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Clinical Applications of the Attachment Framework: Relational Treatment of Complex Trauma

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The self and attachment difficulties associated with chronic childhood abuse and other forms of pervasive trauma must be understood and addressed in the context of the therapeutic relationship for healing to extend beyond resolution of traditional psychiatric symptoms and skill deficits. The authors integrate contemporary research and theory about attachment and complex developmental trauma, including dissociation, and apply it to psychotherapy of complex trauma, especially as this research and theory inform the therapeutic relationship. Relevant literature on complex trauma and attachment is integrated with contemporary trauma theory as the background for discussing relational issues that commonly arise in this treatment, highlighting common challenges such as forming a therapeutic alliance, managing frame and boundaries, and working with dissociation and reenactments.

Trauma, especially of the sort arising from interpersonal violence and exploitation, can have a highly negative impact on its victims' capacity to develop and maintain relationships. According to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV*; American Psychiatric Association [APA], 1994), the diagnostic criteria for Posttraumatic Stress Disorder (PTSD) are interpersonal in nature: avoidance of people who arouse recollections of the event, feelings of detachment or estrangement from others, a restricted range of affect (e.g., unable to have loving feelings), a sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal lifespan), and irritability or outbursts of anger (p. 428). These factors reflect some of the difficulties traumatized individuals have relating to others. Conversely, these problems make it difficult for others to relate to them, in turn, leading to considerable social alienation and isolation and compounding the original effects of the traumatic experiences as individuals are deprived of the very things (i.e., social support and supportive relationships) that have been found to buffer and ameliorate those effects (Bowlby, 1969; Wortman, Battle, & Lemkau, 1997). Deprivation extends to the give-and-take normally found in relationships, often resulting in inaccurate expectations of others along with additional disappointments and emotional injuries.

These relationship problems appear to be even more complicated in individuals who have experienced severe cumulative interpersonal violence, neglect, or abuse. This is particularly true for those harmed in their childhood by primary caregivers or attachment figures as well as for those whose lives involve ongoing traumatic exposure (e.g., war and genocide, refugee status, human trafficking and prostitution, etc.). Characteristics of complex forms of PTSD (or DESNOS, disorders of extreme stress not otherwise specified; Pelcovitz, Van der Kolk, Roth, Mandel, Kaplan, & Resick, 1997; Van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005) comprise alterations in relations with others, including the individual's ability to connect with other people in ways that foster relational

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security and stability. These alterations may impede the formation of healthy relationships, instead patterning ones that are fraught with instability and chaos along with additional abuse, victimization, and loss. Chronically abused and traumatized individuals often form relationships with others who themselves have unresolved trauma or loss experiences and who have complementary relational deficits and needs, with whom they often uncannily reenact relationships with attachment figures from the past (Basham & Miehls, 2004; Johnson, 2002). Not infrequently, relationships such as these lead to additional interpersonal damage, including abandonment and loss, intensifying the mistrust of others while frustrating the need for connection and support that is so important to human development.

Other developmental difficulties observed in persons with complex trauma adaptations have to do with the individual's sense of self, ability to identify and modulate emotions, alterations in consciousness and self-awareness (often in the form of dissociation), difficulty maintaining personal safety, somatic and medical concerns, and alterations in personal meaning or spirituality. Additionally, cumulative trauma survivors develop major cognitive distortions about themselves, their worth in relationships, and the motivations of others (Pearlman, 2003), beliefs that are reinforced when relationships in adulthood recapitulate the dissatisfactions, abandonment, and abuses of the past.

As clinicians we have worked with and studied adult survivors of cumulative abuse trauma for over two decades; we both use a relational framework in treatment (Courtois, 1988, 1999; Pearlman & Saakvitne, 1995; Saakvitne, Gamble, Pearlman, & Lev, 2000). We believe that the self and attachment difficulties that are at the heart of chronic and pervasive trauma especially during childhood must be understood and addressed in the context of the therapeutic relationship for healing to extend beyond resolution of traditional psychiatric symptoms and skill deficits. In this article we apply contemporary research and theory about attachment and complex developmental trauma, including dissociation, to psychotherapy for survivors with complex adaptations, especially as this research and theory inform the therapeutic relationship. We contend that the ensuing difficulties (e.g., with emotions, emotional regulation, self-worth, the ability to form and sustain satisfying relationships, and spiritual connection) can best be addressed through the therapeutic relationship that becomes both the "testing ground" for their emergence and the context in which they are experienced, explored, shared, understood, and ultimately resolved. While our model is consistent with other available interpersonal and affect models of psychotherapy currently applied to the traumatic aftermath of childhood abuse (Alexander & Anderson, 1994; Briere, 1996a, 1996b, 1997, 2002; Davies & Frawley, 1994; Foscha, 2000; Johnson, 2002; Neborsky, 2003; Paivio & Nieuwenhuis, 2001; Paivio & Shimp, 1998; Schore, 2003b; Smucker & Dancu, 1999; Solomon & Siegel, 2003) it is based on a different theoretical model, constructivist self-development theory (CSDT; McCann & Pearlman, 1990a; McCann, Sakheim, & Abrahamson, 1988). Constructivist self development theory emphasizes five key domains (or needs about self and others), safety, trust, esteem, intimacy, and control, along with specific self capacities including affect tolerance, self-worth, and inner connection to benevolent others, that are particularly affected by traumatic life experiences (Pearlman, 2003). This theory also emphasizes four core elements in the therapeutic relationship: respect, information, connection, and hope (RICH) and the necessity for therapist integrity, reliability, self-monitoring, supportive connections, and self-care.

Integrating Trauma and Attachment Theory and Research

Early clinical and research findings regarding cumulative abuse focused almost exclusively on Axis I symptoms; however, researchers soon accumulated data suggesting that Axis II symptoms were also common and that abuse had high potential for major negative developmental impact (Briere, 1984; Briere & Elliott, 1994; Courtois, 1988; Herman, 1992; McCann & Pearlman, 1990a; Neumann, Houskamp, Pollack, & Briere, 1996; Polusny & Follette, 1995; Van der Kolk et al., 1996; see special section articles in this issue). The convergence of Axis I and II symptoms strongly resembled the *DSM-IV* criteria for borderline personality disorder (BPD; APA, 1994) in that trauma survivors were extremely emotionally labile, dissociative, self-injurious, suicidal, and relationally inconsistent. Findings about these similarities led to preliminary research and the acknowledgment of chronic abuse and maltreatment experiences in the histories of the majority of individuals diagnosed as borderline (Herman & Van der Kolk, 1987; Linehan, 1993) and the suggestion that they should instead be identified and less stigmatically labeled as chronically traumatized and as suffering from complex PTSD/DESNOS (Herman, 1992).

In recent years, these findings have been cross-referenced with research findings from developmental psychology, especially its subspecialties, developmental psychopathology and attachment studies. Investigations of the quality of early attachment experiences between caregivers and children on later mental health

and emotional disturbance began with the work of John Bowlby (1969). Based on his ethological studies of the biological and survival needs of young primates and his observational studies of neglected children, Bowlby showed the critical importance of stable or secure attachment in humans as well as in primates. Such attachment, based upon responsiveness and availability of the caretaker, offers protection from over-stimulation and threat, and teaches social interaction and other life skills, enables both physiological and psychological development and regulation, and provides the foundation for healthy development, a secure base from which the child explores the world and to which she or he returns for refuge when overwhelmed or threatened in some way. Negative experiences and disruptions of these affectional and security bonds in both humans and animals, through loss, separation, threat of separation, misattunement, violence, abuse, or neglect, termed insecure attachment, lead to such psychological difficulties as anxiety, depression, anger, and emotional detachment that, in turn, result in relational and social difficulties. Studies investigating the quality of early attachment experiences between caregivers and children on neurophysiology and later mental health and emotional disturbance have found that seriously disrupted attachment without repair or intervention for the child can, in and of itself, be traumatic, as the child is left psychologically alone to cope with his or her heightened and dysregulated emotional states, thus creating additional trauma. Allen (2001), Schore (2003a, 2003b), and others label this form of misattunement, *attachment* or *relational trauma*. Attachment insecurity and trauma also have been found to have a profound and often a severe impact on neurophysiological development, leading to restricted capacities and somatic and emotional dysregulation as well as on psychosexual development, especially identity formation, affective competence and regulation, and ability to relate to others (Schore, 2003a; Siegel, 1999).

Bowlby (1969) introduced the concept of *Inner Working Model* (IWM) to describe cognitive and emotional representations of self and others that operate fairly automatically and unconsciously to monitor attachment-related experiences on an ongoing basis and that form the basis for behavior. Bowlby's initial findings have spawned a rich body of research that is ever developing. His two attachment categories, *secure* and *insecure,* have been expanded into four primary styles (with additional subcategories and specificity over the years) in children that become templates for attachment over the lifespan: (a) secure, (b) insecure–ambivalent (resistant), (c) insecure–fearful/avoidant, and (d) insecure–disorganized/disoriented. Complementary styles in adult caregivers have also been identified, offering research substantiation for mechanisms of the intergenerational transmission of attachment styles and posttraumatic reactions (Ainsworth, Blehar, Waters, & Wall, 1978; George, Kaplan, & Main, 1996). Refinement of the four categories or inner working models has also occurred as findings from attachment research have been synthesized with findings on the posttraumatic aftermath of child abuse and neglect. In particular, researchers and theorists have paid additional attention to the insecure-disorganized/disoriented style and noted its similarity to the dissociative response so often found in individuals (especially children) in the aftermath of cumulative experiences of trauma. This is especially the case in situations of severe and ongoing abuse and neglect where the caregiver is both the source of threat and the source of attachment. Evidence from both the posttraumatic–dissociative and attachment–developmental fields strongly suggests that the majority of chronically abused individuals develop an insecure disorganized *and* dissociative attachment style (Anderson & Alexander, 1996; Liotti, 1995, 1999; Lyons-Ruth & Jacobvitz , 1999; Main & Solomon, 1986; Muller, Sicoli, & Lemieux, 2000; Putnam, 1989). Barach (1991) and Liotti (1992) independently articulated how these insecure disorganized–disoriented forms of attachment can be used to conceptualize dissociative identity disorder as a form of borderline personality, theoretical work that was supported by the later research of Fonagy and his colleagues (1995) who found an association between unresolved adult attachment status and anxiety disorders on Axis I and borderline personality disorder on Axis II.

The attachment research findings about neurodevelopment, self-development, affect identification and regulation, and relations with others can be connected to other theories regarding the effects of chronic developmental abuse. As noted above, constructivist self development theory (CSDT) identifies key domains about self and others: safety, trust, esteem, intimacy, and control; these are particularly shaped in the early years by salient developmental and attachment experiences but can form or change at any time in the lifespan as a result of childhood or adult trauma (see Pearlman, 2003 for a review of the empirical literature). They result in schemas (beliefs about self and others) comparable to similar schemas proposed by other theorists (i.e., Beck, Rush, Shaw, & Emery, 1979; Janoff-Bulman, 1992; Fonagy et al., 1995) and to Bowlby's inner working models in that they directly influence the quality of individuals' interactions and relationships and have enormous resilience, even in the face of contradictory data, as they serve a self-protective function. When relationships are inadequate or disappointing in some way, *and without repair,* these beliefs are reinforced. Importantly, they have been found to be flexible in that

they can be updated with the provision of new relational experiences. Constructivist self development theory draws upon the work of early object relations and self-psychology theorists (Kohut, 1971, 1977; Winnicott, 1965) in describing another aspect of self development impacted by traumatic life experiences, self capacities, broadly defined as the individual's ability to regulate internal psychological experience (Pearlman, 1998).[1] Constructivist self development theory identifies three self capacities: (a) affect tolerance, (b) self-worth, and (c) inner connection to benevolent others (related to the notion that object relations theorists label object constancy). The early life experiences that lead to secure attachment contribute to the development of these self capacities (Pearlman, 1998; Saakvitne et al., 2000). Underdeveloped self capacities are most likely to be found in individuals with disorganized attachment styles, a finding that is concurrent with those of the previously cited attachment researchers and theorists. Without adequate positive early attachment experiences, children and adults will not have learned to regulate their inner states (termed *affect states* by attachment theorists). When individuals are unable to regulate strong feelings (affect tolerance), experiences of emotional pain, disappointment, fear, rage, or shame (what Fosha, 2000, identifies as *core affects*), a sense of desperation may ensue. Many complex trauma survivors manage these emotions and the accompanying desperation by using dissociation or other psychological mechanisms and defenses. They also engage in a variety of behaviors that function as a means of self-soothing and containment of emotional distress but that paradoxically are often self-destructive in some way (e.g., suicidality, self-injury, eating disorders, aggression against others, substance abuse, revictimization, risky sexual behavior, etc.), causing them to resemble patients diagnosed with borderline personality. Another self capacity identified in CSDT is the ability to maintain a sense of self-worth. In addition to its contribution to ongoing attachment difficulties, negative self-worth can severely impede or even derail the individual's life course, including the ability to relate to others in ways that are healthy.

Treatment Implications

Findings about attachment can be used to assist survivors of cumulative trauma who have developed an inner working model of insecure attachment (whether preoccupied, fearful–avoidant, or disorganized–disoriented–dissociative) and complementary relational behaviors. These individuals must have a treatment that addresses their developmental and relational difficulties in addition to their PTSD symptoms (Ford & Kidd, 1998).[2] In 1988, Bowlby suggested that changing inner working models in psychotherapy involves exploring the patient's expectations of therapist and significant others. Attachment researchers and relational therapists have hypothesized that with explicit attention and response to interpersonal and attachment issues, attachment styles can be strengthened and even changed over time from insecure and disorganized to secure (Schore, 2003b; Siegel, 1999). Yet, the task is far from easy as Dozier and Tyrrell (1998) note:

> From an attachment theory perspective, the therapist's work with a client is similar to, yet more difficult than, the mother's with her infant . . . The mother's task is easier than the therapist's because she need not compensate for the failures of other attachment figures . . . exploration of prior working models cannot wait until after a secure base is established; rather, the processes occur in tandem. (p. 222)

In the late 1980s and early 1990s, a number of clinicians (e.g., Briere, 1989, 1991; Chu, 1992; Courtois, 1988; Herman, 1992; McCann & Pearlman, 1990a; Miller, 1994; Sgroi, 1988, 1989) provided preliminary strategies for treating this population. Although they discussed the relational dimensions of treatment, the focus on the significance of the attachment history in general and as the context within which the abuse occurred is more recent following the wealth of attachment research that has become available. Simultaneously, relational forms of psychotherapy have become more sophisticated and have increasingly focused on the challenges inherent in the treatment of abused or traumatized individuals, particularly their dissociative processes and borderline-type relational patterns and on the treatment of their attachment disturbances (Allen, 2001; Bromberg, 1993, 1998; Chu, 1998; Dalenberg, 2000; Davies & Frawley, 1994; Magnavita, 1999; Olio & Connell, 1993; Pearlman, 2001; Putnam, 1989; Ross, 1997; Saakvitne et al., 2000; Schwartz, 2000).

[1] Pearlman and colleagues have developed the Inner Experience Questionnaire to assess self capacities. See Brock, Pearlman, and Varra (in press) for a description of the measure.

[2] Research has shown that the classic symptoms of PTSD alone can often be addressed successfully in a short-term format using cognitive-behavioral techniques with relatively little emphasis on the therapeutic relationship (Foa, Keane, & Friedman, 2000; Van der Kolk, Korn, Weir, & Rozelle, 2004; Solomon, 1997). But such techniques alone may not be effective for the complex trauma population, as these clients often drop out of treatment studies (Spinazolla, Blaustein, & Van der Kolk, 2005).

Integrating Attachment and Trauma Theories in a Relational Treatment Approach

The trauma-focused curriculum entitled *Risking Connection* (Saakvitne et al., 2000) provides a model for attachment-based healing based upon the application of relational treatment, as first described by writers at the Stone Center (Jordan, Kaplan, Miller, Stiver, & Surrey, 1991). It is very consistent with the above-mentioned relational and affect-based models and approaches. The *Risking Connection* (RC) approach is based on the constructivist self development theory described above (McCann & Pearlman, 1990a; Pearlman & Saakvitne, 1995) and takes these other approaches a bit further by more explicitly (a) delineating psychological realms affected by traumatic experiences, (b) combining the relational and attachment perspectives, (c) providing relational guidance and goals for treatment, and (d) emphasizing the importance of the treatment provider's experience in highlighting and integrating an understanding of countertransference and vicarious traumatization into treatment (see Saakvitne et al., 2000).

The development of a therapeutic relationship, one characterized by four essential elements, respect, information, connection, and hope (RICH), is a primary dimension of this treatment approach. The underlying assumption is that the therapeutic relationship provides an opportunity to rework attachment difficulties, or, per Bowlby's model, revising inner working models. More specifically, the treatment model involves the development of a secure therapeutic relationship that, in turn, creates the opportunity for the examination and reworking of self capacities and specific personal and interpersonal skills, management and elimination of self-injurious behaviors, and management of dissociation in the therapeutic relationship and elsewhere. Theoretically, it follows other relational models in providing a therapist who is capable of secure attachment and who has enough affective attunement and competence to engage in relational repair with the client whenever attachment disruption occurs (Dalenberg, 2000; Fosha, 2000; Schore, 2003b; Solomon & Siegel, 2003). It further emphasizes using patterns of interaction in the therapy relationship as "grist for the mill" to discern implicit relational patterns (in the transference and countertransference, using psychodynamics to assist in understanding) and to make them verbally explicit and open to change. The therapist must maintain or regain emotional equanimity and tolerance in the face of the client's push–pull style, disjointed affect, risk-taking behavior and revictimization, and in response to other relational inconsistency (including attempts to foster the therapist's rejection, sometimes with conscious intent and sometimes not). As discussed most specifically by relationally oriented writers, therapists must use awareness of their own countertransference responses as they attempt to understand and name the client's shifting states, and to manage their own emotions which may arise either in response to the real issues posed by the client or as a result of projective identification or more direct provocation (Bromberg, 1993; Davies & Frawley, 1994; Gabbard & Wilkinson, 1994; Pearlman & Saakvitne, 1995; Schore, 2003b; Schwartz, 2000). The therapist also benefits from ongoing support, consultation, and supervision, as discussed by many of these writers.

Alexander and Anderson (1994) helpfully offered a description of client presentation and interpersonal dynamics characterizing the four primary attachment styles that is useful in orienting the relational approach to trauma-based attachment issues. As would be expected, individuals operating from a *secure* model of attachment generally have higher levels of self-esteem and cognitive organization and consistency and are typically better able to express emotion and resolve conflicts. (Alexander and Anderson note that some chronically abused individuals have secure attachment experiences that usually precede the abuse and go on to develop a secure attachment style despite the abuse.) They are therefore likely to be more successful in their relationships, including therapy, and to require less of the therapist.

Clients with *insecure–preoccupied attachment* have a high level of affect-based behavior, without the capacity for cognitive organization found in the secure client. They function based on strong emotions such as anxiety, dependence, anger, and jealousy and often relate to others in ways that are extreme and opposite (i.e., alternating idealization with deprecation). Their self capacities are generally not well developed; they engage in risk-taking or addictive behaviors in the interest of affect management and they may paradoxically cling to unhealthy relationships in a frantic attempt to avoid being alone. Treatment with this type of client involves ongoing attention to consistency and reliability of response on the part of the therapist to model and teach relational reliability that, as internalized, lessens the anxiety at the core of this attachment style, leading to more interpersonal security.

Clients with *insecure–dismissing* attachment are characterized by discomfort with intimacy, defensive self-reliance, denial of distress, and, in some cases, a stance of hostility and opposition toward others. Although in emotional distress, they have learned to deny and minimize their feelings. Until these defenses fail, they are less likely than others to seek treatment. These clients may take a dismissing, condescending, or contemptuous stance with the therapist, creating complementary feelings of

incompetence, discomfort, anger, and an urge to avoid or reject them, thereby placing them at risk for reenactment of the original traumatic rejection. The therapist must be able to look beyond the behavior and to understand and empathize with its origins and self-protective function. The therapist's emotional equanimity rather than defensiveness and a stance of ongoing support and exploration are helpful in treating this type of attachment insecurity and in reversing the rigid self-sufficiency.

Although clients with an insecure–preoccupied and insecure–dismissing style may have a history of chronic trauma, those with *insecure–fearful avoidant–unresolved* (*disorganized–disoriented –dissociative)* attachment styles are likely to be over-represented in complex trauma survivors. For these clients, attachment figures and caregivers have been the contradictory source of both comfort and danger and they often anticipate the same from the therapist whom they approach with both longing and fear. Because these clients are likely to have highly dysregulated emotions due to past and ongoing relational instability and underdeveloped self capacities, they are more likely to utilize approach–avoid and dissociative behaviors and defenses and have an interaction style that is disjointed and that may appear illogical. They are more overtly distressed, depressed, disorganized, have more social and occupational impairment, and may constitute a much greater danger to themselves and to others due to impulse control problems, dissociation, self-loathing, and chronic hopelessness. Treatment for complex reactions of this sort is obviously more complicated and, in response to the need to provide a structure and to organize interventions, a sequenced or phase-oriented model has developed. (See Ford, Courtois, Steele, Van der Hart, and Neijenhuis, 2005, for an overview of this approach and for a review of the various available programs and ongoing research efforts in treating various dimensions of the distress experienced by these clients.) Early treatment efforts are usefully directed toward personal safety, teaching skills, and strategies to keep affect at levels that are tolerable, and emphasizing the therapeutic relationship as a place of consistency and support where feelings can be named and understood. Direct treatment of traumatic memories is approached later, after the client has developed emotional regulation skills to avoid retraumatization.

Application to Complex Clinical Issues

In this section, we apply the attachment–relational approach to four issues that commonly arise in treating this population to illustrate both the challenges to and value of the relational attachment perspective: (a) forming a therapeutic alliance, (b) establishing and maintaining the treatment frame and boundaries, (c) addressing relational and behavioral reenactments of past attachment and trauma or loss, and (d) managing dissociative processes.

Forming a Therapeutic Alliance

Many clinicians have noted the challenges inherent in forming therapeutic relationships with adult survivors of pervasive abuse due to their mistrust, emotional lability, and relational instability (Chu, 1992, 1998; Courtois, 1988, 1999; Dalenberg, 2000; Davies & Frawley, 1994; Herman, 1992; McCann & Pearlman, 1990a, 1990b; Pearlman & Saakvitne, 1995; Schwartz, 2000). Attachment theory adds a developmental perspective to the understanding of the client's history and current psychological and relational difficulties. Importantly, it can help the therapist to empathize with rather than stigmatize the client while serving as a reminder to not take even routine relational interchanges and skills for granted. For example, the therapist cannot assume that chronically traumatized individuals (especially those with insecure–fearful–avoidant or disorganized–unresolved attachment styles) have the experience base to form stable relationships or the ability to maintain relational continuity even when others (including the therapist) are reliable, consistent, and trustworthy. The therapist's very reliability and consistency paradoxically may be incomprehensible and threatening rather than comforting to such a client. This, in turn, may lead to major defensive maneuvering in the client who has no organized way of responding to a consistent relationship. Another challenge to developing a therapeutic alliance is dissociation, especially when it involves alterations in perceptions of self and others, shifting presentations of self, and memory disturbance. Davies and Frawley (1994) descriptively referred to these self and relational alterations as "kaleidoscopic" to underscore their dynamic rather than static nature. When the therapist has no systematic way to understand them, she or he will be hard pressed to empathize with their self-protective or self-regulatory functions or to respond in ways that are exploratory and therapeutic. Applying this theory therefore assists the therapist to expect defensive maneuvering and not take it personally; rather, the therapist is encouraged to observe client behavior and give feedback in tolerable doses with measured pacing to promote changes in relational perceptions and capacities in general, and as applied to the treatment relationship.

Frame and Boundaries

The negotiation and maintenance of professional and personal boundaries are essential in treating those who routinely have been engaged in dual and exploitive relationships. In a relational therapy, time needs to be spent early on addressing treatment frame issues (i.e., explaining therapy and how it works, informed consent and refusal, treatment goals and duration, length and frequency of sessions, fee and payment, forms of address, limits of confidentiality, therapist availability and limitations, safety and procedures for crisis management). Over the course of the therapy, these and other "frame issues" reemerge. Their multiple meanings need to be understood and negotiated, often repeatedly, and the negotiations can be delicate.

In response to the ongoing relational challenges posed by survivor clients, it is not uncommon for therapists to slip boundaries in ways that they normally would not. Possibly the most typical countertransference response to clients with abuse and neglect-based attachment difficulties is to want to rescue or re-parent them in an attempt to make up for what clients deserved but did not receive in childhood. Not infrequently, rescue efforts of this sort (exemplified by over-involvement, over-giving, and over-identification on the part of the therapist) boomerang as he or she becomes exhausted or resentful. This, in turn, results in a negative, rejecting countertransference that, unfortunately, has strong potential for being enacted against the client in a way that reinforces negative relational experiences and messages. Therapists are therefore encouraged to maintain firm — although not rigid — boundaries in treatment and to focus on clients' resilience and strength as well as their damage and vulnerability to help manage countertransference and to offset the development of yet another negative relational experience.

Reenactments

Reenactments of the traumatic past are common in the treatment of this population and frequently represent either explicit or coded repetitions of the unprocessed trauma in an attempt at mastery (Chu, 1991; Messman & Long, 1996; Van der Kolk, 1989). Reenactments can be expressed psychologically, relationally, and somatically and may occur with conscious intent or with little or no awareness. Because the aftermath of insecure–disorganized patterns of attachment includes impaired self-worth and a belief that one deserves to be abused, patterns of traumatic bonding with those who do harm, parentification–caretaking of others, extreme dependency, and fluctuating ego states and dissociation, may all play out in some way, leaving the survivor client particularly at risk for additional exploitation, revictimization, and life difficulty. Behaviors such as self-injury, suicidality, aggression toward others, serious parenting difficulties, risk-taking, and setting up or allowing revictimization by others are often reenactments of some aspect of previous interpersonal trauma. Whatever their specific purpose or meaning, such replaying or reliving may represent a kind of nonverbal "remembering" and may be a way for the client to express dominant relational patterns and posttraumatic themes. Reenactments may also reflect habit, the repetition of familiar behavioral and relational sequences.

One primary transference–countertransference dynamic involves reenactment of familiar roles of victim–perpetrator–rescuer–bystander in the therapy relationship. Therapist and client play out these roles, often in complementary fashion with one another, as they relive various aspects of the client's early attachment relationships. Thus, transference and countertransference constitute reenactments that, if attended to carefully, may provide important information about the client's past attachment or trauma experience. The relational attachment approach includes conceptualizing the underlying attachment needs, respectfully identifying them with the client who is encouraged to use the therapy relationship as a base for exploring their connection to the past while progressively increasing self capacities, including emotional regulation to make behavioral and life changes.

Dissociation

Dissociation can be a highly effective way to manage overwhelming emotions and related attachment distress, although when overused and used out of its original context, it can have high personal and interpersonal costs. Here we address one very specific manifestation of dissociation, the dissociative *process* observed during therapy sessions (i.e., the client's shifting relational, emotional, and identity states) due to its relevance to the attachment perspective and to its understanding and management. The dissociative process is often triggered during moments of emotional intensity associated with past attachment relationship experiences (usually involving core emotions such as fear and terror, disappointment, despair, shame, and rage) that cause the client to shift internally, for example, from feeling adult and in charge, to feeling young, overwhelmed, and out of control of behavior or surroundings. At times, these shifts are very subtle and not readily identified — the only clue to them may be the therapist's own shifting feeling state or confusion. At other times,

they are pronounced and florid. Whatever its manifestation, dissociation is an alteration of self and relational capacity that is usually in the interest of self-protection and often occurs outside of the client's conscious awareness. From our perspective, the therapist's job is to observe and name the process while maintaining a position of relational equanimity and constancy (i.e., to remain within the RICH relational framework), using it as the secure base from which to help the client explore the emotional response, its specific triggers and associations, and the dissociative process. As the client comes to understand these aspects of his or her experience and they are no longer as threatening or alien, they no longer require such strong defenses and allow exploration of new behavioral patterns. Repeated processing of this sort assists the client to develop an increased awareness of his or her own inner experience and a stronger relationship with the therapist, leading over time to the growth of self capacities and revised, more secure, inner working models.

Challenges in Relational Trauma Therapies

The collaborative process involved in relational trauma treatment is demanding of both therapist and client. In keeping with the RICH formulation and the process research findings of Dalenberg (2000), the therapist must be authentic and emotionally available in the interactions and must have emotional integrity as well. Being authentic (or genuine) means maintaining an awareness of one's own feelings and needs, working to understand their origins, and using them to understand and assist the client. Emotional availability means being open about one's motives and goals in the therapy relationship (e.g., answering honestly yet sensitively when the client asks what the therapist feels). Authenticity and emotional availability are not to be confused with over-disclosure of personal information or engagement in dual roles with the client such as using him or her as a confidante, personal friend, romantic or sexual partner, or business partner. Such boundary violations and role reversals are against professional standards and countertherapeutic as they have high potential to retraumatize via reenactment, no matter how well intended or how much they are rationalized. While this may seem self-evident, reports from a variety of sources (clients, subsequent treatment providers, licensing and ethics, law enforcement) indicate how often these behaviors occur.

Therapist Support

As discussed earlier, working with complex trauma survivors holds many relational and personal challenges for therapists who, like clients, benefit from the support of RICH relationships (Saakvitne et al., 2000). Because no one is immune from countertransference responses and errors or the vicarious or secondary traumatization that can occur in these treatments from the traumatic material or from the relational process or attachment disturbance itself (McCann & Pearlman, 1990b; Wilson & Lindy, 1996), the importance of frequent trauma-sensitive consultation and supervision for this work for all therapists, at every level of experience, cannot be overstated (Pearlman & Saakvitne, 1995; Saakvitne & Pearlman, 1996). The consultation relationship must be safe and supportive enough to allow for the open discussion of all aspects of the treatment including the entire range of countertransference responses to support a treatment that harms neither the therapist nor the client and that provides a healing context.

Research Implications

Research on the efficacy of treatment for complex trauma is just beginning, most of it on structured, time-limited, cognitive therapy approaches directed at stabilization of PTSD and other psychiatric symptoms and skill-building (including skills in affect-management) although several preliminary studies of emotion-focused techniques are also available (Cloitre, Koenen, Cohen, & Han, 2002). Ford et al. (2005) provide a partial review of the various treatment protocols that are under development and research efforts that are now underway to test their efficacy. Research efforts to test a model such as the one proposed here would need to be oriented toward specific knowledge and skills of the treatment provider (such as therapist knowledge of attachment and complex trauma issues and adherence to the treatment model) and the quality of the treatment relationship as they affect outcome, including the development of specific self capacities, the changing of inner working models and attachment style, the changing of behavior, in addition to the lessening of PTSD and psychiatric symptoms. In all likelihood, the most comprehensive and effective treatment for the population of complex trauma survivors will be multimodal and will therefore require research efforts that capture different facets of the treatment, including the significance of the relationship between the treatment provider and the client.

Conclusion

In this article we highlight the need for a relational approach to the treatment of complex trauma clients in light of current understandings of attachment. While most

of these clients need to develop skills and many benefit from direct treatment of PTSD and psychiatric symptoms, we draw the reader's attention to the fundamental attachment disruptions that are at the core of complex trauma adaptations and suggest that the treatment must match the problem. Ideally, treatment includes elements presented in the RICH model. The therapeutic relationship is both the catalyst and the setting for the client's relational history to be played out and examined. The treatment relationship also provides a secure base from which the client can make the necessary changes for a greatly expanded repertoire of self capacities and relational skills.

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