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Relational Healing for Relational Injury in the Treatment of Trauma

(Christine Courtois, PhD, ABPP)
Relational Healing for Relational Injury in the Treatment of Trauma
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Disclosure


Relating to Traumatized Individuals

• Can be quite daunting
• Impacted by the trauma experience including the details
• Especially impacted if interpersonal/relational/betrayal
• More complex dynamics and relational patterns
• Ambivalent attachment and bonds
• More disbelief, even in the victim
Traumatized Persons’ Presentation for Treatment

- Pre-trauma history and development (if any)
- Attachment history & style (Inner Working Model)
- Trauma and type
- Post-trauma adaptation and response
  - No PTSD (non-pathological); sub-clinical PTSD
  - ASD
  - Classic PTSD (w/ associated conditions)
  - Complex PTSD/DES/NOS (w/ associated conditions)
- Life course development
  - Intensification/acceleration of development
  - Retrogression & regression
- Co-morbid conditions
- Contextual variables
  - Family of origin, cultural, religious, gender

Response to Trauma is Impacted by Objective and Subjective Factors

(Wilson, 1989)

- Objective
  - details of the experience and how it happened
- Subjective
  - the individual’s unique experience of the situation

Therapist must seek to understand the unique circumstance and meaning

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 are often compounded by trauma (including attachment trauma)
Transference is Colored by Aspects of All Forms of Trauma, Especially Interpersonal

- Shock at being traumatized
- Shattering of assumptions
- Just world
  - Ability to be in control and to understand
- Cognitions
- Attributions
- Meaning-making & spirituality
  - Why me? Why not you?
- Pre- and post-trauma self
- Trauma impact
  - Physiological and psychological
  - Injuries and damages
    - Physical
    - Emotional

More So When Interpersonal

- All of the above and...
- Betrayal
- Premeditation
  - “no one is trustworthy or to be trusted”
- Deliberateness
- Entrapment
- Intrusiveness
  - physical 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/personal...

More So When Relational/Attachment and Developmental

- Attachment styles developed in primary attachment relationships within first 18 months
- Secure
- Insecure: anxious-fearful (vigilant)
  - Dependent ("velcro")
  - Avoidant
  - Self-defeating
  - With borderline characteristics
Relational/Attachment and Developmental Trauma

- Insecure: Anxious-avoidant (dismissive)
  - Counterdependent/self-sufficient ("teflon")
  - Detached/avoidant
  - Contemptuous
  - Dissociated
- Insecure: Disorganized/disoriented
  - Avoidant, self-defeating, borderline highest likelihood
  - Contradictory, approach/avoid; push-pull style
  - Dissociated
  - By age 6, often involves a sub-style of controlling/caretaking

Developmental Trauma

- Altered physiology, starting at neuronal level
- Altered brain structures
- Altered brain functions
- Patterns of hyper- and hypo-arousal
  - Patterns of defense
- Altered self & personality (Herman)
- Altered relationships

PTSD/DD Defenses

- **Purpose**: To avoid experiencing trauma memories, responses and emotions (pain, overwhelming emotions, and feelings of powerlessness).
- **Involves ego splitting and/or creation of new ego states** (through splitting of consciousness and awareness via dissociation) to project and contain disavowed and unacceptable feelings, impulses, or objects.
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
  - intimate
  - parenting
  - work
- In the therapeutic relationship
  - transference
  - enactments, reenactments, projective identification
- May give somatic/behavioral/relational (vs. narrative) clues especially in response to internal (i.e., feelings, felt-sense, state of mind) or external triggers

Psychotherapy is a “shared journey of inescapable mutual influence”
(Schultz-Ross, Goldman, & Gutheil, 1992)

Attachment Patterns Resulting from Interpersonal Trauma that Might Play Out in the Treatment Relationship*

- Secure
- Insecure: anxious-fearful (vigilant)
  - Dependent (“velcro”)
  - Avoidant
  - Self-defeating
  - With borderline characteristics
Attachment Patterns Resulting from Interpersonal Trauma that Might Play Out in the Treatment Relationship*

- Insecure: Anxious-avoidant (dismissive)
- Counterdependent/self-sufficient (“teflon”)
- Detached
- Dissociated (Barach, 1991)

Insecure: Disorganized/disoriented
- Avoidant, self-defeating, borderline highest likelihood
- Contradictory, approach/avoid; push-pull style
- Dissociated (Liotti, 1992; 1993)

By age 6, often involves a sub-style of controlling/caretaking

Interpersonal Neurobiology

--Right brain to right brain attunement: implicit factors
--Development of new neuronal pathways: “neurons that fire together wire together” connection enables genetic expression
--“Earned secure” attachment through relationship

(Schore, Seigel)

- Affect regulation: from co-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, Siegel)

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

Interpersonal Neurobiology

(Schore, Siegel, others)

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

The Importance of Relational Repair

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

Posttraumatic

Involving one or a combination of re-enactment, re-experiencing, and re-victimization phenomena and alterations between numbing/denial and intrusion symptoms along with hyperarousal and startle responses.

(Loewenstein, 1993)

The Therapy Relational Matrix

Dissociative

Involving such properties as absorption, heightened suggestibility, focused attention, and amnesia; altered perceptions; and cognitive distortions such as literalness and the tolerance and rationalization of illogic and contradiction (trance logic).

(Loewenstein, 1993)

Relationship with the Patient

• transference/countertransference
• therapeutic alliance
• real relationship
Non-countertransference (but may be affected by countertransference):
• positive attitude
• warm, connected stance
• responsive/interactive
• compassionate
• empathic
• appropriate and empathic confrontation
• interpretation

(adapted from Turkus, 1993)
The Therapeutic Relationship

- Need for empathy
- Need for attunement
- Misattunement is an opportunity for repair
  - When ruptures occur (as they always will), the therapist uses the opportunity for communication and problem-solving leading to repair
  - owns mistakes
  - shares feelings in the moment (with discretion)
  - is not blaming
  - seeks to understand, collaborate
- Therapist must not make self the “all-knowing authority on high”

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 clients
  - Must try to stay steady state and responsive, curious

Boundary Issues

- Therapist must be aware of “treatment traps”, transference, countertransference issues and carefully monitor the relational process
  - Therapeutic errors and lapses will occur and how they are handled can either be disastrous or can be restorative to the patient and the relationship
  - knowing about them can help the therapist get out of them more rapidly 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 vigilance and the integrity of frame
  - Be thoughtful as to setting boundaries/limits
  - re: availability, personal disclosure, touch, fees, gifts, tolerance for acting out behavior, social contact, etc.
- On average, start with tighter boundaries
- Avoid dual roles wherever possible
- Be prepared to hold to boundaries/limits but also to have some flexibility
- Complete 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 who have a strong need to caretake or are enticed by the patient
  - may give patient 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 patient is blamed
  - may relate to malpractice suits, in some cases (see BPD literature)
- 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

Boundary Issues

- Responsibility of supervisors
  - To protect patient and the supervisee
  - To document supervision
  - Response to a patient’s report of past or ongoing sexual relationship with previous therapist [The “Sitting Duck-Syndrome” (Kluft) / “Professional Incest” (Courtois)]
  - Know state law—varies by jurisdiction
  - Consult state board, professional organizations, attorneys, insurance trust
  - Patient welfare issues
    - be aware of ambivalent attachment
    - work slowly and carefully
    - mistrust and boundary issues
  - Therapist welfare issues
    - Impairment, CT, VT, & self-care
Transference Reactions

Transference reactions, 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 seeking to understand their meaning with the patient.

Transference

“… a specific illusion where the patient mistakenly attributes to the person of the therapist some of the features of a significant relationship from the patient’s past, but which is nevertheless believed by the patient to be appropriate to the therapist.”

(Sandler, 1970)

Five Selected Transference Themes in Trauma Treatment

1. Traumatic
2. Shame-Based
3. Merger-Abandonment
4. Sadomasochistic
5. Loss-Based
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!”

Victimizer

Victim

Rescuer

Passive Bystander

Trumatic Transference Reactions

- Fear of being known & fear of being re-abused
  - Therapy may feel like torture to the patient due to control and power dynamics
    - patient is “intruded upon” and made vulnerable
    - Patient may behave like a victim and “invite” the role of perpetrator/intruder
  - As compensation, perfection may be expected of the therapist—anything less is intolerable
    - “You must be perfect, or you are like them”
    - “You must take of me, love me, etc. perfectly”
Traumatic Transference Reactions

- Erotic/eroticized transference may develop
  - Patient may resist or try to control/protect self through dependence/attachment/seduction
- Erotic Transference: Pertaining to the need to be special, exceeding the usual boundaries of treatment
- Erotized Transference: “an intense vivid, irrational, erotic preoccupation with the analyst characterized by overt, seemingly ego-syntonic demands for love and sexual fulfillment from the analyst” (Blum, 1973)
- Erotic and traumatic/dissociative transferences may cause the development of a sadomasochistic aspect to the therapy relationship (Chefetz, 1991)

- Patient may victimize/“torture” the therapist
  - Direct action: assault, threats, property destruction, self-harm, suicidality, risk-taking, stalking, intrusion into the therapist’s life
    - “I’ll show you what it feels like”
  - Restitution and entitlement dynamics
    - “You owe me and must make up for the past”
    - “You are not good enough/anything you do is good enough”
  - “Malignant” dependence, passivity and regression
    - “rescue me!”
  - Resistance and non-cooperation with treatment contract
    - “I’ll prove to you how bad I am and make you give up on me”

Shame-Based Transference

- Personal devaluation
  - “I am bad”
  - “Don’t notice me”
  - “I deserve mistreatment and neglect”
  - “I’m unworthy and flawed, you’re not”
  - “To work with me, you risk being like me”
  - “I’ll contaminate you”
- Grandiosity as a defense
  - “I’m better than you and don’t need/want anything”
  - “Don’t see me for who I really am”
  - “I won’t let you in”
Merger-Abandonment Transference

- BPD-type dynamics
  - Preoccupation with regulating space
  - Relationships are viewed as rigid, non-elastic
  - Attachment to defend against fear of abandonment: fusing/losing
  - Attachment/rejection
  - Longing/dread
  - Connect/disconnect
  - Idealization/devaluation
  - Splitting

Merger-Abandonment Transference

- Transference bondage (Kohut)
  - Patient trades autonomy for safety/attachment
  - Reparenting dynamic
  - Dependence/passivity
  - Idealization/devaluation
    - “You are my savior/you are no good”
  - Other-directness/superficial compliance
    - “What is it that you want?”
    - “Let me take care of you because that is what I know/those is how I stay safe”

Sado-Masochistic Transference

- Power and control dynamics
  - often to defend against terror, pain, and sadness
  - attachment/detachment through controlling or being controlled
- Victim/victimizer role enactments
  - identification with the perpetrator
  - revictimization and repetitions/reenactments
- Rage and pain to violence/sexualized violence
- Therapist as sadist or masochist
  - May be abuser, bystander, rescuer, or victim
Sado-Masochistic Transference

“In short, the psychodynamics of severe sexual trauma include the transformation of the normal function of erotic arousal to absorb aggression into its opposite—the deterioration of the erotic response under the dominance of aggression and the development of a ‘perversity’; that is, an unconscious and often also conscious transformation of sensual arousal into an instrument of aggression.”

Kernberg

Loss-Based Transference

- Patient often has multiple losses to grieve
  - Of self, lifetime, personal development
  - Exploitation and betrayal
  - Lack of protection, neglect, abandonment
  - Reenactments and other behaviors/reactions
- Losses may be denied
  - Anger may mask grief
  - Patient may defend against the painful affects associated with losses and resist attempts to work with them
- Abandonment may be expected/fearred
  - Patient may expect no empathy and abandonment if losses are acknowledged
  - Losses may continue in the present

Projective Identification

NB: not the same as projection

**Projection:** onto the object

**Projective Identification:** into the object with the resultant experience of the object being changed

"A mechanism revealed in phantasies in which the subject inserts his or herself in whole or in part into the object in order to harm, possess or control it"

(Laplanche & Pontalis, 1973)

It may also be a way to communicate.
**Enactment**

“Any action occurring during the psychotherapy or psychoanalysis that repeats an earlier similar experience or fantasy and communicates feelings from such an experience or fantasy by non-verbal means in a way that will draw the therapist or analyst into non-verbal communication.”

(Helm, 1998)

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**Newer Concepts**

- Resilience
- Posttraumatic Growth
- Countertrauma
- Counterresilience
- Vicarious PTG

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**Countertransference**

“The therapist’s unconscious contribution to the therapy, both subjective (a very personal response by the therapist to the patient) and objective (how most people would respond to the patient):”

(Gorkin, 1987)

“The total emotional reaction of the analyst to the patient.”

(Kernberg, 1965)

Includes images, feelings, thoughts, impulses, sensations, and so on, whether conscious or unconscious and including dreams, fantasies, and images about the patient outside of the session.

(Baker, 1997, quoting Usher, 1993)
**Countertransference**

- **Always present, so expect it!!!**
- Consider it a valuable source of information
  - Seek to talk about it
  - Seek to explore and understand it
    - alone, in consultation and supervision
  - with the patient
- When caught in enactments, try to use them to understand the patient. Maintain therapeutic boundaries!!! Be aware of personal limitations and vulnerabilities. Seek consultation as needed.

**Factors That Interact to Determine Countertransference**

- The nature of stressor dimensions in the trauma and trauma story
  - personal meaning
- Personal factors in the therapist
- Patient factors relevant to understanding countertransference
- Institutional/organizational/societal factors relevant to therapeutic process

**Countertransference Indicators**

- Physiological and physical reactions
- Emotional reactions
- Psychological reactions
- Signs and symptoms that may be conscious or unconscious:
  - forgetting, attention lapses
  - loss of empathy
  - anger, hostility
  - relief when appointment is missed
  - denial of feelings or need for consultation
  - excessive concern
  - psychic numbing
  - self-medication
  - loss of boundaries  
  (Wilson & Lindy, 1994)
### 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

### The Bottom Line

The therapist cannot reparent or take away the pain of the abuse/abandonment. The patient must take responsibility for his/her own recovery (and memories when they are in question) and must grieve associated losses.

Calof
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.

Symptoms of Secondary Trauma

- Sleep disturbances/nightmares
- Anxiety, fear, hypervigilance
- Depression, despair
- Hyperarousal, startle response
- Anhedonia
- Intrusion of traumatic material
- Numbing, alexithymia
- Dissociative experiences
- Anger, irritability
- Other…

- Obsession with evil in the world/increased sensitivity to violence
- Sexual disturbances
- Eating disturbances
- Addictions
- Social withdrawal, exhaustion
- Cynicism and loss of empathy and hope
- Exacerbation of symptoms related to any prior trauma history
Symptoms of Secondary Trauma

- Disruptions in:
  - general frame of reference
  - world view
  - identity
  - self capacities
  - ego resources
  - psychological needs and cognitive schema
  - sensory experience

(Pearlman & Saakvitne, 1992)

Professional Strategies for Secondary Trauma

- Identify and de-stigmatize it
- Seek peer support/consultation
- Seek supervision
- Seek psychotherapy
- Assess personal capacity to do this work
- Find or renew meaning in the work
- Diversify caseload and professional activities
- Seek training
  - specialized workshops/retreats
  - Establish work/private life boundaries
  - Focus on recovery possibilities and realities

Personal Strategies for Secondary Trauma

- Boundaries
- Assess fit with life and personality
- Decrease stressors
- Focus on the positive and loving
- Develop and use a personal support network
- Diversify activities and have fun
- Exercise/bodywork/massage
- Nature/spirituality
- Vacations

Have a life outside of work!!!!
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