Specialized techniques, applied later
 - ▼ EMDR starting w/ resource installation/affect mgt, CBT (graduated and/or direct exposure), CPT, stress inoculation, relaxation, hypnosis, group, education, wellness, couple's or family work

Complex Trauma Treatment

- “Not trauma alone” (Gold, 2000)
- Multi-theoretical and multi-systemic
- Integrative
- Addresses attachment/relationship issues in addition to life issues and trauma symptoms and processing of traumatic material
- Takes context into consideration
- Intensity is titrated to client
- Relational approach

Complex Trauma Treatment

- ▼ Specialized techniques, **applied later**
 - EMDR for resource installation/affect mgt, CBT (exposure therapies), CPT, stress inoculation
- ▼ Other techniques as needed (careful application)
 - relaxation, exercise, group, education, wellness
- ▼ Couple or family work

Complex Trauma Treatment

- PTSD symptoms
- Depression, anxiety, & dissociation
- **Problems with affect regulation**
 - ▼ may rely on maladaptive behaviors, substances
 - ▼ problems with safety
- Negative self-concept
- **Problems with self, attachment, relationships**
 - ▼ revictimization/re-enactments
 - ▼ needy but mistrustful
- Problems functioning?
- Physical/medical concerns
- Other...

Bio/Physiological Treatments

▼ Psychopharmacology

- evidence base developing re: effectiveness
- algorithms developed
- not enough by itself

▼ Medical attention

- preventive
- treatment

▼ Movement therapy

Bio/Physiological Treatments

- Stress management
- Self-care/wellness:
 - ▼ Exercise (w/ care)
 - ▼ Nutrition
 - ▼ Sleep
 - ▼ Hypnosis/meditation/mindfulness
 - ▼ Addiction treatment
 - Alcohol, drugs, prescription drugs
 - Smoking cessation
 - Other addictions (sexual, spending)
 - Relapse planning

Bio-physiological Treatments

- Somatosensory/Body-focused Techniques
(Levine; Ogden; Rothschild, Scaer)

Remember: The brain is part of the body!

- Paying attention to the body in the room
 - ▼ interpersonal neurobiology
- Neurofeedback/EEG Spectrum
- Massage and movement therapy
- Dance and theatre
- Yoga

Psychosocial/Spiritual Treatments

- The therapy relationship--has the most empirical support of any “technique”
- Especially important with the traumatized
- Especially important in interpersonal violence and in developmental trauma
 - ▼ attachment studies
 - ▼ brain development studies
 - ▼ striving for secure attachment

Psychosocial/Spiritual Treatments

- Psych-education (individual or in group)
- individual and group therapy
 - ▼ trauma focus vs. present focus
 - ▼ skill-building
 - ▼ core affect and cognitive processing
 - ▼ developing connection with others
 - identification and meaning-making
 - ▼ concurrent addiction/ED
- couple and family therapy

Psychosocial/Spiritual Treatments

- adjunctive groups/services
 - ▼ AA, Al-Anon, ACA, ACOA, etc.
 - ▼ Social services/rehabilitation
 - ▼ Career services
 - ▼ Internet support and information
- spiritual resources: finding meaning in suffering
 - ▼ Pastoral and spiritual care
 - ▼ Organized religion
 - ▼ Other religion/spirituality
 - ▼ Nature, animals

Cognitive Behavioral, Emotional/ Information Processing Treatments

- Education & skill development
 - ▼ numerous workbooks now available on a wide variety of topics
 - general, CD, self-harm, risk-taking, eating, dissociation, spirituality, career, etc.
- Exposure and desensitization (Foa et al.)
 - ▼ prolonged & graduated
- Writing/journaling
 - ▼ CPT (Resick)
 - ▼ Journaling (Pennebaker)

Cognitive Behavioral, Emotional/ Information Processing Treatments

- Schema therapy (Young; McCann & Pearlman)
- DBT (may involve “tough love stance”) (Linehan)
 - ▼ mindfulness and skill-building
- Narrative therapies (various authors)
- Strength/resilience development
 - ▼ EMDR resource installation (Leeds & Korn)
 - Developmental Needs Meeting Strategy (Schmidt)
 - ▼ Internal Family System work (Schwartz)
 - ▼ Solution-focused treatment (O’Hanlon)

Cognitive Behavioral and Information-Processing Treatments

- EFTT: emotion-focused therapy for trauma
(Paivio)
- ACT: acceptance and commitment therapy
(Hayes, others)
- FAT/FECT: Functional Analytic Therapy
(Tsai, Kohlenberg)
- IRRT: imaginary re-scripting and re-processing therapy
(Smucker)
- Virtual Reality
(Rothbaum, others)

Psychosocial/Spiritual Treatments

- adjunctive groups/services
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- IRRT: imaginary re-scripting and re-processing therapy
(Smucker)
- Virtual Reality
(Rothbaum, others)

Affect-Based Treatments

- AEDP: Accelerated Experiential-Dynamic Psychotherapy (Fosha)
- Affect Experiencing-Attachment Theory Approach (Neborsky)
- Healing the Incest Wound (Courtois; Roth & Batson)
- Repair of the Self (Schore, others)
- Techniques for identifying and treating dissociation (ISSD, Kluft, Putnam, Ross, others)
- Relational and affect-based psychoanalytic techniques (Bromberg, Davies & Frawley, Chefetz, others)

Core Affects

- Fear/terror
- Anxiety
- Depression
- Anger/rage/outrage
- Shame
- Self-blame/guilt
- Confusion
- Grief/mourning/sadness
- Alienation
- Other...

Complex Trauma Treatment Sequence

- 1. **SAFETY**, stabilization, skill-building, education

BUILDING OF RELATIONSHIP

- 2. Trauma processing
- 3. Integration and meaning, self and relational development



Treatment Sequence: General Stages of Treatment

- ***Pre-treatment stage:*** Contracting, assessment, pre-treatment issues
- ***Early stage:*** Safety, stabilization, skill-building, self-management, security in tx relationship
- ***Middle stage:*** Trauma de-conditioning, processing, mourning, resolution, moving on
- ***Late stage:*** Self and relational development from a new perspective

Note: Non-linear and not lockstep: a back and forth, titrated process with attention to and planning for relapse

Treatment Goals

- increase capacity to manage emotions
- reduce levels of hyperarousal
- reestablish normal stress response
- decrease numbing/avoidance strategies
- face rather than avoid trauma, process emotions, integrate traumatic memories
- reduce comorbid problems
- educate about and destigmatize PTSD sx

Treatment Goals: Self/Relational Issues

- restore self-esteem, personal integrity
 - ▼ normal psychosexual development
 - ▼ reintegration of the personality
- restore psychosocial relations
 - ▼ trust of others
 - ▼ foster attachment to and connection with others
- restore physical self
- restore spiritual self

□ SAFETY IS THE FOUNDATION

III. Treatment: The Clinical Consensus Evidence-Based Meta-Model

● Relational Issues

- ▼ Relational approach: RICH model
- ▼ Treatment relationship defined and delimited
 - Ethics and risk management
- ▼ Attachment-based understanding & approaches
- ▼ Interpersonal neurobiology
- ▼ Intersubjective and unformulated experience and contextual-based approach
- ▼ Use of relationship to understand the client
 - transference, countertransference, enactments, VT
- ▼ Support & consultation for therapist

RICH relationship/Risking Connection

- Trauma-oriented approach involving:
 - ▼ Respect
 - ▼ Information
 - ▼ Connection
 - ▼ Hope

(Saakvitne et al.)

The Therapeutic Relationship

- Empathy, kindness
- Mindfulness
 - ▼ observing, open, available, interested/curious, active, collaborative
- Safety
 - ▼ stable, reliable, consistent, responsive
- **Attunement and reflection**
 - ▼ Mis-attunement is an opportunity for repair
 - ▼ When ruptures occur, used as an opportunity for communication and problem-solving leading to repair

The Therapeutic Relationship

- Therapist must not make self the “all-knowing authority on high”
 - ▼ “Good enough”/not perfect
 - ▼ Exploration of client’s experience
 - ▼ Working in the moment with the unformulated
 - mutual exploration

Interpersonal Neurobiology

(Schore, Seigel, others)

- The crucial significance of **being with a responsive therapist**
 - ▼ Offers **reassurance** of the other's presence
 - ▼ The client is **NO LONGER ALONE**
 - ▼ Attention and attunement reflects **SELFHOOD** back to client
 - through emotional attunement & reflection
 - communicates being *worthy* of attention
 - ▼ May be difficult to accept but may be craved
 - ▼ Titrate to window of tolerance: “Can you accept a bit more? What does it feel like? Are you open to more?”

Interpersonal Neurobiology

(Schoore, Seigel)

- Right brain to right brain attunement:
implicit factors, somatosensory: “bottom up approach”
- Development of new neuronal pathways:
“neurons that fire together wire together” (Hebbs)
--enables genetic expression
--allows association /integration vs. dissociation
- “**Earned secure**” attachment through secure base of the therapeutic relationship
 - ▼ Freedom to explore: self, affect, emotions, physical reactions, relations with others, etc

Interpersonal Neurobiology

(Schore, Seigel)

- Affect regulation: from co-regulation to auto-regulation
- Development of the pre-frontal cortex: ability to think/judge before acting (**inhibit/override stress alarm—amygdala/limbic system**)
 - ▼ learn to differentiate responses: separate past from present
 - ▼ other ways to self-soothe including through the use of internalized others
 - ▼ “therapist and others on your shoulder”, offering support, counsel, acceptance

Interpersonal Neurobiology

(Schore, Seigel)

- Allows the hippocampus to come online
 - ▼ autobiographical memory more available
- Putting it into words: development of a **coherent narrative** due to processing and integration of what had been split off and incoherent/unspoken (left brain)
- **Coherent rather than fragmented**
- **Knowing vs. unknowing/unconscious**
- **Integration rather than dissociation**

Interpersonal Neurobiology

(Schore, Seigel, Ogden)

- **Bottom up strategy:** Paying attention to implicit/unconscious communication via body, behavior, transference, CT, enactments, projective identification *to understand with the client*
- Paying attention/attunement/synchrony/somatosensory: **right brain to right brain communication**
- Goal: neuronal growth based on **being mirrored by a significant other** (*being seen and being felt by another*)—"felt security"; "feeling you feeling me"; "enabling me to be me"

The Importance of Relational Repair

- Consistent, reliable relationship, *not perfect!*
- “Good enough”
- Accepting: non-punitive, non-judgmental
- Encourage collaboration, curiosity
- Encourage reflection and reflexive functioning
- Therapist self-disclosure about feelings *in the moment* (Dalenberg research)
 - ▼ especially anger
- Therapist owns own mistakes and apologizes (carefully)
 - ▼ negotiates relational breach and repairs
 - ▼ **may be the most significant moments in treatment**

Boundary Issues

- Potential for boundary violations (vs. crossings) common with this population (indiscretions, transgressions, and abuse)
 - ▼ Playing out of attachment style and issues
 - ▼ Playing out the roles of the **Karpman triangle**, plus
 - victim, victimizer, rescuer, passive bystander
 - potential for sado-masochistic relationship to develop
 - ▼ Roles shift rapidly, especially with dissociative patients
 - ▼ Therapist must try to stay steady state *and* emotionally resonant

Boundary Issues

- ▼ “Risky Business”
- ▼ Therapist must be aware of “treatment traps”, carefully monitor transference, CT and VT issues and the relational process
- ▼ Therapeutic errors and lapses will occur and how they are handled can either be disastrous/retraumatizing or restorative
 - knowing about them can help the therapist get out of them and manage them with less anxiety

(Chu, 1988)

Boundary Issues

- Safety of the therapeutic relationship is essential to the work
- Responsibility of therapist to
 - ▼ **Maintain integrity of the frame**
 - ▼ Be thoughtful and clear about boundaries/limits but not rigid
 - re: availability, personal disclosure, touch, fees, gifts, tolerance for acting out behavior, S-I, suicidality, social contact, Googling, Facebook, etc.
 - May need to revisit and revise

Boundary Issues

- ▼ On average, start with tighter boundaries
 - ▼ Teach limits and boundaries, “rules of the road”
- ▼ Reinforce the right thing!!
- ▼ Expect boundary challenges
 - Teach negotiation and collaboration
 - Hold to important boundaries
- ▼ *Be conditional while being unconditional*

Boundary Issues

- ▼ Expect shifts in transference/attachment according to different self-states or states of mind
 - try to respond with equanimity/acceptance, especially with “state switches”
- ▼ Avoid dual roles where possible
- ▼ Engage in personal therapy as necessary
- ▼ Engage in ongoing continuing education, consultation/supervision, peer support

Boundary Issues

- Rescuing-revictimization “syndrome”
 - ▼ “vicarious indulgence” as a treatment trap, especially for novice therapists and those with a strong need to caretake or who are enticed by the client
 - ▼ may give client permission to overstep boundaries, ask for and expect too much
 - ▼ may then lead to resentment/rage on the part of the therapist and abrupt, hostile termination for which the client is blamed (**triple bind**)
 - ▼ may relate to malpractice suits, in some cases (see BPD literature)

Boundary Issues

- Progression of boundary violations: the “slippery slope” e.g., from excessive disclosure to patient as confidante, excessive touch to sexual comforting and contact
- It is **NEVER OK** to sexualize the relationship
 - ▼ patient may seek to sexualize directly or indirectly
 - ▼ therapist may develop sexual feelings
- Guideline: welcome and discuss *when presented by patient*; hold the line, keep your seat, do not touch, **DISCUSS**. When belongs to the therapist, seek consultation. Only discuss if therapeutically warranted and then, very carefully w/ ownership.

Boundary Issues

- **Responsibility of supervisors**
 - ▼ Contractual obligation
 - ▼ To protect client and the supervisee
 - ▼ To document supervision
- Response to a client's report of past or ongoing sexual relationship with previous therapist
 - ▼ Know the law--varies by jurisdiction
 - ▼ Consult state board, professional organizations, attorneys, insurance trust

Transference and countertransference...

“traditionally refer to the reciprocal impact that the patient and the therapist have on each other during the course of psychotherapy. In the treatment of PTSD..., the transference process may be trauma-specific...and/or generic in nature, originating from pre-traumatic, life course development as well as from traumatic events.” (Wilson & Lindy, 1994)

therefore, transference/countertransference reactions can be compounded by trauma

Transference Reactions

Transference reactions, IWM, projective identification, and enactments are all ways that the traumatized, dissociative patient might communicate with the therapist who must strive to be open to experiencing them, identifying them, and seek to understand their meaning with the client.

Transference Is Colored by Aspects of Interpersonal/Attachment Trauma

- Betrayal
- Premeditation
 - ▼ “no one is trustworthy or to be trusted”
- Deliberateness
- Entrapment/powerlessness
- Intrusion
 - ▼ physical/sexual as well as emotional
- Lack of protection and intervention
- Abandonment and neglect
- Used for the abuser’s gratification, sadism
- Used for family stabilization in cases of incest
- Other...

Transference is Colored by Aspects of Attachment/Interpersonal Trauma

- Lack of empathy, attention, protection
- Blame
- Shame/sense of badness and responsibility
- Attachment styles with the abuser and others
 - ▼ often ambivalent and insecure
 - ▼ may be disorganized/disoriented/dissociative
 - ▼ may involve a trauma bond and unrequited “crazy” loyalty
 - ▼ may be co-dependent/controlling/aggressive
- Numerous maturational/developmental issues
 - ▼ absence of a sense of self or self-reference
 - ▼ inability to recognize or modulate affect
- Others...

The Three R's: Reenactment, Repetition Compulsion, and Revictimization

- Abused individuals may play out what they “know” **implicitly**, giving clues to their history
 - ▼ In relationships in general
 - ▼ In the therapeutic relationship
 - Transference
 - IWM/attachment style
 - enactments, reenactments, projective identification
 - ▼ May give somatic/behavioral/relational (vs. verbal/narrative) clues especially in response to triggers or feelings

NB: the therapist must beware of interpreting too literally or over-interpreting, especially when memories are unclear

Attachment Patterns That Play Out in the Therapeutic Relationship*

- Secure
- Insecure: anxious-fearful (preoccupied)
 - ▼ Dependent (“velcro”)
 - ▼ Avoidant
 - ▼ Self-defeating
 - ▼ With borderline characteristics

{*per the work of Bowlby, Ainsworth, Main and colleagues; Alexander & Anderson (1994); DeZulueta (1993); and Liotti (1992,1993) applied to PTSD/DD’s}

Attachment Patterns That Play Out in the Therapeutic Relationship (con't)

- **Insecure: Anxious-avoidant (dismissive)**
 - ▼ Counterdependent/self-sufficient (“teflon”)
 - ▼ Detached
 - ▼ Dissociated (Barach, 1991)
- **Insecure: Unresolved/ Disorganized/ Disoriented/Dissociative**
 - ▼ Avoidant, self-defeating, borderline highest likelihood
 - ▼ Contradictory, approach/avoid; push-pull style
 - ▼ Dissociated memories, awareness (Liotti, 1992; 1993)
 - ▼ **By age 6, often involves a sub-style of controlling/caretaking**

Attachment Styles in Therapy

● Secure:

- ▼ much more straightforward; can relate well and have access to a range of feelings
- ▼ trusts others and turns to them for support
- ▼ can self-soothe
- ▼ judgment and reflection/mentation about self are developed
 - thinking before acting
 - aware of consequences

Attachment Styles in Therapy

● Treatment approaches:

- ▼ Client is trusting and relatively easy to work with
 - Client's feelings are generally accessible and regulated
 - Client's self-esteem is positive
 - Client is able to self-soothe, be alone
 - Client has support system
- ▼ General trauma-responsive treatment is called for
 - Shorter vs. longer-term

Attachment Styles in Therapy

- **Insecure/Dismissive**

- ▼ *detached/hypo-activated attachment*
- ▼ self-sufficient, self-reliant, “normal”
 - minimizes mistreatment/abuse
 - apologizes for self, having needs/wants
 - may have underlying self-hatred of self and needs
 - avoidance of memories, feelings, longings
- ▼ often devaluating of therapist/therapy
 - therapist as threat
- ▼ reluctant to feel emotion

Attachment Styles in Therapy

- Treatment approaches:

- ▼ must challenge with a different style
 - challenge de-activation of attachment
 - “follow the affect”
 - identify needs, challenge minimization, support longings, use symptoms as motivators
- ▼ encourage re-activation of attachment
 - offer relationship/attachment
 - balance empathy and confrontation
- ▼ encourage facing the trauma/re-connection
 - point out discrepancies
 - use ambivalence
 - challenge “I’m not a victim” stance with reality
- ▼ work with projective identification and enactments

Attachment Styles in Therapy

● Insecure/pre-occupied

- ▼ Super-or **hyper**-attached
- ▼ Worried/anxious about attachment status
- ▼ Constantly tracks the therapist's behavior/
motivation/caring
 - May even result in stalking: in person, internet
- ▼ Desperate to be **special**
- ▼ May be entitled/demanding/narcissistic/
grandiose

Attachment Styles in Therapy

● Treatment approaches:

- ▼ Set boundaries, boundaries, boundaries...
- ▼ Have limits
- ▼ Have client work to recognize and internalize security of relationship
- ▼ May need to offer more reassurance
- ▼ Be careful about over-disclosing!!
 - Who's needs are getting met?
- ▼ Challenge entitled stance and don't overgratify

Attachment Styles in Therapy

- **Insecure/unresolved/disorganized:**
 - ▼ *Inconsistent/unpredictable/paradoxical*
 - fearful, mistrustful yet needy
 - approach-avoid
 - idealizing/denigrating of caregivers
 - reactive and impulsive, without recognition of consequences
 - ▼ **Dissociative**
 - different presentations of self: on a spectrum
 - Karpman triangle of projections and enactments
 - reenactments/revictimization
 - lack of self-continuity
 - confusion

Attachment Styles in Therapy

- ▼ Negative self-concept
 - idiocratic self-loathing
 - **SHAME/SELF-BLAME**
 - suicidal and self-harming
- ▼ Crisis lifestyle
 - addictions common
 - revictimization common
- ▼ Overwhelmed by history, past and present
- ▼ Interpersonal avoidance
- ▼ Major problems with affect and other forms of self-regulation

Attachment Styles in Therapy

● Treatment approaches:

- ▼ Limits and boundaries
- ▼ Reliability and consistency; responsiveness
- ▼ Create different relational experience
- ▼ Safety focus and planning (ongoing)
- ▼ Address fear of security/phobia of relationship
- ▼ Challenge dissociation/avoidance
- ▼ Ongoing attunement, misattunement, relational repair
 - don't take a lot personally
 - use as an opportunity to understand the client's world and to challenge it in the present
- ▼ Encourage mentalizing

Attachment Styles in Therapy

- **With DDNOS/DID:**

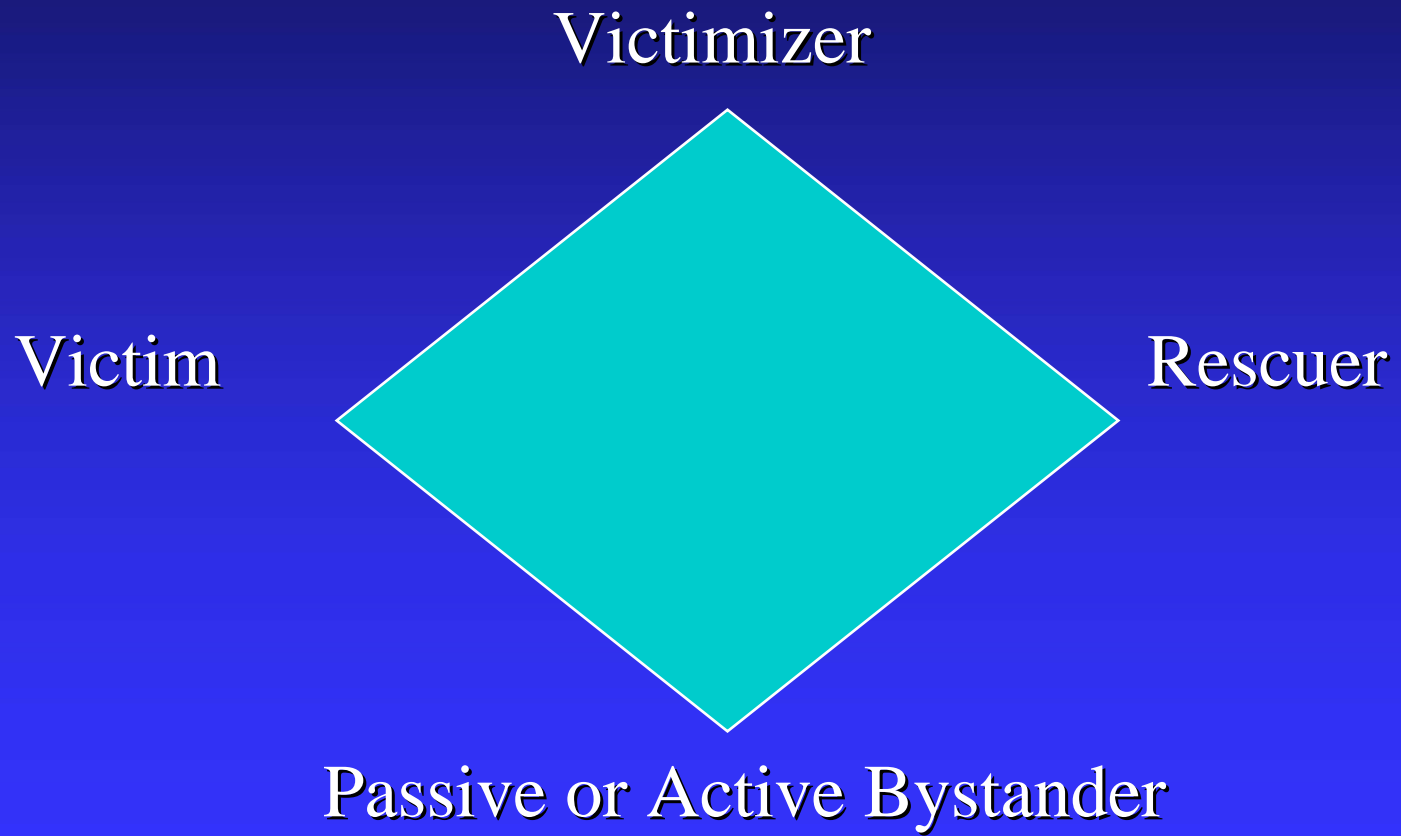
- ▼ Identify different states of mind/part-selves, their history and agenda
- ▼ Develop an alliance with all
- ▼ Increase communication between them and you
- ▼ Increase communication between them to increase co-consciousness
- ▼ Follow treatment guidelines for DD's

Insecure Attachment

- Therapist likely to feel...
 - ▼ De-skilled
 - ▼ Devalued
 - ▼ Helpless
 - ▼ Hopeless
 - ▼ Manipulated?
 - ▼ Confused
 - ▼ Exhausted
 - ▼ Grandiose? Overfascinated? Privileged?
 - ▼ Superior?

Some Traumatic Transference Reactions

- May be very confusing; shifting and alternating
 - ▼ **kaleidoscopic** (Davies & Frawley, 1994)
- Reenactment of Karpman Drama Triangle Plus
 - ▼ shifting roles of persecutor, victim, rescuer
 - ▼ additional role of passive bystander
- Projection of abuser role on the therapist
 - ▼ “You will be like my abuser”
 - ▼ “You will use me for YOUR purposes”
 - ▼ “You will be gratified by my pain”
 - ▼ “You are venal and self-serving”
 - ▼ “You too will betray me, are not to be trusted, ever!”



Relational Perspective

“...highlights the fact that in becoming part of the patient’s world through enactments, the therapist is able to experience and know the patient **in an emotionally direct way that is unmediated by language**. This give the therapist access to the ‘**un-verbalized and un-verbalizable**’ realms of the patient’s experience”

(Wallin, 2007)

Relational Perspective

- **Intersubjective approach**

- ▼ the uniqueness of each relationship
- ▼ co-development of relationship
- ▼ mutuality and dialogue
- ▼ understand the meaning of the enactment and discuss it (put words to it)
 - implicit to explicit
 - Unformulated to possibilities
- ▼ immersion with the patient to understand and to provide the experience of being felt by the other reciprocally

Relational Perspective

- Strengthening the reflective self and **fostering integration**
- Mentalizing
- Mindfulness
- Making the implicit explicit, the unconscious conscious, the incoherent coherent, the unformulated available
- Identifying and welcoming affect in order to transform
- Fostering a **coherent subjective narrative** and putting language to it

Factors That Interact to Determine Countertransference

- The nature of stressor dimensions in the trauma and trauma story
 - ▼ personal meaning
- Personal factors in the therapist
 - ▼ WHO ARE YOU? HOW HEALTHY ARE YOU?
- Client factors and attachment style relevant to countertransference
- Institutional/organizational/societal factors relevant to therapeutic process

Common Countertransference Reactions in Trauma Treatment

- Fascination, overinvolvement
- Disbelief, denial, underinvolvement
- Horror, disgust, fear
- Shame, guilt
- Anger, rage, irritation
- Sadness, sorrow, grief
- Powerlessness, overwhelmed, exhausted
- Incompetence, de-skilled, confusion
- Sexualization, voyeurism, exploitation, sadomasochism
- Difficulty with boundaries and limits

Countertransference Categories in Trauma Treatment

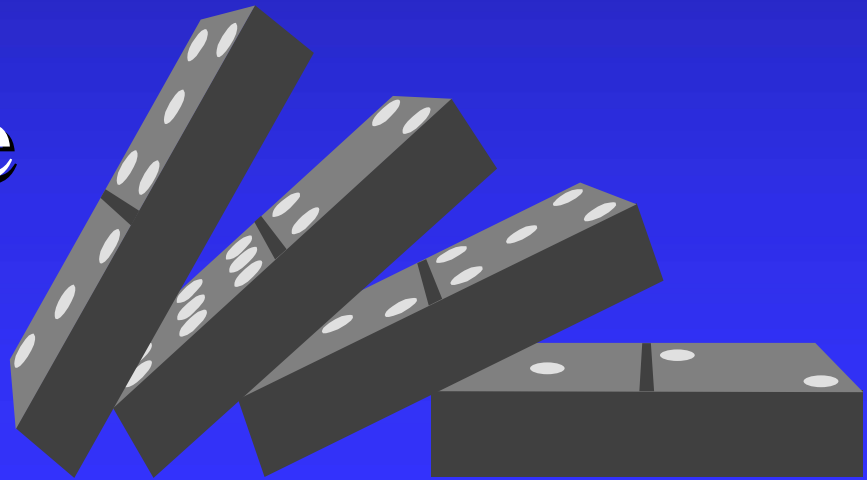
- Type I: Avoidance, detachment
 - ▼ empathic withdrawal/empathic repression
- Type II: Attraction, overidentification
 - ▼ empathic disequilibrium/empathic enmeshment
- Type III: Aggression, hatred, exploitation
 - ▼ absence of empathy

Secondary or Vicarious Trauma

Generally refers to traumatization of the therapist (or significant other or witness) by the nature and intensity of the victim's experiences and by interaction with the victim including hearing the victim's story

Effects of vicarious traumatization

- Cumulative
- Permanent
- Modifiable



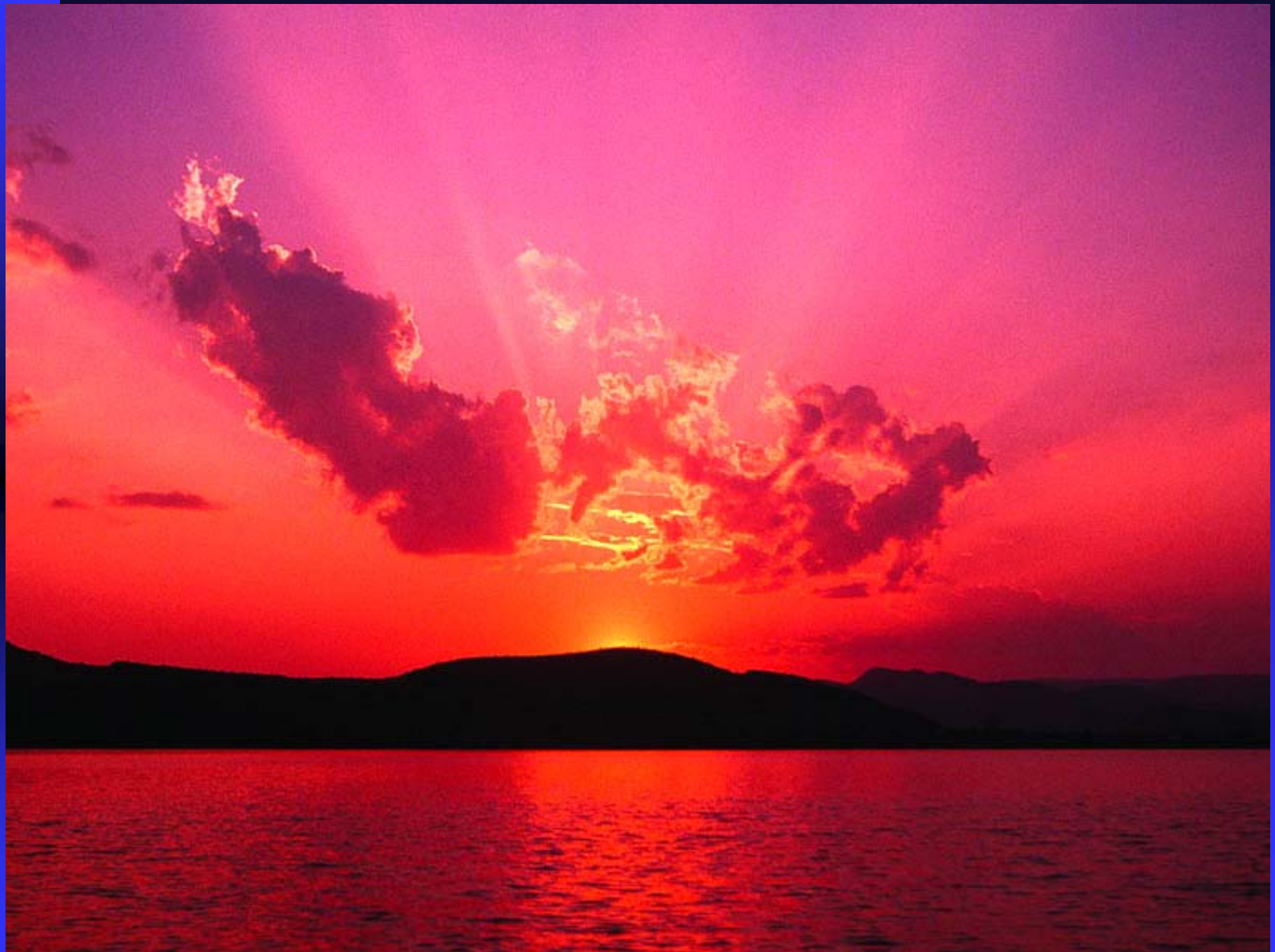
The ABC's of Addressing VT

- Awareness
- Balance
- Connection



The Rewards of Trauma Therapy

- Witnessing and swimming against the tide
- Exposure to human resilience and courage
- Exposure to human goodness
- Involvement in the healing journey
- Healing is possible
 - ▼ “strong in the broken places”
- Survivor missions
- Bringing a trauma paradigm to traditional psychological/psychiatric viewpoints



Resources

- Schore, A. N. (2004). *Affect dysregulation and disorders of the self*. WW Norton.
- Schore, A. N. (2004). *Affect regulation and repair of the self*. WW Norton.
- Solomon, M. & Seigel, D. (eds). (2000). *Healing trauma*. WW Norton.
- Van der Hart, O., Neijenhuis, E., & Steele, K. *The haunted self* (2006). WW Norton.
- Wallin, D. J. (2007). *Attachment in psychotherapy*. Guilford.
- *Psychiatric Annuals* (2006):
 - ▼ May, PTSD (B. van der Kolk, ed.)
 - ▼ Oct., Dissociation (R. Chefetz, ed.)
- *Psychiatric Clinics of North America* (March, 2006)
 - ▼ Dissociative Disorders (R. Chefetz, ed.)

Resources

▼ ISST-D.org

- look for 9 month-long courses on the treatment of DD's--various locations internationally, nationally, and on-line beginning Sept-Oct

▼ ISTSS.org

▼ www.ChildTraumaAcademy.org

▼ NCPTSD.va.gov (info and links)

▼ NCTSN.org (child resources)

▼ Sidran.org (books and tapes)

▼ **APA Div. 56: Psychological Trauma—new!!**

traumadivision@apa.org Please join us!!