RELATIONAL DIMENSIONS OF HEALING FROM TRAUMA

Christine A. Courtois, PhD, ABPP
Psychologist, Independent Practice
Washington, DC
National Clinical Training Consultant
Elements Behavioral Health, Promises, Malibu/LA
202-362-2776
www.drchriscourtois.com

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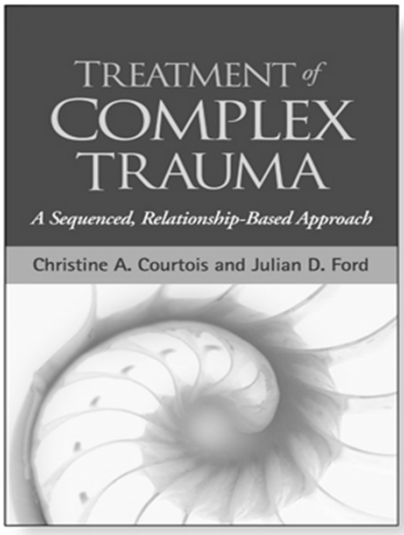

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Relational Dimensions of Healing

- Interpersonal trauma
  - Shattering to self and to relationships
  - Betrayal trauma
  - Second injury
  - Institutional betrayal

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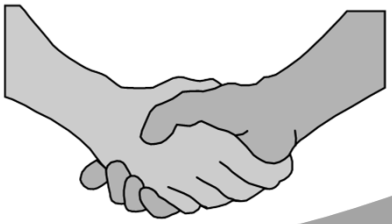
Relational Healing for Interpersonal Attachment (Relational) Trauma



RICH Relationship/ "Risking Connection"

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

(Saakvitne, Pearlman, et al.)

The Therapeutic Relationship

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

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The Importance of Relational Repair

- Therapist must not make self the "all-knowing authority on high"
  - Consistent, reliable relationship, *not perfect!*
  - "Good enough"
  - Accepting: non-punitive, non-judgmental
  - Emotionally regulated
  - Encourage collaboration, curiosity
  - Working in the moment with the unformulated, often implicit material
    - mutual exploration and collaboration
  - Encourage reflection and reflective functioning

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Boundary Issues

- Potential for boundary violations (vs. crossings) common with this population (indiscretions, transgressions, and abuse)
- Therapist must try to stay steady state *and* emotionally resonant
- Avoid dual roles where possible
- Engage in personal therapy as necessary
- Engage in ongoing continuing education, consultation/supervision, peer support

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Boundary Issues

- "Risky Business" (Pearlman)
- "Treatment traps" and challenges
- Transference, CT and VT issues and the relational process
- Therapeutic errors and lapses
  - how they are handled can be restorative or disastrous/retraumatizing
  - knowing about them can help the therapist get out of them and manage them with less anxiety (Chu, 1988)

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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*

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Boundary Issues

- Rescuing-revictimization "syndrome"
  - "vicarious indulgence" a "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)

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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.

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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

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The Importance of Relational Repair

- 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

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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

- 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 over-gratify

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, mis-attunement, 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

Insecure Attachment

- Therapist likely to feel…
  - De-skilled
  - Devalued
  - Helpless
  - Hopeless
  - Manipulated?
  - Confused
  - Exhausted
  - Grandiose? Overfascinated? Priviledged?
  - Superior?

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 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...

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)

So, we can see the importance of compassion, although it is often at odds with what the survivor client feels about him/herself

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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

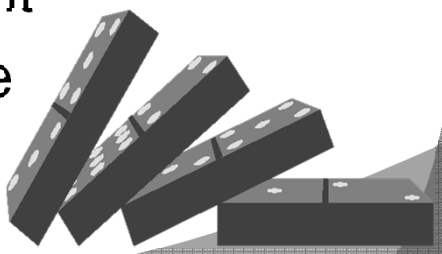
- Type I: Avoidance, detachment
  - empathic withdrawal/empathic repression
- Type II: Attraction, overidentification
  - empathic disequilibrium/empathic enmeshment
- Type III: Aggression, hatred, exploitation
  - absence of empathy

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

Post-traumatic Growth

- "Compassion reward or satisfaction"
- Awe about survivor resilience, spirituality, conscience
- Positive changes in the therapist

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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