UNC SCHOOL OF SOCIAL WORK CLINICAL LECTURE SERIES

Relational Dynamics in Treatment for Complex PTSD

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PART I: Definitions & Goals

A note on wording

- Psychodynamic bias in wording
  - Most relational explorations of C-PTSD have been authored by folks at least influenced by psychodynamic theory.
  - Also reflects my most recent trainings (AEDP & ISTDP)
- Other language
  - DBT: Therapy Interfering Behaviors (Therapist and Client) & Quality of Life Behaviors
  - Cognitive Therapy: Maladaptive Schemas and Modes (Therapist and Client)
  - Behavioral Therapy: Functional Analysis of Problematic Relational Behaviors (Therapy and Client)

Purpose of this Talk

- Training programs undertrain in relational dynamics in general but specifically for treating clients with C-PTSD.
  - Most therapists don't have training to manage the relationship (and therefore the treatment) with clients who have severe trauma.
    - Without training and experience, the pitfalls are intense and both people in the treatment end up failing and developing negative associations about clients (the therapist) and therapists (the client)
  - Like everyone else, these clients deserve the best possible care they can receive.
  - Phase Oriented Treatment
    - We live in era of quick fixes and managed care expectations
    - No shortcuts

Purpose of this Talk

- Risk of Vicarious Traumatization is high and we need support and understanding.
  - We as therapists also have the right to the best possible information to help keep us healthy.

> "The most painful form of countertransference reactions occur when therapists are unable to acknowledge their countertransference anger and actually project their own anger… onto their patients. In the therapists, the patients then become a seemingly real and substantial threat.
>
> The therapists actually develop a mild form of posttraumatic stress disorder, complete with unwanted intrusive thoughts, nightmares and disturbed sleep, avoidant responses, and even startle responses." (Chu, 2011)

My Personal Motivation

- On a more personal note:
  - Acknowledging my own missteps
    - Ways my own lack of training and my Relational Dynamics have interfered or harmed treatments.
  - I've trained with experts for the past 9 years
    - Want to pass on what I've learned through my own mistakes, failures, and also my training.
    - Always refining!
  - Most meaningful quote for me:

> "There are few shortcuts, and even with competent treatment and maximal effort from both patients and therapists, the early treatment process is often punctuated by crisis and anxiety. It is a common experience for therapists and patients to feel as though they are riding some kind of roller coaster with little sense of control or direction, and to have a constant feeling of impending crisis and potential danger." (Chu, 2011)

Diagnostic Drama

- C-PTSD is not recognized disorder by DSM or ICD
  - Closest definitions: PTSD, chronic subtype (ICD-10)
    - Not specific enough
    - Push from experts to get into DSM-5 was unsuccessful
- Borderline Personality Disorder; Dissociative Identity Disorder; Somatoform Disorders; Multi-Diagnosed Persons; etc.
- For now, C-PTSD does not have official place as a diagnosable disorder.
  - For this talk we will focus on:
    - Workable Definition
    - Consequences (sequelae)

What is Complex PTSD?

- Complex Psychological Trauma = Results from exposure to severe stressors that
  - 1) Are repetitive and prolonged
  - 2) Involve harm or abandonment by caregivers
  - 3) Occur at developmentally vulnerable times in a victim's life, such as early childhood or adolescence
    - When critical periods of brain development are rapidly occurring or being consolidated (Courtois & Ford, 2009)
- C-PTSD can also develop in adulthood as a result of repeated, chronic traumas, natural catastrophes, war, & displacement (ISTSS, 2012; Herman, 2015).
  - Unmasking
  - Diathesis-Stress Model
  - Lack of Institutional, Governmental, and Community Support

How C-PTSD is different

"Complex trauma is a subset of the full range of psychological trauma that has as its unique trademark a compromise of the individual's self development …

Complex Trauma involves not only the shock of fear but also, more fundamentally, a violation of and challenges to the fragile, immature, and newly emerging sense of self.

Complex trauma often leaves the child unable to self-regulate, to achieve a sense of self-integrity, or to experience relationships as nurturing and reliable resources that support self-regulation and self-integrity." (Courtois & Ford, 2009)

Consequences of C-PTSD

- Changes on most human dimensions of experience
  - Functioning is altered across multiple levels: thinking, acting, feeling, memory, sense of self.

"Changes to the mind, emotions, body, and relationships experienced… including problems with dissociation, emotional dysregulation, somatic distress, or relational or spiritual alienation." (Courtois & Ford, 2009)

"Complex Trauma results in a variety of reactions, generally divided between attempts to avoid the trauma or reminders of it and indirect attempts to confront it. The goal of the behavior, whatever form it takes, is to deal with intolerable events while simultaneously staying apart from full knowledge of the trauma." (Danylchuk, 2017)

Consequences (cont.)

- Complex Dissociation = "involves a fragmentation or "disintegration" of the person's sensory-perceptual awareness, thoughts, feelings, memories, and sense of self such that these are no longer adequately cohesive or coordinated " (Steele & Van Der Hart, 2009)
  - This will likely show up in the therapy and the way the client relates to you from session to session.
- Dissociation increases likelihood and Frequency of Traumatic Reenactments
  - Traumatic reenactment = "an unconscious (out of awareness) reliving of the traumatic experience" (Clark et al., 2015)
  - Can be conceptualized as an attempt by the trauma survivor to gain control or mastery over the experience" (Herman, 1992)

Working Set of Criteria

1. Problems with Regulating Affect (e.g., hyper/hypo arousal)
2. Problems with Regulating Impulses (e.g., risky behavior)
3. Impairments, on a biological level, on the ability to self regulate (e.g., somatic symptoms)
4. Impairments in Attention or Consciousness (e.g., dissociation)
5. Impairments related to perceptions of perpetrator(s) (e.g., idealizing abuser)
6. Impairments in Self-Perception (e.g., feelings of self-hate or self-blame)
7. Impairments in Relational Functioning (e.g., difficulty trusting others or feeling overly dependent)
8. Impairments in ability to make meaning and sustaining beliefs (e.g., feeling hopeless about the future)

(Courtois & Ford, 2009)

Part II: Treatment Guidelines & Therapist Stance

Limitations of this Talk

- Will not be covering C-PTSD in children
- Cannot take the place of supervision
- Many of the pieces we will be discussing today are about treatment in Phase I
  - Won't be covering therapists reactions to disclosure
  - Won't be covering managing safety crises.
- Will not be explicitly covering adult onset C-PTSD.
- Attachment Theory is implied but not explicitly detailed in this presentation.
- Dissociation is touched upon but given time restraints cannot be adequately covered.
  - Highly recommend people learn more about Structural Dissociation Model (Steele & Van Der Hart, 2009)
  - Also Noga Zerubavel @ Duke has an excellent paper from a cognitive behavioral perspective (Zerubavel, 2015)

C-PTSD: Treatment Guidelines

1. Establishing safety, stabilization, control of symptoms, and overall improvement in ego functioning

   Early phase of treatment is often "most complex and difficult," as dilemmas "are most formidable for patients and clinicians."

   SAFER Model describes tasks in early treatment phase:

   - **S**afety and Symptom control,
   - **A**cknowledgment of the role of trauma,
   - **F**unctioning,
   - **E**xpression of affect and impulses in a productive manner, and
   - **R**elational work.
2. Confronting, working through, and integrating traumatic memories
3. Cont'd integration, rehabilitation, and personal growth

(Chu, 2011)

Setting Basic Frame of Psychotherapy

Ideas below are about managing relational difficulties most effectively while keeping client focused on goals

- Must have agreed upon Goals!
  - Goals must be client focused (not others focused)
  - Interpersonal Treatment but with Intra-Psychic Focus (Shapiro, 2017)
  - You must, as a therapist, keep grounded in those goals and reorient the client to them as much as is needed.
    - Most stages of treatment cannot be completed unless the goals are clear and returned to.
- Focus on Empowerment
  - Manage Dependency (Steele, 1991)
- Keep your interpersonal and practice boundaries solid, "Good Fences make Good Neighbors" (Chu, 2011)

Part III: Working Relationally

The Case for a Relational Treatment in C-PTSD

- Relational Psychotherapy (no agreed upon definition)
  - Having a relationship will in itself cure a client
- What I am suggesting: psychotherapy that takes into account relational functioning of client, the primacy of relationships in the human experience, and focuses interventions on increasing interpersonal/relational functioning
- C-PTSD is a relational disorder

  "Given their beliefs about themselves and expectations about others, survivors often experience their present relationships in ways that are similar to past abusive relationships – including the abusive relational dynamics" (Clark, et al., 2014)

The Case for a Relational Treatment in C-PTSD (cont.)

- The dynamics of transference and countertransference are important to recognize because they can not be avoided
  - "Recognizing transference enables the therapist to step back in order to reflect on the dynamic that is being played out in the relationship." (Clark, et al., 2015)
  - "Transferentially, the therapist is always on the brink of becoming an abusing or abused other" (Davies & Frawley, 1994)

Going Further: Setting a Realistic Frame for Relational Work

- Not completely neutral but not too close
  - Too close, even if elicited by client, is intrusive and increases likelihood that intra-psychic focus can't be sustained.
  - Too much warmth by therapist can cause problems
- Establishing "Good Enough" safety
  - "Safe but not too safe" (Bromberg, 2013)
- Clear Boundaries are Relational
  - Too far in, you can't get enough perspective to be useful and you increase likelihood you and client will be (re)traumatized.
  - Too far out, you aren't likely to elicit enough collaboration or instances to be experiential about relationships.
- Empowering vs. Caretaking
  - See your job as one in room who can model a healthy working relationship to help client navigate their world. People tend to live up or down to our expectations of them.
  - Many clinicians go towards supportive, non-directive psychotherapy not because the client requires that treatment, but because the therapist and client have colluded to not navigate difficult waters.

Relational Treatment

"Many investigators and clinicians have described these difficulties that impair the relational capacity of chronically traumatized patients. However, the experience of this interpersonal world is most vividly communicated by abuse survivors through their relationships with others, including the relationships with the clinicians that treat them.

Their communications – in the form of unarticulated feelings and behaviors based on fear, anger, and despair – speak with mute torment about their past relationships and the harshness of the interpersonal world they continue to inhabit.

Only by entering this interpersonal world – and by intermittently sharing the experience of the chronically abused patient – are clinicians able to understand their patient's dilemmas and effectively treat their relational dilemmas."

(Chu, 2011)

7 common Pitfalls

- The "Love Cure"
- Not recognizing relational patterns early
- Reinforcing disempowerment, regression, and dissociation
- Not doing experiential work
- Invalidation
- Not getting consultation
- Trying to do more than is possible

Being Real about what Love Can do

"Therapists who expect patients to respond positively to an approach that consists primarily of caretaking or reassurance will be ill-equipped to weather the vicissitudes of the therapeutic process with abuse survivors. Patients who have been damaged by early interpersonal trauma cannot be "loved into health."

"It is not easy for therapists to understand and accept that they will be able to consistently relieve patients' suffering, avoid conflict, or be seen as positive and helpful." (Chu, 2011).

- Clients cannot have different pasts than they have. There is no redo at one level.
  - You, as the therapist, cannot undo the truth of how your clients were treated as a child.
    - Must watch for your part in reenactments here.
    - **The Good News:**
      - Modern day psychotherapy treatments can help clients sensitize themselves to their avoidance and reprocess their trauma in a way that is more tolerable.

Love (cont.)

- It is OK for you to be cautious!
- If you're main intervention is to correct early client's attachment system through explicit care and reassurance, chances are you are mis-attuned with many other tasks necessary for a client to recover.
  - Frequently causes more disorganization and distress.
- Attachment is earned over time (Siegel, 2015).
  - Three additional components: Attunement, Rupture, and Repair (Siegel, 2015).
- Pay attention to ruptures
  - Some ruptures cannot be resolved immediately
    - Some new evidence that not all ruptures must be resolved early in treatment (Zilcha-Mano & Errázuriz, 2017)
  - Over focusing on Repairing Ruptures can quickly turn into a therapy interfering behavior for both parties.

Look for Relational Patterns Early

- Pay attention to presenting problem.
  - What are they coming in to therapy for?
  - What are their initial expectations of therapist role?
    - Set frame as quickly as possible about your role.
    - How well are they listening to you as you set the frame?
- Begin assessing immediately for relational issues and dynamics.
  - What is the person saying about important past and current relationships?
  - What are they not saying?
- Look for "double binds"

Relational Patterns (cont.)

- Pay close attention to how you're feeling in room.
  - Dissociated?
  - Anxious?
  - Connected very quickly?
  - Disconnected?
- If they have been in previous therapies, how are they describing those treatments?
- Do you both have a mutually agreed upon goal of therapy?
- Begin writing down hypotheses around relational dynamics.

Relating in a way that is Empowering and Integrating

A primary task of treatment is to teach self regulation skills. Many people who come to us have no confidence in their ability to regulate themselves.

- This must be an explicit goal that is followed through upon.
- How much are you reassuring? What is function of reassurance? Is it helping towards long term goals?
- Useful distinctions:
  - You and the present day client being with their pain versus you being there for their prior pain.
  - You coaching a client on how they have choices to improve quality of life versus you problem solving for the client about how to improve their life.
    - **Subtle but profound distinctions here.**

Empowering & Integrating (cont.)

- How are you speaking (from a language perspective) to your client?
  - Are your interventions integrative or disintegrative?
  - Are clients learning to hold mixed feelings in their body?
  - Do functional analysis if you choose to do explicit parts work?
    - Is the client overusing this strategy?
    - Is this strategy helping in their daily life?
    - If not, here are some suggestions on language:
      - "Different way of being you" (Chefetz, 2015)
      - What happened right before you shifted into this way of being?
      - When you describe yourself in that way, what feelings are located there that are difficult?

Being Experiential

- "Believing intellectually that it is likely that world has changed and knowing emotionally that different behaviors are preferable are two entirely separate conclusions" (Dalenberg, 2005)
- Because trauma happens in mind/body context, it helps for interventions (including in Phase I) to be experiential, not just cognitive
  - Clients need in-situ practice:
    - Lowering arousal
    - Redirecting attention
    - Expressing Emotion
- Experiential interventions in Phase I should be tailored to build capacity and stability.

Validating

- Clients have frequently gotten the message: "It's not me, it's you." "It's not me, it's them."
  - This presents a very delicate dance because the therapy cannot become about you
    - Internal longings for corrective emotional experience can pull you both there
  - Have to find a way to keep intra-psychic focus but be VALIDATING
  - Admit your mistakes or missteps but keep an intra-psychic focus.
  - Linehan (1993) and later DBT works are excellent source on how to work with validation in psychotherapy.

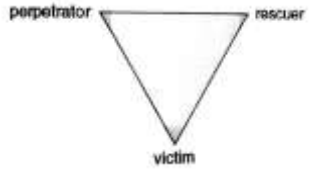
Avoiding Consultation

- Personal Anecdote: asking me not to get consultation with colleagues
  - Totally understandable
  - Our job here
- Shame around own feelings and interactions with clients.
  - Fears of judgment by supervisor
- Shame around having to look at/re-visit unresolved attachment failures and or traumas from their personal life
- Fears around having to confront ways their reactions are affecting their relationships with loved ones

Realistic Commitments

- General Rule = Don't Make Promises!
  - "Traumatized patients report their therapists often disappointment or betray them" (Dalenberg, 2005)
  - Agreements should be made by stating, "I will do my best (*in this way*)."
  - Your effort and attention to ethics and care are what are needed, not your reassurances of perfection.
- Out of session Contact:
  - DBT concept of phone coaching (Linehan, 1993) is an excellent protocol for phone calls.
  - When possible, try to anticipate with clients situations that are going to be difficult for a client and come up with plan.

Original Karpman Triangle



Clark, 2015
Karpman, 2007

Karpman Triangle (cont.)

- Originally developed by Stephen Karpman, MD in 1968, developer of Transactional Analysis (Karpman, 2007)
- "…identifies set roles in relationships [and] … has become a very popular and useful representation of a common dynamic in dysfunctional families and systems" (Danylchuk, 2017)
- Useful early in treatment as a psychoeducation tool and way to prepare clients for later reenactments.
- "People who have lived in dysfunctional families, and learned one of the three fairly rigid roles, **abuser, victim, or rescuer,** will bring those roles into therapy. Helping professional are often looked to for rescue. When that doesn't happen, they may be seen as powerless, like victims, or powerful and deliberately not helpful, like abusers."
  - Not intentional, may be the only way a person knows how to relate (Danylchuk, 2017)

Victim Role

Person caught in role may feel:
- Powerless, oppressed, helpless, hopeless, victimized, vulnerable, weak, devalued, used, self-blaming, despairing.

A Provider is in Role may feel:
- Unwanted, unhelpful, unimportant.
- May be working extremely hard to make a connection.
- Like giving up, there is no use.

A Survivor may feel:
- Compelled to deny their feelings and put provider's needs first.
- Must be "good" to retain relationship.
- Provider is either intentionally or unintentionally harming them.
- Provider is taunting them or playing games with them.

(adapted from Clark, et al., 2015)

Perpetrator Role

Person caught in role may feel:
- Omnipotent, controlling, invasive, intruding, crossing boundaries, demanding, manipulative, destructive.

A Provider is in Role may feel:
- Overactive and Intrusive.
- Controlling the session and provider.
- Can feel this way when working with hospitalization issues.
- Anger eruptions.

A Survivor may feel:
- Intruding on professionals personal and professional life of provider.
- Entitled and demanding.
- Threatens termination or other forms of retaliation (litigation) for a felt injury.

(adapted from Clark, et al., 2015)

Rescuer Role

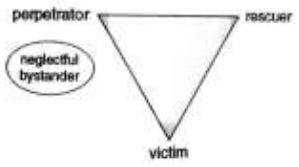
Person caught in this role may feel:
- Caretaker; savior; omnipotent protector; needed by the other; guilty for making the other feel hard feelings.

Provider is in the Role may feel:
- Fantasies about bringing the client home with them.
- Urge to protect the survivor from certain feelings and people.
- Open to giving extra time or special care.

A Survivor may feel:
- Overly attuned to the provider's mood and needs.
- Tries to make the provider feel better if they seem stressed or dysregulated.
- Protects the provider from their feelings.
- Protects the provider from their trauma narrative.

(adapted from Clark, et al., 2015)

Modified Karpman Triangle



Clark, 2015

Modified Karpman Triangle (cont.)

- Developed by Clark, Classen, Fourt, & Shetty (2015).
  - Added 4th person identified in earlier work of Davies and Frawley (1994)
    - Clients frequently recognize this role for example in a "neglectful parent who turned a blind eye" (Clark, et al., 2015)

Neglectful Bystander Role

Person caught in this role may feel:
- Dismissive
- Uninterested
- Forgetful
- Bored, angry, or withholding
- Non-responsive

A Provider is in the Role may feel:
- Uninterested or bored in their work with client.
- Forgets important details of client's life or story
- Unusually tired or impatient

A Survivor may feel:
- Uninterested in therapist's questions.
- Dismisses their own vulnerabilities as unimportant

(adapted from Clark, et al., 2015)

But there are only two people in the room?

- It can indeed be the case that client and therapist are simply acting out two roles on the triangle.
- When we take an intra-psychic and relational perspective, or there is prominent dissociation, it is equally likely that multiple roles are being played out all at once.
  - Example: A client that self-harms describes being severely distressed and ashamed about what they are doing to themselves but sees no other choice but to punish themselves for their vulnerability (Perpetrator – Victim). The therapist feels distressed and wants to fix the issue and also has strong feelings of wishing the client would quit therapy (Rescuer – Neglectful Bystander)

(cont.)

- A third common scenario: It is also possible for both parties to feel like victims (and the other is the perpetrator) at the same time.
  - Example: Anxiously attached client sees that therapist is newly wearing an engagement ring. Fearing abandonment, client goes into attachment panic and demands details of when therapist is marrying and what that means for their therapy. Client asks whether therapist will have a child and begins demanding extra sessions and phone calls. Therapist is enraged at intrusiveness, feels flooded and violated, and responds in a dysregulated way that communicates client is hopeless and crazy.

Getting off Triangle with Clients

- It is the provider's role to intervene and get things unstuck.
  - Provider should identify where they are on the triangle and respond accordingly (below)
- Victims should act/do:
  - Provider should set limits on things the survivor does or says that are overtly abusive.
  - Consider sharing their experience, in a mindful manner, of feeling like a victim to help client understand dynamic.
    - May help client empathize
    - Careful! Client may immediately switch to shame and degradation (rapidly switching to victim)
      - Avoid becoming rescuer
      - Instead acknowledge the cycle and validate it is understandable given the client's history

Getting off Triangle (cont.)

- Perpetrators should empathize:
  - Provider should empathize with survivor. "If the survivor does not identify with the role of perpetrator (i.e., cannot recognize any feelings within themselves that align with the perpetrator role) but the survivor is acting as if the provider is the perpetrator, it is important for the provider to pause and imagine some of the feelings the survivor might be having in response to the provider" (Clark, et al., 2015)
  - Provider should VALIDATE (Linehan, 1993)
    - Validating is not the same as necessarily agreeing (if not justified).

Getting off the Triangle (cont.)

- Rescuers should stop and wait:
  - Act opposite to urges to fix or resolve.
  - Stop and reengage in a collaborative and empowering fashion.
  - Also explore with client if there are ways client can rescue self.
- Neglectful Bystanders should become "Wise Observer"
  - Ask client about their thoughts and feelings in the moment
  - Consider openly acknowledging where they are and helping client tie it to early experiences.

The Possibilities of Relating

"When the survivor does step out of the triangle, able to separate self from roles both in terms of identifying with them and behaving within their constraints, he or she will be able to say:

- 'I have been traumatized—I am not my trauma. I have been victimized—I am not a Victim. I have hurt others, intentionally or not—I am not an Abuser. I have helped others—I am not a Rescuer. I am a human being, a unique person, separate from and connected to all around me. I am not in control, but I do have personal power. I do not know everything, but I do have wisdom" (Danylchuk, 2015)

- Clients will have learned powerful lesson and tool set in order to relate to you and others in their life in non-abusive ways.

"To redeem one person
is to redeem the world"

Frieda Fromm-Reichmann

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