Complex Trauma: Contributions from Depth Psychology

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The Challenge of Defining Trauma:

- "Like everyone else, I have tended to use the term "trauma" rather loosely up until now…Whenever I am tempted to call an event in a child's or adult's life "traumatic," I shall ask myself…Do I mean the event was upsetting? That it was significant for altering the course of further development; that it was pathogenic? Or do I really mean traumatic in the strict sense of the world…i.e. shattering, devastating, causing internal disruption by putting ego functioning and ego mediation out of action?" (A. Freud, 1967, p.242).
- "But I suppose life has made him like that, and he can't help it. None of us can help the things life has done to us. They're done before you realize it, and once they're done they make you do other things until at last everything comes between you and what you'd like to be, and you've lost your true self forever."

(Eugene O' Neill, *Long Day's Journey into Night*, p. 63, Act 2, Scene 1)

Complex Trauma

- A type of trauma that occurs repeatedly and cumulatively, usually over a period of time, and within specific relationships and contexts.
- Refers to all forms of domestic violence and attachment trauma occurring in the context of families and other intimate relationships.

Neglect	Disease, Surgical Procedures
Emotional/Verbal Abuse	Natural Disasters
Physical Abuse	Poverty
Sexual Abuse	Slavery – child labor, sex trade
Attachment Trauma	Human Trafficking
Loss of Primary Caregivers	Refugees
Domestic Violence	War
Family Chaos/ Family Dynamics	Ongoing Combat
Violence	Acute/Chronic Illnesses
Famine	Intensive Medical Interventions
High Infant Mortality	

(Courtois, 2008; Ross, 2009)

Complex Posttraumatic Syndromes

- *Complex PTSD* (CPTSD) or *Disorders of Extreme Stress Not Otherwise Specified (DESNOS)*
- Research demonstrates high specificity to trauma.
  - Some research (DSM-IV Field Trial) suggests it is co-morbid with PTSD
  - Other research finds CPTSD/DESNOS is fundamentally distinct from PTSD
  - Early interpersonal trauma, especially childhood abuse, predicts higher risk for CPTSD/DESNOS.
  - Show greater number of problems than encountered with simple PTSD diagnosis:

•Affect dysregulation	•Preoccupation with danger
•Relational problems	•Mood disturbance
•Cognitive distortions	•Binge-purge eating
•Dissociation	•Impulsive aggression/sociality
•Tension reduction behaviors	•Self-mutilation
•Somatization	•Depression
•Symptoms with Trauma Exposure	•Anxiety
•Cognitive disturbance	•Self-Hatred
•Low self-esteem	•Substance Abuse
•Self-blame	•Self-Destructive/Risk-Taking Behavior
•Hopelessness	•Revictimization
•Expectations of rejection	•Medical and Somatic Concerns

Complex Trauma: Conceptualization

- Alterations in regulation of affective impulses (difficulties with affect regulation, self-soothing behaviors; self-destructiveness)
- Alterations in attention and consciousness (more prominent emphasis on dissociative experiences; depersonalization)
- Alterations in self-perception (includes chronic guilt, shame, feeling responsible, inaccurate self worth)
- Alterations in perception of the perpetrator (incorporation of belief system in beliefs or actions)
- Alterations in relationships to others (including lack of trust and intimacy)
- Somatization and medical problems (includes psychosomatic and poorer physical health)
- Alterations in systems of meaning (Courtois, 2008)

Contributions from Depth Psychology: Pierre Janet (1907; 1914; 1925)

- **Trauma Response**
- **Three stages**:
  - Dissociative reactions, obsessive ruminations, and generalized agitation (anxiety)
  - A blend of symptoms "in which it often is difficult to recognize the traumatic etiology of the symptoms"
  - Post-traumatic decline characterized by somatization disorders, depersonalization and melancholia, leading to apathy and withdrawal
- "Psychological tension:" level of psychic energy, or "psychological force," available for reflective action. Determines response to trauma.
  - Chronic and complex trauma decreases psychological tension, resulting in wasted mental energy towards compulsive repetitions, psychosomatic symptoms, and anxiety leading to mental exhaustion and disorganization (Van der Hart, Brown & Van der Kolk, 1989)

Contributions from Depth Psychology: Carl Jung

- **Dissociability of Psyche:** the way our psyche is structured. On a continuum from normal to pathological
  - "Let us turn to the question of the psyche's tendency to split. Although this peculiarity is most clearly observable in psychopathology, fundamentally it is a normal phenomenon. The tendency to split means that parts of the psyche detach themselves from consciousness to such an extent that they not only appear foreign but lead an autonomous life of their own.
  - "This peculiarity arises from the fact that the connecting link between the psychic processes themselves is a very conditional one. Not only are unconscious processes sometimes strangely independent of the experiences of the conscious mind, but the conscious processes, too, show a distinct loosening or discreteness" (Jung, CW 8, 365).
  - "There is an age-old experience of mankind which is reflected in the universal supposition of a plurality of souls in one and the same individual. As the plurality of psychic components at primitive levels shows, the original state is one in which the psychic processes are very loosely knit and by no means form a self-contained unity…it often takes only a little to shatter the unity of consciousness so laboriously built up in the course of development…" (Jung, CW 8, 365)
  - "The inherent tendency of the psyche to split means on the one hand dissociation into multiple structural units, but on the other hand the possibility of change and differentiation. It allows certain parts of the psychic structure to be singled out so that, by the concentration of the will, they can be trained and brought to their maximum development."

Contributions from Depth Psychology: Carl Jung

- **Affect:** the central organizing principle of the psyche.
  - "The essential basis of our personality is affectivity. Thought and action are, as it were, only symptoms of affectivity." (Jung, CW 3, para 78)
  - Central part of human complexes
- **"Survival Self" vs. "Individuating Self":** Survival Self operates when energies of the Self that normally go towards individuation are preoccupied with an earlier developmental task.
- **Trauma: Single, specific experience or a group of ideas and *emotions* that form a psychic wound that become *dissociated* from the psyche.**
  - "…for the trauma is either a single, definite, violent impact, or a complex of ideas and emotions which may be likened to a psychic wound. Everything that touches this complex, however slightly, excites a vehement reaction, a regular emotional explosion" (Jung, CW 16, 262).
  - "…the essential factor is the dissociation of the psyche and not the existence of a highly charged affect and, consequently, that the main therapeutic problem is not abreaction but how to integrate the dissociation" (Jung, CW 16, 266).

Contributions from Depth Psychology: Carl Jung

- **Trauma Archetype: "…universal forms of traumatic experiences across culture, time, and history" (Wilson, 2006).**

- **Trauma Complex: "The unique, individual constellation of the trauma experience in cognitive-affective structures located in the self and intrapsychic processes" (Wilson, 2006). A constellation of factors that interact dynamically, and manifest in a range of phenomena (PTSD; changes in personality) (Wilson, 2006).**
  - "Hence, one could easily represent the trauma as a complex with a high emotional charge, and because this enormously effective charge seems at first sight to be the pathological cause of the disturbance, one can accordingly postulate a therapy whose aim is the complete release of this charge." (Jung, CW 16, 262)
  - "…a traumatic complex brings about dissociation of the psyche. The complex is not under the control of the will…and possesses the quality of psychic autonomy…in direct opposition to conscious tendencies: it forces itself tyrannically upon the conscious mind. The explosion of affect is a complete invasion of the individual, it pounces upon him like an enemy or a wild animal…the typical traumatic affect is represented in dreams as a wild and dangerous animal" (Jung, 1928a, paras 266-7).

Contributions from Depth Psychology: Carl Jung

- **Healing Trauma: Relationship with human interest and devotion is most important---not abreaction/catharsis/exposure.**
  - "…the dramatic rehearsal of the traumatic moment, its emotional recapitulation in the waking or in the hypnotic state—often has a beneficial therapeutic effect….The unbosoming gradually depotentiates the affectivity of the traumatic experience until it no longer has a disturbing influence" (Jung, 1928a, 262).
  - "But I rather question whether the thing is as simple as that, or whether there may not be other factors essential to the process. For it must be emphasized that mere rehearsal of the experience does not itself pose a curative effect: the experience must be rehearsed in the presence of the doctor….the intervention of the doctor is absolutely necessary. One can easily see what it means to the patient when he can confide his experience to an understanding and sympathetic doctor. His conscious mind finds in the doctor a moral support against the unmanageable affect of his traumatic complex. No longer does he stand alone in his battle with these elemental powers, but some one whom he trusts reaches out a hand, lending him moral strength to combat the tyranny of uncontrolled emotion (Jung 1928a, 269-270).
  - "In this way the integrative powers of his conscious mind are reinforced until he is able once more to bring the rebellious affect under control. This influence on the part of the doctor, which is absolutely essential, may, if you like, be called suggestion. For myself, I would rather call it his human interest and personal devotion. These are the properties of no method, nor can they ever become one; they are moral qualities which are of the greatest importance in all methods of psychotherapy, and not in the case of the abreaction alone" (Jung, 1928a, 270-271).

Contributions from Depth Psychology: Carl Jung

- **Healing Trauma: Relationship is required to heal the dissociation and address the transference.**
  - "The rehearsal of the traumatic moment is able to reintegrate the neurotic dissociation only when the conscious personality of the patient is so far reinforced by his relationship to the doctor that he consciously bring the autonomous complex under the control of his will" (Jung, CW 16, 271).
  - "Only under these conditions has abreaction a curative value. But this value does not depend solely on the discharge of affective tension…it depends…far more on whether or not the dissociation is successfully resolved. Hence the cases where abreaction has a negative result appear in a different light….If the rehearsal of the trauma fails to reintegrate the autonomous complex, then the relationship to the doctor can so raise the level of the patient's consciousness as to enable him to overcome the complex and assimilate it….The prime cause is always the transference to the doctor, and this is established without too much difficulty provided that the doctor evinces an earnest belief in his method" (Jung, CW 16, 272-275).

Contributions from Depth Psychology: Carl Jung

Healing Trauma: Relationship that enters into the patient's psyche is required. The transference is the way of entering into the therapeutic relationship.

•"…the analytical method is most unassailable just where the cathartic method is most shaky: that is, in the relationship between doctor and patient. It matters little that, even today, the view prevails in many quarters that analysis consists mainly in "digging up" the earliest childhood complex in order to pluck out the evil by the root. That is merely the aftermath of the old trauma theory. Only in so far as they hamper the patient's adaptation to the present have these historical concerns any real significance…"(Jung, CW 16, 276).

•"…the therapeutic effect comes from the doctor's efforts to enter into the psyche of his patient, thus establishing a psychologically adapted relationship. For the patient is suffering precisely from the absence of such a relationship. Freud himself has long recognized that the transference is the alpha and omega of psychoanalysis. The transference is the patient's attempt to get into psychological rapport with the doctor. He needs this relationship if he is to overcome the dissociation" (Jung, CW 16, 276).

Contributions from Depth Psychology: Sigmund Freud

- **Trauma:** one significant experience or a series of smaller experiences which "…generated distressing affects…fright, anxiety, shame, or physical pain" (Freud, 1893, p. 6).
  - "A person is brought so completely to a stop by a traumatic event which shatters the foundation of his life that he abandons all interest in the present and future and remains permanently absorbed in mental concentration on the past" (Freud, 1916, p. 342)
- **Repetition Compulsion**: "…the patient abandons himself to the compulsion to repeat, which is now replacing the impulse to remember…" (Freud, 1914).
- **Hysteria**: "Hysterics suffer mainly from reminiscences" (Freud, 1893)
- **Abreaction:** The process of abreacting the traumatic ideas and affects to join normal associations allows them to be healed.
- **Partial Traumas**: "..instead of a single major trauma, we find a number of partial traumas forming a group of provoking causes…exercise a traumatic effect by summation…" (Breuer & Freud 1893, p. 6)

Contributions from Depth Psychology: D.W. Winnicott

- **Primitive agonies:** Unthinkable; unimaginable experience
- **"Fantasying:"** Transitional space where play and symbol formation is foreclosed. Individual can't imagine but is involved in "fantasying"—a dissociated state whereby individual self-soothes by using imagination defensively to avoid anxiety (Winnicott, 1971b)
- **Personalization:** Gradual process of "indwelling" where mother repeatedly introduces baby's mind and psyche to each other
  - "…the feeling of the mother's existence lasts X minutes. If the mother is away more than X minutes, then the imago fades, and along with this the baby's capacity to use the symbol of the union ceases. The baby is distressed but this distress is soon mended because the mother returns in X + Y minutes. In X+ Y minutes the baby has not become altered. But in X+Y+Z minutes the baby has become traumatized. In X+Y+X minutes the mother's return does not mend the baby's altered state. Trauma implies that the baby has experienced a break in life's continuity, so that primitive defences now become organized to defend against a repetition of "unthinkable anxiety" or a return to the acute confusional state that belongs to disintegration of nascent ego structure." (Winnicott, 1971b: 97)
- **Good Enough Mother**
- **Holding Environment:** Environment where infant is cared for and contained

Contributions from Depth Psychology: Sandor Ferenczi

- **"Identification with the aggressor:"**
  - "…the weak and undeveloped personality reacts to sudden unpleasure not by defense, but by anxiety-ridden identification and introjection of the menacing person or aggressor" (Ferenczi, 1949; as quoted in Howell 2005).
  - "Through the identification, or let us say introjection, let us call it introjection of the aggressor, he disappears as part of external reality and becomes intra- as opposed to extra-psychic" (Ferenczi, 1949; as quoted in Howell, 2005).
- **Caretaking Function**: Dissociated self states involve a process where one part of the psyche assumes the caretaker role for the rest of the psyche.
- **"Wise baby:"** Teaches wisdom to the individual. This split-off part does not experience the pain of trauma and can be precociously helpful.

Contributions from Depth Psychology: W. R. D. Fairbairn

- **"Bad Objects:"** When coping with abusive/frustrating attachment figures/objects, the child internalizes the "bad" aspects which allows the child to see the object as "good." Result is an object split. If the child is the "bad object," then there is control and hope.
- **The Central Ego** is conscious (not repressed) and connected to the "good" object. The sub-egos are repressed ego splits and connected to the "bad" object.
- **Ego Strength**: The strength of the central ego determines functioning in daily life. The emotionality of sub-egos results in sub personalities. If the central ego is not strong enough, the sub-egos take over.

Contributions from Depth Psychology: Henry Krystal

- **Affective Development**: Capacity to use affects as signals. Disrupted in traumatized individuals.
- **Mature/differentiated affects**: Attend to affect/cognition/meaning/story and capable of elaboration/narration.
  - Developmentally accomplished by reinforcing differentiation, clarifying, encouraging recognition of feelings, assisting child in putting feelings into words (not acting upon feelings or acting out verbally)
- **Immature/undifferentiated affects**: Attend to physiological/unawareness of affect/unable to observe feeling precluding their signal function
  - "Affect precursors:" Precede mature affect; in regressed states; trauma; infantile mind
  - Affect becomes overwhelming leading to greater escalations
  - When affect too intense caretaker responds in way that (s)he is controlled by the affect
  - Child learns to use affects to control others instead of being an internal signal
  - Manipulation, disavowal or unawareness of own feelings may be a method for obtaining care from object
- **Stimulus barrier:** Threshold
- **Catastrophic Traumatic State:** Describes traumatized sequence

Contributions from Depth Psychology:

- **"Good/Bad/Not Me-Self-Conceptualization:"** The Good-Me: Conscious, personifies experiences of approved activities; The-Bad-Me: Conscious, personfies experiences of forbidden activities; The-Not-Me: Unconscious, dissociated. Personifies experiences of intense anxiety (Stack Sullivan)
- **"Attacking the linkages:"** between affect and image, perception and thought, sensation and knowledge. Annihilates capacity for meaningful experience, disrupts memory and disturbs individuation (Bion, 1959) .
- **Total Caretaking Relationship**: Asserted significance of, "…a more meaningful examination of the pathogenic interplay of specific variables in the total relationship of an infant-child's psychic and physical equipment and how the environment meets it" (Khan, 1963, p. 47).
- **Cumulative Trauma:** "The strain trauma…the effect of long-lasting situations, which may cause traumatic effects by accumulation of frustrating tensions." (Khan, 1963, p. 52)

Complex Trauma: Impact on Functioning (Briere, 1996)

- Impacts **preverbal associations** and implicit, **internalized relational schemata**.
  - Trauma before language: nonnarrative, sensorimotor
  - Implicit sensory recollection is devoid of autobiographic material
  - Intrusion of unexpected sensation
- Brain and psychological systems for encoding, organizing, and processing **explicit narrative memory are bypassed or flooded** by emotional input resulting in implicit, **less integrated, sensory recollections**.
- **Conditioned emotional response** to abuse-related stimuli: Encoded as simple associations that are evoked--**not elaborated upon or remembered**—embedded in generalized, "fear structures" of brain.
- **Feeling tones, sensorimotor activity**, and disparate shards of inner material constitute the "**organizing element**s" of the psyche and dominate its functioning as opposed to discrete cognitions, episodic memories, or narratives.
- **Attachment styles in adulthood**:
  - Fearful—high need for acceptance, compliant, avoidance of intimacy;
  - Preoccupied—high need for acceptance, but attain through relationship
  - Avoidant/Dismissing—Self-reliance; avoid relationships
- **Narrative/autobiographical memories** of maltreatment may be **explicit** and autobiographical and **trigger** distressing and avoided **implicit** reactions

Overview of Infant Trauma (Schore, 2003)

- **Arousal and caregiving**: Levels of brain arousal in infants differ depending on caregiving. Nurtured children show normal arousal; neglected--low arousal; abused--high arousal.
- **First State– Hyperarousal**:
  - Initiated by the sympathetic nervous system and a distress response. Accompanied by the stress hormone corticotropin releasing factor (regulates noradrenaline and adrenaline)
- **Second State– Dissociation**:
  - Initiated by the parasympathetic nervous system and a response involving numbing, avoidance, compliance, and restricted affect. Mediated by high levels of behavior-inhibiting cortisol and opioids. Induces severe dysregulation of right hemisphere.
  - "Early trauma more so than later trauma has a greater impact on the development of dissociative behaviors." (Owaga et al., 1997; as stated by Schore, p. 69)
- **Brain chemistry and traumatic relational interaction**:
  - Increased production of key neurotransmitters which impedes early brain development and alter interaction of neurotransmitters and receptors
- An infant with an early history of "cumulative trauma" must utilize defensive projective identification to cope with interactive stress that disorganizes the developing self. (Mordecai, 1995; Khan, 1974; as stated by Schore, p. 68)
- Second generation" effects of trauma are transferred by attachment patters from parent to child

Cognitive and Behavioral Impact

- Behavior can be conceptualized as a form of memory.
- May reflect Internalization of attachment patterns and caregivers:
  - Risk-taking
  - Poor self-care
  - Revictimization
  - Impulsive behaviors (incapacity to tolerate affect)
  - Aggression, violence
- Disturbs capacity for cognitive processing. Prevents or threatens development of coherent thoughts and beliefs which may preclude narration and limit or obliterate meaning
- Cognitions are separated from affect/sensation/body
- Challenges and destroys cherished beliefs
  - Cognitive "retructuring" may not make any sense or be possible
- "People's previctim view of self and the world involves the basic assumptions about invulnerability, personal safety, others as mostly trustworthy, and a just world. Trauma introduces new data that are incompatible with these assumptions. Following exposure to trauma, people are hypervigilant and can experience self-blame, survivor guilt, distrusts, and alienation." (Paivio & Pascua-Leone, 2010, p. 21)

Affective Impact

Alexithymia develops:

- Condition of being: "Without words for feelings"—difficulty recognizing basic feeling states
- Continuum. Higher with: addictions, pain, physical/psychosomatic illnesses, trauma
- Impairments in affective development lead to undifferentiated, vague, diffuse emotions
- Emotional reactions expressed somatically—physiological features of affects but little verbalization of thoughts and feelings
- Fail to process cognitive/affective dimensions of emotions consciously. Without conscious awareness, focus on somatic component of emotional arousal.
- Difficulties range from complete inability to experience feelings to problems knowing, naming, and/or differentiating feelings.
- Impaired ability to use emotions as signals
- Can't discern physical sensations from psychological feelings
- Can't describe nuances to sensations/feelings

Affective Impact

- Dissociation and avoidance strategies employed
- Affective instability
- Inability to terminate dysphoric states
- Inability to experience or sustain positive emotions
- Inadequate modulation of emotion—hyperresponsive and hyporesponsive; moody

- "Affective disruptions including underregulation and overcontrol of emotion, are at the heart of disturbances stemming from trauma, particularly complex trauma. Affect dysregulation problems in childhood can interfere with core developmental tasks and become habitual ways of dealing with affective experience. Moreover, dysregulation of this kind can result in long-term impairments in functioning, including chronic depression and anxiety; difficulties recognizing and describing emotional experience (alexithymia); numbing of affective experience; anger control problems and self-esteem and interpersonal difficulties…" (Paivio & Pascua-Leone, 2010, p. 26)

Implicit and Explicit Memory (Siegel, 1999)

- **Implicit memory** is a type of memory based on **previous exposure** or experiences, which influence our current experience **without** having **conscious awareness** of these previous experiences
  - **Emotional memory** (amygdala/limbic system); **behavioral memory** (basal ganglia/ motor cortex); **perceptual memory** (perceptual cortices) (Siegel, 1999. p. 29).
- **Implicit memory** plays an integral role in the development of **early attachment** and in forming **interpersonal relationships** throughout life.
- **Explicit memory** involves **conscious recall** of experiences (episodic) and the world around us (semantic).
- **Explicit memory** depends on "medial temporal lobe (includes hippocampus) and orbitofrontal cortex." (Squire & Zola-Morgan, 1991; Perner & Ruffman, 1995; Tulving, 1993; Schacter et al., 1996; as stated by Siegel, 1999, p. 34).
- **Implicit memories** form at **birth** (possibly prenatally) while explicit memory begins at approximately 2 years.
- **Traumatic memories** are implicit, behavioral, and somatic. They tend to be vague, overgeneralized, fragmented, and incomplete…included primarily in right-brain experiential (nonverbal) memory, in the form of emotions, images, and bodily sensations, but are not processed on a symbolic or verbal level and are left unintegrated with other life experiences" (van der Kolk et al., 1996; as stated by Paivio & Pascua-Leone, 2010, p. 19).

Neurobiological Impact

- Trauma **impairs integration** and the mind becomes **less flexible** and shows **nonintegrated memory** function.
- Trauma **alters** the development of the **corpus callosum** that transfers information between right and left hemispheres.
  - Damage to the corpus callosum, which can ensue from early trauma, may cause the communication between hemispheres to be poorly regulated and affect memories.
- The **limbic system**, especially **hippocampus**, are vulnerable to the neurotoxic effects of long-term excessive cortisol (Siegel, 2003, 2011)
  - "Excessive stress hormone or catecholamine release appears, respectively, to impair the hippocampal and amygdala contributions to memory processing." (Howe, 1998; as stated by Siegel, 1999 p. 50).
  - Decreased hippocampal volume (some treatment studies report this changes/increases after treatment).
  - In traumatic situations memories may not be consolidated from high levels of cortisol and damage to the hippocampus as observed in PTSD.
  - High levels of stress or trauma may result in heightened awareness and memory, while in other cases certain aspects may become blocked (such as explicit memory).
  - Trauma alters the synaptic connections in the brain and the development of the corpus callosum and the neural nets that transfer information between the two hemispheres.

Interpersonal Neurobiology (Siegel, 1999, 2011)

- The brain is affected by the development of our mind.
  - Characterized by neuroplasticity and capable of changing through lifespan, functionally and structurally through experience.
  - We change our brains by our experiences and responses to our environment.
- The quality of our mind is impacted by how well it is integrated
  - Characterized by: flexibility, adaptiveness, stability, self-understanding, greater understanding of others/world.
  - Neurologically, integration occurs through the wire/rewire process with right and left brain hemispheres engaged in narrative process.
  - Hippocampus and orbitofrontal cortex construct a narrative view of self and meaning making through time.
- Trauma impairs integration
  - Maladaptive child-caregiver relations (neglect, abuse and insecure attachment) can affect the development of the right brain and, "lead to a blunting of the stress regulating response of the right (and not left) prefrontal cortex that is manifest in adulthood" (Brake et al., 2000; Sullivan & Gratton, 2002; as stated by Schore, 2003, p. 238).
  - The right amygdala, involved in emotional processing, can get stuck resulting in intensified and dysregulated stress

Neurobiology of Attachment (Schore, 2003; Siegel, 2010)

- **Attachment and brain development**: Developmental neuroscience affirms the parenting environment shapes developing patterns of neural connections in infants thereby shaping their nervous systems.
- **Attachment and the right hemisphere**:
  - Operative from birth. Dominant first two-three years. Matures earlier.
  - Processes visual and prosodic emotional information
  - Recognizes facial affective expression
  - Influenced by early social experiences
  - Influences "imprinting" by utilizing output from caregiver's right cortex
- **Attachment and mirror neurons:**
  - "…Mirror neuron systems that specialize in…..the social meaning of…behavior and…emotion. …allow us to grasp the minds of others not through conceptual reasoning but through direct simulation. By feeling, not only by thinking." (Siegel, 2010, p. 60)

Neurobiology of Attachment (Schore, 2003; Siegel, 2010)

- **Attachment**:
  - Caregiver synchronizes and resonates with the rhythms of the infant's dynamic internal states. Caregiver egulates arousal level of negative and positive states. The dyadic (interactive) regulation of emotion. Includes eye to eye; auditory; tactile stimulation (Sroufe, 1996; as stated by Schore, p. 39)
- **Attachment synchrony and asynchrony**:
  - "When stress (asynchrony) occurs, it is important to reestablish synchrony, which allows for stress recovery or a pattern of 'disruption and repair' and a 'good-enough' mother, who induces a stress response in her infant through a misattunement and self-corrects and in a timely fashion." (p. 39)
- **Attachment and positive affect**:
  - "Attachment is not just the reestablishment of security after dysregulating experience in a stressful negative stats; it is also the interactive amplification of positive affect, as in play states." (p. 40)
- **Attachment and Reciprocal Facial Signaling**:
  - Sharing of reciprocal states. Facial mirroring allows for entering into feeing states. These experiences are stored in 'pre-symbolic representations.'" (Lichtenberg, 1989; Beebe and Lachmann, 1994; as stated in Schore, p.p. 14 - 15)

Affect Regulation & Attachment Overview (Schore, 2003)

- **Affect Regulation:**
  - Capacity for **tolerating and internally managing affective states**.
  - Development **flourishes first 2-3 years** when right hemisphere is dominant.
  - **Visual experience** –central for social/emotional development. Reciprocal gaze transmits attunement/misattunement. Related to release of endorphins and dopamine in the subcortical reward center.
  - Individuals with **impaired affect regulation** may respond with increased **avoidance, resistance and dissociation**. (Briere, 2006)
  - **Prolonged negative states are toxic** and predispose infant to psychopathology (p. 11)
  - **Caregiver participation** is critical for facilitating child to **shift** from **negative affective state** of hyperaroused distress or hypoaroused deflation to **re-establish positive affect**. (p. 11)
  - **Re-experiencing positive affect** following negative experience teaches that negativity can be endured. (Malatesta-Magai, 1991, p. 218; as stated by Schore, p. 11)

Long-Term Developmental Implications: Attachment Theory

- Individuals can move from an insecure childhood attachment to a secure adult attachment status.
- An adult's ability to make sense of his/her life and early life experiences, tell a coherent story (narrative) of their life experiences, and integrate their past, present and future is the best predictor of their child's attachment style.
- Insecurely attached children tend to be insecurely attached adults who later, have their own insecurely attached children UNLESS they can reflect on their own childhoods and make sense of their lives.
- "Earned secure" attachment: Achieving a secure style of attachment later on in life often through experiences with an important attachment figure or psychotherapy. (Demonstrated in adults who are able to report negative experiences coherently.)
- The presence of at least one available attachment figure is a protective factor, preventing a child from suffering from long term psychological problems even in the face of great stress.

Assessment

- **Clinical assessment/interview**. Important to note relational exchanges, transference/countertransference, nonverbal and somatic information, and therapeutic process with traumatized individuals.
- **Guidelines for assessments:**
  - **Establishing rapport**: Information may need to be sacrificed until this occurs
  - **Immediate concerns**: safety; stability; level of psychological functioning; revictimization
  - **Explore reason for seeking treatment now**
  - **Initial investigation of trauma**:
    - Type of trauma
    - Perpetrator(s)
    - When it started
    - Frequency
    - Who knew about it
    - When it stopped
    - Why it stopped
    - What was done about it
    - Who the patient disclosed it to
    - What the reaction was when it was disclosed (Ross, 2009)

Assessment

- **Activation Responses**: Overactivated?
  - Level of anxiety; intrusive posttraumatic symptoms; anger
- **Avoidance Responses**: Underactivated?
  - Numbing; avoidance, dissociation; defenses: suppression, denial,
- **Affective Responses**: Dysregulated?
  - Mood swings, behavioral acting out, sudden dissociative responses with strong emotions, relational disturbances
- **Structured Assessments:**
  - The Clinician-Assisted PTSD Scale (CAPS)
  - The Acute Stress Disorder Interview
  - The Structured Interview for Disorders of Extreme Stress (SIDES)
  - Trauma Symptom Inventory (Briere)
  - Stuctured Interview for Disorders of Extreme Stress (Pelcovitz)
  - Inventory of Altered Self Capacities (Briere)
  - Cognitive Distortion Scale (Briere)
  - Trauma and Attachment Belief Scale (Pearlman)
  - Dissociative Experiences Scale (Bernstein and Putnam)
  - Multiscale Dissociation Inventory (Briere)
  - Somatoform Dissociation Scale (Nijenhuis)

Psychotherapy for Trauma: Stages of Treatment Approach- Pierre Janet

- Original formulation by Janet: Flows in Recursive Spiral – Back and Forth; Starts and Stops

Three stages:

- Stage 1: Stabilization, symptom-oriented therapy, and prepare to liquidate traumatic memories
- Stage 2: Identification, exploration, and modification or traumatic memories
- Stage 3: Relapse prevention, relief of residual symptoms, personality reintegration

Self-Trauma Model (Briere, 1996).

- **Treatment**: Integrative. Addresses explicit/implicit; affect/cognition.
- "**Therapeutic window**": Window of intervention that facilitates healing—challenging but not overwhelming.
  - **Undershooting** therapeutic window: Avoidance of traumatic material; undiscriminating support/validation; basking in positive transference; avoiding problematic personality issues or destructive behaviors.
  - **Overshooting** therapeutic window: Excessive exposure intensity; focusing on material that needs work before addressing; too fast-paced; countertransference problems; inadequately processing previously activated material
- Therapeutic relationship is primary and curative
- Weighing exploration versus consolidation
- Monitoring intensity control:
  - Aim for higher intensity, mid-session
  - More cognitive focus decreases intensity
- Managing more intrusive symptoms: more containment
- Managing avoidance symptoms: more exploration

Self-Trauma Model: General Therapeutic Considerations

- **Treating intrusive symptoms**:
  - Identification of traumatic events
  - Gradual reexposure to implicit/explicit
  - Acknowledging disparity between original trauma and current
  - Emotional/cognitive processing
  - Direct and indirect exposure to abuse material
- **Affect regulation**
  - Gradual, titrated exposure and repeated activation allows processing distressing affect teaches one to be at home with distress. Promotes moving in and out of affective states
- **Working with relationship and transference issues**:
  - Transference: the cued activation of implicit, relational memories in therapeutic context
  - Activation of relational schema is "transference"
  - Engaged, motional activation is critical
- **Processing and Resolution:**
  - Includes integrated cognitive (left hemisphere) and emotional (right hemisphere) processing
  - Requires developing a coherent narrative: as the narrative becomes more clearly articulated, well organized, and detailed trauma symptoms decrease
  - Processing relational schemas is paramount
  - Hallmark : coherent narrative with regulated affect and cognition (Briere, 1996)

Psychotherapy for Trauma: Stages of Treatment -Christine Courtois (2008)

- **Whole-person** philosophy that is highly individualized.
- Referred to as, "**trauma responsive therapy**" that is, "**not trauma alone**."
- **Summary** of **three-stage** model:
  - **Pretreatment Issues**: treatment frame, alliance-building, safety, affect regulation, stabilization, skill building, education, self-care, support
  - **Processing**: Deconditioning, mourning, resolution, processing, and integration of the trauma
  - **Development**: Self and relational; enhanced daily living.
- Some never complete or move beyond first stage although good work in first stage usually substantially improves patient's life (Courtois, 2008).

Psychotherapy for Trauma: Stages of Treatment -Christine Courtois

- **Stage 1: Longest stage**
  - Pretreatment Issues
  - Treatment Frame
  - Alliance-Building
  - Safety
  - Affect Regulation
  - Stabilization
  - Skill-Building
  - Education
  - Self-Care
  - Support
- **RICH**: (Saakvitne and colleagues, 2000)
- **R**espect
- **I**nformation
- **C**onnection
- **H**ope
- Therapeutic relationship provides opportunity to rework past attachment difficulties within the therapeutic context

Psychotherapy for Trauma: Considerations in First Stage of Treatment -Christine Courtois

- Unlike psychotherapy for non-traumatized, clinician sees:
  - More victimization-related schemas
  - Development of alliance is threatening: fear of being judged, seen, and exposed.
  - Therapist is an untrustworthy and abusive authority to be feared, mistrusted, challenged, tested, distanced from, raged against, sexualized or the longed for good parent, rescuer, deferred to, nurtured by. Two may often alternate.
- Therapeutic tasks:
  - Targeting dissociation is primary
  - Educating about trauma and its impact
  - Education/skills training: identifying and regulating emotional states; mindfulness, self-care, life skills, coping skills, problem solving, social skills, decision making
  - Affect Regulation
  - Self-Care
  - Mind-Body Issues
  - Attachment Issues: excessively self-sufficient; caretaking; constant anxiety and insecurity; disorganized and dissociative—shifting states of identity/emotional lability/ shifting relationships with others; self-harm
  - Focus of the work is not directly on trauma processing and resolution
  - Traumatic material addressed more educationally and cognitively

Psychotherapy for Trauma: Stages of Treatment -Christine Courtois

Stage Two

- Processing
- Deconditioning
- Mourning
- Resolution/Integration of Trauma
- Exposure and narrative-based techniques
- Gradual and titrated according to what patient can feel without resorting to destructive behaviors including dissociation.
- Reprocessing can be more naturalistically (i.e. working with associative material; analytical approaches; symbolically/metaphorically; dreamwork; nonverbally) or formalized (EMDR: guided imagery; imaginal rescripting; narrative; sensorimotor).

Stage Three

- Self and relational development
- Enhanced daily living
- Unresolved developmental deficits and fixations
- Self regulatory skills
- Spiritual development
- Personality Growth

Psychotherapy for Trauma: Stages of Treatment Approach

- **Stage 1: Developing safety & stabilizing harmful behaviors. Affect regulation. Acronym SAFER** (Chu, 2011):
  - **S**elf care & symptom control
  - **A**cknowledgement of the role of trauma
  - **F**unctioning
  - **E**xpression of Affect & Impulses productively
  - **R**elational work – most challenging. Intense transference/ countertransference. Via projective identification, patient and therapist may be in emotionally intense scenarios and reenact abuse-related roles.
- **Stages 2, 3, and 4: Processing trauma** (Brand, 2009a)
  - 2. Accepting & exploring patient's history
  - 3. Cognitive processing
  - 4. Emotional processing including mourning: "Effective work…involves remembering, tolerating, processing, and integrating overwhelming past events." (Chu, 2011, p. 122).

Psychotherapy for Trauma: Stages of Treatment Approach

Stage 5: Integration and Self Development: **Unresolved areas encountered.**

Healing dissociation

Develop stable sense of self capable of healthy relationships and a sense of meaning and purpose in life (Brand, 2009a).

Research Findings on Model with DID Patients:

- Patients in later stages of treatment showed fewer symptoms
- 38% of stage-1 patients attempted suicide in the previous year. No stage-5 patient made attempts.
- 40% of stage-1 patients required hospitalization in the prior year. Only 5% of stage-5 patients needed hospitalization.

Accelerated Experiential Dynamic Psychotherapy (Fosha, 2004)

- Affect is central to healing trauma. Core affect unleashes adaptive and self-righting capacities in mind/body. Predicated upon:
  - Dyadically coordinated/regulated experiences with therapist that are experienced viscerally, worked through to completion, and emphasize *relational, restructuring, experiential affective*, and *integrative-reflective* processes (Fosha, 2000b).
- Optimal dyadic regulation occurs through sequences of *attunement* (mutual coordination of affective states), *disruption* (lapse of mutual coordination*), and repair* (reestablishment of mutual coordination).
  - In pathogenic dyads, disruptions do not motivate dyadic repair but lead to disconnection, withdrawal, alienation, and self-reliance (Tronick &Weinberg, 1997, as cited in Fosha & Yeung)
  - Dyadic interactions become internalized as the individual's *affective competence,* i.e., the capacity to "feel and deal while relating" (Fosha, 2000b, 2001, as cited in Fosha & Yeung).
- Emphasizes right brain mediated processing of emotion and attachment through "right brain language:" igaze, visual imagery, play, vocal tones and rhythms, touch, and somatosensory experiences.

Accelerated Experiential Dynamic Psychotherapy (Fosha, 2004)

- First State:
  - Defenses to exclude emotional experience
  - Therapist respectsthe once adaptive defenses
  - Works in the here and now with the wall of defenses
  - Presence of protective other provokes an intrapsychic crisis (1st state transformation)
- Second State:
  - Access visceral experience and expression/processing of core affective experiences emotional narrative emerges; attunement; timely repair of inevitable disruption
  - Somatic sensory experience
  - Receptive affective experiences (ie., feeling seen, understood, cared for) emerge
  - Experiential affective strategies effective. Adaptive action occurs when processing emotional experience. Adaptive action mark the 2nd state transformation into 3rd state
- State 3
  - Core State follows from the full and complete experience of any core affect – sense of calm, authenticity – 'I feel at home with myself'
  - Reflective integrative strategies as patients construct coherent and meaningful autobiographical narratives (correlated with secure attachment and emotional resilience) (Main, 2001; Siegel, 2003,as cited in Fosha & Yeung)
  - Deeply spiritual experiences

Mentalization

"Look, call it denial if you like, but I think what goes on in my personal life is none of my own damn business."

"**Look, call it denial if you like, but I think what goes on in my personal life is none of my own damn business**."

Mentalizing Based Therapy

(Bateman & Fonagy, 2010; Allen, Fonagy, & Bateman, 2008)

- From developmental and psychodynamic psychology. Applied to a range of patients and contexts (i.e. PTSD; Borderline Personality Disorder; substance abuse; eating disorders; depression and inpatient/outpatient/partial hospitalization patients).
  - more concerned with the way in which the experience is transformed and with the shape of its expression than with its content (Lecours & Bouchard, 1997, p. 861).
- Our understanding of self and others depends on how our mental states were adequately understood and nurtured by attuned adults and not solely through maturation. Trauma disrupts the capacity to mentalize, limiting a person's capacity to reflect upon mental states or narrate past experiences.
- Mentalization depends on the primary attachment figure's capacity to recognize, tolerate, and respond empathically to the infant. Deficits impact how an infant represents his/her mental states, and his/her caregiver's mental states (thoughts, feelings, wishes and motives).

Mentalizing (Allen, Fonagy, & Bateman, 2008)

- *Mentalizing:* The process of making sense, implicitly and explicitly, of subjective mental states in self/others. Understanding that a particular mental state represents one of many possible representations of reality.
  - Interpreting and responding to behaviors of self and others in terms of intentional mental states: desires, feelings, beliefs.
  - Capacity for meta-representation, ability to think about thoughts and feelings.
  - Involves the capacity to feel our thoughts and think our feelings.
  - Becoming curious about the workings of one's mind and the minds of others.
  - Engaging in a process of exploring various possible meanings of mental states including feelings, dreams, and actions.
  - Thinking and feeling about thinking and feeling

Sample Assessment Questions: Possible Indicators of Mentalization Quality

- How do you understand how this experience affected you?
- How do you describe the traumas you have experienced in your life?
- How do you understand the way your parents interacted with you?
- Can you tell me a story about your childhood?
- What connections do you perceive between your childhood experiences and your adult life?
- Can you think of anything that happened to you as a child that created problems for you?
- How has your relationship with your parents changed since childhood?
- In what important ways have you changed since childhood?
- Looking back, can you think a bit about what made her behave like that?
- How do you explain his action? Is that something that has happened before? Is there any other explanation? What do others think?

Indicators of Poor Mentalization Quality

- Anti-reflective: hostility; active evasion; non-verbal reactions; uncoherent
- Failure of adequate elaboration; lack of integration; lack of explanation
- Inappropriate: non-sequiturs; assumptions about clinician; literal meaning of words

Therapeutic Stance: The Art of MBT (Allen, Fonagy, & Bateman, 2008)

- Therapist **embodying** characteristics of **secure attachment**:
  - Reflectiveness, lively consciousness, fresh speech, humor, minimal self-deception, openness including capacity to change views, ease with "imperfections," in self/others, and compassion.
- **Empathizing not Systematizing**:
  - Systematizing: "the drive to analyze, explore, and construct a system…extracts the underlying rules that govern the behavior of the system…to understand and predict the behavior of the system (Baron-Cohen, 2003, p. 3)….Systematizing works for phenomena that are…lawful… deterministic..Systematizing is of almost no use when it comes to predicting the moment to moment changes in a person's behavior (p. 476).
- Collaborative treatment relationship: joint responsibility for understanding mental states together, inside and outside psychotherapy.
- Active rather than passive stance
- Therapist assumes responsibility for, and actively reflects upon, lapses of mentalizing—acceptance of it being human and part of treatment
- Share and provoke curiosity: Inquisitive attitude
- Humility: The wisdom of "not knowing"
- Eschewing the need to make sense of the nonsensical

Therapeutic Stance: The Art of MBT (Allen, Fonagy, & Bateman, 2008)

- **Patience:** Allowing time to identify differences and legitimizing differences
- **Active questioning** of patient's experience—obtaining detailed descriptions of experience: "what" rather than "why" questions
- **Avoid** using certain words: "**Just,**" "**clearly**," "**obviously**," "**only,**" "**must**…"
- **Pause and search**: i**nterrupt** a **non-mentalizing interaction** by **expressing interest** in **patient's experience** including thoughts and feelings.
- **Identify** preferred **non-mentalizing patterns** and **narratives**
- Use **hypothetical** and **counterfactual** interventions ("What if?")
- Make **complementary moves** according **to patient's process** (i.e. shift overly inward focus to outward; overemphasis on other to self; etc.).
- **Challenge over-mentalizing** and **pseudomentalizing** (manipulative, controlling)
- Attend to "**angels in the nursery**," (Lieberman, 2005), which supports patient from becoming overwhelmed and unable to mentalize, and supports resilience.
- Do not foster **misuse** or **overuse** of mentalizing

Therapist Stance: Promoting Mentalization

Therapeutic process involves a continual process of questioning his/her own experience and the patient's experience

- What is happening now?
- How has the therapy session shifted to this topic?
- What may be related to the patient's/therapist's current disclosures?
- Why am I feeling as I do now?
- What has happened recently in therapy to account for current state?
- What purpose is this story serving?
- What theme is repeating?
- How has the topic transformed throughout the session?

Managing Non-Mentalizing Interactions:

- Stop, gain more information, investigate.
- Resist the temptation to foreclose the interaction. Allow it to unfold.
- Attend to the process
- Highlight feelings and thoughts that are present in patient and you
- Identify understandings of each aspect from multiple perspectives
- Challenge reactive material that obscures attending to mental states. Attend to how it impacts therapeutic process and not the content.
- Identify how inner material feels and what reactions occur
- Challenge pseudomentalizing: manipulative, controlling, and unattuned actions

Interventions to Promote Mentalization

- Let's go back and see what happened just then.
- At first you seemed to understand what was going on but then…
- Let's try to trace exactly how that came about.
- Hang on, before moving along, let's rewind, and see if we can understand where we have been.
- How has the therapy session shifted to this topic?
- What has happened in therapy to account for current state?
- What do you think it feels like for X?
- Can you think of other ways you to understand your feelings?
- What do you make of your distress?
- What just happened here inside of you? Between us?
- If someone else was in your position what would you tell them?
- What do you make of what has happened?

Working with the Transference: MBT (Bateman and Fonagy, 2010)

- Aim of transference interpretation is not to provide insight or link past to present. It provides an experience of relating to mental states in self and others within a trusted relationship where different experience and perspectives can be understood.

Six Steps:

1) Validate transference feeling: Differs from agreeing with patient (establish patient's perspective).
2) Exploration: Events generating transference feeling, especially present-day, are identified. Behaviors that link to the thoughts and feelings are explicated.
3) Accepting enactment on part of therapist: Affirmation that patient's reactions have some basis in reality. Reflecting on how therapist's actions have been consistent with perception. Therapist to acknowledge partial enactment of transference as voluntary actions that s/he accepts agency for. Only after this step, can distortions be explored.
4) Collaborating on arriving at an interpretation—spirit of mutuality.
5) Therapist proposes alternative perspective. Engagement with feelings and thoughts in mutual, reflective process.
6) Careful monitoring of patient's and own reactions to this process.

Mentalizing: Affective Development

"Could we up the dosage? I still have feelings."

"**Could we up the dosage? I still have feelings**."

Mentalizing in Action: Affective Interventions (Allen, et al, 2008)

- "Not a cognition occurs but feeling is there to comment on it, to stamp it as of greater or less worth" (William James, in Richardson, 2006, p. 183).
- Identifying Emotions:
  - Labeling basic emotions; nuances of emotions; and layers of emotions
  - Naming and elaborating upon emotional conflicts and ambivalence
  - Clarifying meaning of emotions within relationship
  - Identifying adaptive, instrumental (i.e. "signal") value, and existential value and functions
- Modulating Emotions
  - Regulating intensity (activating or deactivating)
  - Tracking and sustaining level of arousal
- Expressing Emotions:
  - Facilitating engagement with emotional responses outwardly and inwardly.
  - Fostering inner relationship to emotional experience
  - Understanding outer emotional process with attachment figures
  - Differentiating inner from outer process in relationships and with attachment figures

Affect Regulation: Interventions

- **Affect Regulation**: Fostering affective development through attuned therapeutic relationship and attention to (affective) process and content.
- **Affect Activation**: Facilitate experience and expression of affect
  - Establishing conditions of safety (attuned frame and boundaries)
  - Listen for allusions to feelings—verbal and nonverbal
  - Follow up on affective content
  - Increasing tension---less "supportive" stance
  - Withstanding the negative transference
  - Working with images
  - Having well developed empathy
  - Somatic interventions
- **Affect Modulation**: Facilitate expression of affects within limits
  - Attention to boundaries
  - Examining consequences of unbridled or suppressed emotions
  - Nonverbal adjuncts to treatment
  - Affective engagement that is containing & protective of self/other
  - Engaging with projections (not defending; reframing or noting distortions)
  - The value of silence

Affect Regulation: Interventions

- **Affect Labeling:** Assist in putting feelings into words
  - Learn to differentiate between physical states/feelings; feelings/cognitions
  - Differentiating between feelings and action; action and fantasy
  - Careful attention to process including nonverbals
  - Offering own internal experience
  - Sensitive monitoring of affective interplay in transference and countertransference
- **Affect Tolerance**: Feelings must be accepted, tolerated, not acted upon.
  - Empathic, steady, containing presence in response to affects
  - Asserting that feelings change, subside, and can't be eradicated
  - Understanding feelings as a signal
  - What function is this feeling serving?
  - Explore beliefs and fantasies re: expression of affect and feelings
  - Not acting (by therapist) especially with problem without good solution
  - Differentiating between feeling and action: "Your feelings are not going to go away—today you must bear them without acting."
  - Avoid getting into action mode, becoming problem solver, savior. Focus on the process instead and the patient's responsibilty.

Effectiveness of Partial Hospitalization using MBT vs. Standard Psychiatric Care

- **OBJECTIVE:** This study compared the effectiveness of psychoanalytically oriented partial hospitalization, offering MBT, with standard psychiatric care for patients with borderline personality disorder. Treatment included individual and group psychoanalytic psychotherapy, for 18 months maximum.
- **RESULTS:** Outcome measures included frequency of suicide attempts and acts of self-harm, the number and duration of inpatient admissions, the use of psychotropic medication, and self-report measures of depression, anxiety, general symptom distress, interpersonal function, and social adjustment. Partial hospital patients showed a statistically significant decrease on all measures in contrast to the control group, which showed limited change or deterioration over the same period. Improvement in depressive symptoms, a decrease in suicidal and self-mutilatory acts, reduced inpatient days, and better social and interpersonal function began at 6 months and continued through the end of treatment at 18 months.
- **CONCLUSIONS:** Psychoanalytically oriented partial hospitalization that utilizes MBT is superior to standard psychiatric care for patients with borderline personality disorder.
  - Bateman A, Fonagy P. The effectiveness of partial hospitalization in the treatment of borderline personality disorder - a randomised controlled trial. Am J Psychiatry. 1999;156:1563–1569.

MBT: Partial Hospital Program vs. General Psychiatric Care: 8 year follow

OBJECTIVE: Evaluate impact of mentalization-based treatment by partial hospitalization compared to treatment as usual for borderline personality disorder 8 years after entry into a randomized, controlled trial and 5 years after completing all mentalization-based treatment.

RESULTS: Five years after discharge from mentalization-based treatment, the mentalization-based treatment by partial hospitalization group continued to show clinical and statistical superiority to treatment as usual on suicidality (23% versus 74%), diagnostic status (13% versus 87%), service use (2 years versus 3.5 years of psychiatric outpatient treatment), use of medication (0.02 versus 1.90 years taking three or more medications), global function above 60 (45% versus 10%), and vocational status (employed or in education 3.2 years versus 1.2 years).

CONCLUSIONS: Patients with 18 months of mentalization-based treatment by partial hospitalization followed by 18 months of maintenance mentalizing group therapy show better health and functioning than those receiving treatment as usual, although some impairments in general social function remained.

- Bateman A, Fonagy P. 8-year followup of patients treated for borderline personality disorder: mentalization-based treatment versus treatment as usual. Am J Psychiatry. 2008;165:631–638.

MBT: Outpatient Research

- **OBJECTIVE:** This randomized controlled trial tested the effectiveness of an 18-month, outpatient mentalization-based treatment (MBT) approach versus a structured clinical management (SCM) outpatient approach for borderline personality disorder.
- **RESULTS:** Significant improvements were demonstrated in both conditions across all outcome variables. Patients randomly assigned to MBT showed greater decline in self-reported and clinically significant problems, including suicide attempts and hospitalization.
- **CONCLUSIONS:** Structured treatments improve outcomes for individuals with borderline personality disorder. A focus on specific psychological processes, as offered in MBT, offers additional benefits.

- Bateman A, Fonagy P. Randomized controlled trial of outpatient mentalization-based treatment versus structured clinical management for borderline personality disorder. Am J Psychiatry. 2009;166:1355–1364.

Psychotherapeutic Considerations:

- Research suggests that **complex trauma** (prolonged, repetitive, or childhood-related) is best treated using **long-term therapy**.
  - Most treatment outcome research on trauma has been conducted on people with simple PTSD or anxiety disorders.
- Building **attuned therapeutic relationship** is paramount
- **Trauma demands representation** for healing to occur.
- **Representation** can occur **verbally and nonverbally** with words, images, movement, behavior, thoughts, feelings, story, non-verbal modalities.
- **Representing** material—**not necessarily verbalizing or narrating**--is key.
- **Holding and containment**: " Holding … often takes the form of conveying in words at the appropriate moment something that shows that the analyst knows and understands the deepest anxiety that is being experienced, or that is waiting to be experienced." (Winnicott)
- **Stabilization, safety, and containment**: Holding environment. Respect and work with defenses; listen for metaphorical and symbolic references.
  - **Grounding** techniques: Therapist presence; breathing (4x4x4); somatic work
- Identify and focus on **processing—working through**--**past** experiences especially those recurring **in the present**.

Psychotherapeutic Considerations:

- More **regressed/traumatized**: more **non-verbal** representation
- Work with **fantasy life** (**intapsychic and interpersonal**)—exploring and encouraging.
- **Narration** is **central** to transformation and may be not be possible until later.
- **Narration** can be **directive** or **non-directive**.
  - Directive: hypnosis, EMDR, imagery, focusing.
  - Nondirectve: tracking associations and associative themes, links, symbolic, metaphorical work; working with relational patterns, transference work.
- **Transference work**, addressing relational cycles and patterns, for changing disturbed patterns of relating and characterological issues.
- Prominent **defenses**: dissociation; splitting; projective identification. **Defense analysis**.
- **Mind-body work**—somatic interventions/somatic language
- **Creative growth**-- enhancement of personality
- **Spiritual/soul** work

Psychotherapeutic Implications

1.Trust and testing: develops in context of relational testing.

2. Blame and behavior: therapist contains rather than reacts; does not hold patient consciously responsible for distress, symptoms or behaviors.

3. Shame and symptoms: sensitivity to shame without judgment.

4. Consistency and connection: connection and support through stable personal style, regular appointment times, punctuality, availability.

5. Humility: therapist does not take self too seriously, acknowledges errors, expresses sorrow and regret, and repairs damage to therapeutic relationship; present and mindful, engaging honest and direct manner.

6. Demeanor: creates a "holding environment" through warmth, kindness, gentleness, interest, empathic attunement.

7. Awareness: of own emotional states, and countertransference.

8. Professionalism: a safe and professional environment through articulated practice policies, billing practices, discussion of boundary crossing, respectful record keeping, maintaining an established structure.

(Kinsler, et al. 2009)

Psychotherapeutic Considerations

- ***Complex trauma and dissociative disorders require careful attention to affect:***
  - Affect found in patient's history and grounded in reality
  - Affect must be acknowledged and experienced in body
  - Affect must find verbal expression in language, and be organized in narrative life history
- ***Work with the somatic and nonverbal—speaking language of the body and physical sensations***
  - Bridge physical and psychological including naming the physical and linking
  - Focus on physical feeling, close eyes, breathe into the sensation. What images are part of the physical pain? Let the physical pain speak in the room.
  - Therapist stays embodied in the room in literal, concrete ways (frame, stable presence) and symbolically (relationship, attunement, availability, grounded, watching overly interpretive or intellectual stance)
  - Non-verbal, somatic, creative, expressive arts generally access traumatic affect more quickly than verbal means

Psychotherapeutic Implications

- ***Addressing inner figures/voices—***
  - Understand these figures as part of self-care system
  - Sensitize patient to voices (s)he is identified with
  - Attempt to make ego-syntonic voices ego-dystonic
  - The therapist's voice must also cultivate an attitude that can manage the pt's aggression—authoritative, compassionate
- ***Address defensive system through relationship and work with defense***
  - Necessary to constellate part of original trauma/conflict in the transference and not bask in positive transference
  - Naming defensive system/parts and acknowledging defensive, self-preserving aspects
- ***Managing regression: Differentiate between imagination/regression in service of ego versus fantasying and malignant regression***
  - Regression occurs naturally in holding, containing environment that invites developmental progrssion
  - Integrating with therapeutic relationship and transference/ countertransference is of prime importance

Psychotherapeutic Implications

- ***Integration of split worlds in patient (inner and outer; adult and child; protector and persecutor) through participation in both worlds***
  - Internal world infused with intensity: meaningfulness and meaninglessness. Developing healthy relationship with this intensity.
  - Addressing the world of the therapeutic frame; the world of reality; the world of limitations, facts and history
  - Noting there is a "real relationship" and illusory one
  - Therapist's acknowledgment of difficulties, feelings, struggles and authentic reactions
  - Navigating symbiosis/fusion/merger with distance/withdrawal/retreat to mature self-object relatedness

Common Psychodynamics and Emotional Beliefs in Abused Individuals:

- I am responsible for the abuse.
- If I was not so bad; ugly/beautiful; seductive; needy; vulnerable; open; helpful; stupid; caring; etc., the abuse would not have happened.
- I provoked the abuse and deserve to be punished. I will punish myself by doing what you want me to do even if it hurts me.
- If I were more perfect I would not have been abused. I will now do everything perfectly to avoid being abused in the future.
- I will abuse myself before you do. (And I can abuse myself better than you.)
- I will control the overwhelming feelings and unpredictable abuse by abusing myself in predictable ways.
- I will be abused if I expose myself. I will not be abused if I stay hidden.

Common Psychodynamics and Emotional Beliefs in Abused Individuals:

- I will not be abused if people don't see me (or fail to see me as desirable).
- Other people have not had it as hard as me. I am entitled to special treatment.
- I have been abused. You have the power to make it better and take the pain away.
- The past is in the present. The past is about betrayal, exploitation, pain, suffering.
- Others (especially intimates or authorities) want to hurt me or see me suffer.
- Others (especially intimates or authorities) get sexually aroused listening to my abusive experiences…and enjoy the sexual arousal.
- If I tell others about my abuse, they will see how vulnerable I am and hurt me.
- Others will not be able to manage my feelings if I express them.

Psychotherapeutic Implications: Complex Trauma Relational Themes

1. "Re-parent/rescue me."
2. "Promise you won't ever leave or hurt me."
3. "You will neglect me, or you have abused me."
4. "How dare you have faults?"
5. "Your boundaries are killing me. Make me special/get involved in my life (including sexual involvement in some cases)."
6. "You solve this chaos/you make it all go away."
7. "You find my memories for me."
8. "Money: What am I worth to you?"
9. "Emergencies: On call or on tap?" (Kinsler, et al. 2009)

Dissociation: Clinical Implications

- When dissociating, consider **using patient's first name** when addressing him/her. Consider commenting on room and surroundings.
- **Silence** can be effective with **mild forms** of dissociation. Provides **unintrusive space** and time to leave and return when she feels safe. Watch how your anxiety regarding silence may interfere.
- **Prolonged silences** are generally c**ounterproductive**. Consider noting the silence, querying into what is happening, how (s)he is experiencing the silence and if they would like to talk about their experience of the silence.
- **Watch** how the **patient responds** to your **verbal** and **nonverbal** behaviors. Note the patient's verbal and non-verbals.
- Consider **addressing core need or anxiety** as **reflected in** his/her **need to dissociate** (e.g. what is s/he needing to separate from? A painful feeling, memory, you, herself?).
- **Track affects** and **communication process** to guide clinical hour
- Help **organize dissociative** and **fragmented thought processes**
- **Assist** with the process of **completing thoughts** and sentences but don't provide the material

Forms of Psychoeducation

Psychoeducation on trauma may involve educating on the following topics:

- **The prevalence of trauma**: connects patients to others and softly begins to counter malignant personality dynamic of feeling "special" or "chosen."
- **Relational trauma**: an expression of cultural and personal wounds and vulnerabilities that stem from adversity in life and inadequate caregiving.
- **Typical acute responses** to trauma: avoidance, reexperiencing, intrusion; peri-traumatic dissociation ("spacing out," out of body experiences, experiencing time distortions at time of trauma); sexual responses to sexual traumas; relief at not being injured or killed; "Stockholm effects" (victim becomes attached to perpetrator); survivor guilt.
- **Lasting post-traumatic responses** : Stress symptoms are common, logical, and serve a purpose (to preserve life and health) and include: flashbacks, numbing, hyper-arousal; vigilance, panic attacks, interpersonal issues; fear of intimacy.
- **Safety concerns and plans**: Address psychosocial problems and inform patients on community resources if necessary (i.e. how to access medical or social services, a child protective worker, police). Increase the power of the victim to ensure her/his own safety.

Psychoeducation Topics

Psychoeducation on trauma may involve educating on the following topics:

- **Posttraumatic symptoms** are normal responses to toxic or abnormal circumstances.
- **Future symptoms may erupt during treatment:** Possible, short-term, increased trauma symptoms after psychotherapy sessions. Educate that psychotherapy is a place that these kinds of experiences can be addressed differently than when (s)he is in a naturalistic setting.
- **Enhancing treatment**: Psychotherapy sessions may be enhanced by bringing post-session experiences back into the next psychotherapy session.
- **Symptoms are expressions of trauma processing**: demonstrate psychological processing; posttraumatic avoidance is an adaptive response in reducing unbearable reactivated distress.
- **Approaching symptoms differently once in treatment**: re-experiencing responses can be addressed differently—engaged with together through the therapeutic relationship. They are a movement towards recovery since the patient now has the safety and containment to work though this symptoms.

Vicarious Traumatization

- "The negative transformation in the helper that results from empathic engagement with trauma survivors and their trauma material, combined with a commitment or responsibility to help them." It manifests as "disrupted spirituality" in which there is loss of meaning and hope (Pearlman & Caringi, 2009).
  - "If left unaddressed, [vicarious trauma] can escalate in severity until it meets criteria for a psychiatric diagnosis such as PTSD, other anxiety disorders, mood disorders, and substance abuse disorders."
- Psychotherapists with trauma histories are more vulnerable particularly if they have not received treatment.
- Psychotherapists with insecure styles of attachment report more vicarious traumatization.

Concluding Thoughts

- "In many cases in psychiatry the patient who comes to us has a story that is not told, in which as a rule no one knows of. To my mind, therapy only really begins after the investigation of that wholly personal story. It is the patient's secret, the rock against which he is shattered." (Jung, 1963: 117)

- "To say the very thing you really mean, the whole of it, nothing more or less or other than what you really mean: that's the whole art and joy of words. A glib saying. When the time comes to you at which you will be forced at last to utter the speech which has lain at the center of your soul for years, which you have, all that time, idiot-like, been saying over and over, you'll not talk about joy of words….why the Gods do not speak to us openly, nor let us answer. Till that word can be dug out of us, why should they hear the babble that we think we mean? How can they meet us face to face until we have faces?" (C.S. Lewis, 1956, p. 294, *Till We Have Faces*)