CHAPTER 9

Therapeutic Alliance and Risk Management

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Child abuse and attachment failures are relational events and experiences, occurring most often within families, between parents and children. The consequences profoundly affect the child's physiological/biological and psychological development, and ability to form close and trusting relationships. Victimized children are *hurt in relationships*, yet, paradoxically, *relationships can be the core component of healing from these injuries*. At times, special relationships, such as close friendships, mentorships, marriages, partnerships and, in some cases, parenting of one's own children, can be restorative when they provide the attachment security the individual needs to learn new ways of relating and trusting others. Psychotherapy may also provide the needed "safe haven" within which to modify old relational patterns that were built on insecurity and exploitation. Stated simply, whether it occurs within or outside of psychotherapy, healing of complex and chronic trauma associated with abuse (especially when there is a foundation of attachment trauma) occurs in safe, dependable, kind, and bounded relationships.

Therefore, in this chapter, we briefly review the psychological circumstances that bring about complex traumatic stress outcomes and disorders, and define some major parameters of psychotherapy that promote relational healing of traumatized persons. The client's relational history and the "lessons of abuse" he or she has learned are brought to the treatment relationship, often creating barriers to the development of a collaborative working alliance. They may also create tumultuous and challenging relationships that test client and therapist alike. Chu (1988) wrote of the treatment traps (including intense

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relational demands, extreme mistrust coupled with neediness, and dysregulated emotions) facing therapists in the course of their work with traumatized individuals. In a later article, he characterized the treatment of previously abused adults as "the therapeutic rollercoaster" due to its intensity and instability at times. Chu exhorted therapists to be mindful of the many relational challenges that attend treatment with this population, and the risks that they can pose for client and therapist (Chu, 1992). Many of these issues have also been discussed in Dalenberg (2000), Pearlman and Courtois (2005), and Pearlman and Saakvitne (1995). Therefore, in this chapter we also review management of risks inherent in providing this type of therapy.

THE RELATIONAL HISTORIES OF PERSONS WITH COMPLEX TRAUMA

The histories of patients with complex trauma include a variety of abusive experiences across the life cycle, beginning in family contexts that make processing and resolving these experiences extremely difficult. Patients with complex trauma do not typically grow up in a benign context, then suffer an act of abuse. Rather, they typically live in chronically abusive environments that *combine* varied types of abuses. Children often experience combinations of emotional, physical, and sexual abuse; parental substance abuse; domestic violence; a parent or parents with mental illness; and/or the criminal incarceration of a parent. There is a dose–response relationship between the number of types of abuse suffered and later effects (Dube, Anda, Felitti, et al., 2001; Dube et al., 2007; Edwards, Holden, Felitti, & Anda, 2003).

Multiple-category childhood victimization has important consequences for how children view themselves and their worlds, especially influencing their later relationships with others. In overwhelming circumstances of violence and exploitation perpetrated by other human beings, there is a major attempt to make meaning, to understand (Frankl, 1946). When abuse starts early and continues over much of a child's life, and especially when it is perpetrated by a parent/caregiver and there is no escape and no help from others, how does the child understand and make sense of it? Chronic abuse impacts the entire meaning of life—what McCann and Pearlman (1990) termed the individual's overall *frame of reference*. In general, persons who experience severe abuse *come to believe, at a very deep level, that the world is unsafe, that other people are not trustworthy*. By virtue of their repeated experiences of abuse and neglect, they come to "know," *in the deepest sense of internal knowing, that they are somehow to blame and deserving of the abuse*. They feel "in their bones" that they are bad, that it is fruitless to hope, that they will never be safe, and that they must keep their pain a secret from others. They may look to others for help but simultaneously they often expect to be beyond help and to be betrayed by the person(s) to whom they turn. Erik Erikson (1950) called this *basic mistrust*.

In recent years, findings from developmental psychology have expanded understanding of the relational circumstances that usually precede frank physical, emotional, and/or sexual abuse in a family. Adverse childhood events and experiences occur within and interact with difficulties in early attachment patterns between infants and primary caregivers. Numerous researchers investigating the quality of early attachment experiences between primary caregivers (usually parents) and young children (before age 2) have found that seriously disrupted attachment, without repair or intervention for the child can, in and of itself, be traumatic (labeled *attachment trauma* by Allen [2001], and Schore [2003a, 2003b]). British psychiatrist John Bowlby (1969, 1980) pioneered the study of attachment between caregiver and young child, and its significance to human development. He noted that children need a stable caregiver who is affectively attuned, offers protection from overstimulation and threat, and teaches social interaction skills. Four primary attachment styles in childhood have been identified, each of which has a corresponding style in adulthood: (1) *secure*; (2) *insecure–ambivalent (resistant)*; (3) *insecure–fearful/avoidant*; and (4) *insecure–disorganized/disoriented*. These patterns have been found to be relatively stable over the lifespan but are subject to modification according to individual factors, such as the child's temperament and perceptual style; and contextual factors, such as idiosyncratic life events and experiences, including other primary and influential relationships.

Accumulated evidence now strongly suggests that the majority of chronically abused individuals develop an insecure and/or disorganized/dissociative attachment style (Lyons-Ruth & Jacobovitz, 1999) that impacts their view of others and their sense of self, both within and apart from relationships. Beliefs such as "No one is trustworthy," "It's a dog-eat-dog world," "To feel safe, I need to be in control," "I feel disconnected from other people," "I am bad," and "I deserve to be treated badly by others" influence the quality of individuals' interactions and relationships. When interactions are disappointing in some way, these beliefs get reinforced. These convictions often have enormous resilience, even in the face of contradictory data. They arise from the child's needs to protect him- or herself in the crucial relationship with the primary caregiver. Children use these nonconscious beliefs, full of self-blame, to maintain the crucial illusion that the world could be safe "if only they were better" (Janoff-Bulman, 1992).

Attachment theory posits that these early experiences are organized internally and implicitly as the template for adult personality and all interpersonal relationships (Shorey & Snyder, 2006). Bowlby (1969) introduced the concept of *inner working model* (IWM) to describe cognitive and emotional representations of self and others that typically operate automatically and unconsciously to monitor attachment-related experiences, and that form the basis for behavior. These IWMs are comparable to schemas about self and others proposed by other theorists (e.g., McCann & Pearlman, 1990; Young, Klosko, & Weishaar, 2003). Importantly, these IWMs are flexible enough to be updated through the provision of new relational experiences. It is on this basis

that we posit the importance of the relationship in the treatment of clients with complex trauma.

TECHNIQUE OR RELATIONSHIP?: A "BOTH–AND"

Recent years have seen an enormous push for "empirically validated treatments." Research in psychotherapy effectiveness has focused on treatment provided according to manual-based protocols (Binder, 2004), designed in part to eliminate variations between therapists. In contrast, however, a long line of therapeutic outcome research suggests that it is *precisely these individual therapeutic relational differences*, a part of each treatment relationship, that contribute to and predict outcome (Hubble, Duncan, & Miller, 1999). Client factors account for approximately 40% of therapeutic change; the therapeutic relationship, for 30%; expectancy effects, for 15%; and specific therapeutic techniques, for only 15% (Hubble et al., 1999).

The consensus among therapists treating the severely traumatized is that *both technique and relationship* are important influences on outcome. Researchers are now studying this very issue as it pertains to the treatment of survivors. Cloitre, Stovall-McClough, Miranda, and Chemtob (2004) reported that "in the treatment of childhood abuse-related PTSD, the therapeutic alliance and the mediating influence of emotion regulation capacity appear to have significant roles in successful outcome" (p. 411). They also noted that two specific areas of technique are important in treating complex traumatic stress disorders: (1) teaching of stabilization/emotional regulation/self-soothing and (2) processing of traumatic experiences. Each area requires specialized training, approaches, and interventions; therefore, therapists must be skilled and comfortable working in both of these areas. Clients who report a history of pervasive childhood abuse and neglect, especially one that occurs in the context of insecure attachment, have emotional regulation deficits that may in turn cause reliance on a variety of problematic behaviors (i.e., addictions, compulsions, self-injury, chronic suicidality) in the interest of self-soothing leading to emotion and self-regulation. Thus, therapists need a repertoire of skills and approaches to help the client approach rather than avoid emotion, and to learn to tolerate and modulate a variety of emotional states through more adaptive self-soothing strategies. Therapists also must be able to tolerate the personal feelings they experience in working with these maladaptive coping strategies, that often are based on self-harm and self-invalidation. A variety of available workbooks now provide specific information, guidance, and a series of exercises and worksheets on these various topics (Allen, 2005; Cloitre, Cohen, & Koenen, 1996; Conterio & Lader, 1998; Copeland & Harris, 2000; Jobes, 2006; Linehan, 1993; Miller; 1994; Najavits, 2002; Vermilyea, 2000).

In addition to these important interventions geared toward client self-regulation, the authors' experience, in concordance with the findings of many

other clinicians and clinical researchers, strongly supports the view that *the therapy relationship is itself the vehicle of change*. Optimally, it models secure attachment and provides containment of the patient's anxiety, the opportunity for expression of other core emotions, a context within which to work out relational issues, and a basic *valuing of or validation* that the patient may never have had. As expressed by a patient of Kinsler at the end of treatment, "I was always OK with you. You saw me *and let me be me*."

A healing therapy relationship handles relational distress, including mistrust, hypervigilance, and mistakes made by each member of the dyad, without retaliation or defensiveness on the part of the therapist. As such, it becomes a model for what can be. As attachment becomes more secure over the course of treatment, emotions become more accessible and less onerous, the client's self-regard increases, and relationship skills develop. As a result, the client has a new template for relationships and new abilities to apply in his or her interpersonal world.

The remainder of this chapter covers some aspects of what we have learned in attempting to create this type of relationship with clients through our own direct clinical experience, reading of expert literature, peer consultation, supervision, personal reflection, and professional training. Guidance is offered on how to approach the treatment relationship, as well as manage the risks inherent in it, because the relationship itself tends to elicit strong feelings and reactions of both client and therapist. Without forethought and preparation, treatment mistakes, including misalliances and misadventures, can develop, an unfortunately common occurrence in the treatment of those with complex traumatic stress (and dissociative) disorders.

A "WORKING ALLIANCE"

Virtually all schools or orientations to psychotherapy discuss helpful qualities in the clinician–patient relationship. *The quality of the therapeutic relationship is of central concern*. The central features for most schools and writers include a sense that both clinician and patient are working hard, with shared goals, a common language (and, for that matter, a mutual acceptance of situations for which there is no adequate language; see Dalenberg, 2000, p. 59), and a mutual respect for what is shared and learned over the course of treatment. The therapist is open to the client and provides acceptance for his or her emotions, thereby countering the invalidation of the past. The client can learn self-respect, self-calming, and effective interpersonal negotiation—central goals of treatment with this population. The therapist also strives to be "interpersonally transparent" to counter the client's lack of information about relationship dynamics and to bolster the client's trust and security. Thus, the relationship becomes both context and container for interpersonal experimentation and learning.

COMPONENTS OF A WORKING ALLIANCE WITH COMPLEX TRAUMA CLIENTS

Working alliances with trauma survivors are characterized primarily by the growth toward safety within the relationship (Herman, 1992). As a starting point, therapists must work from the principle of "Do no *more* harm" (Courtois, 1999) and constantly strive to be accessible, yet with clear boundaries. We list below some of the most central components of establishing safe treatment for this population, as presented and discussed by Frankel (2002) in his Presidential address to the International Society for the Study of Dissociation.

1. *Trust and testing*: The clinician cannot and should not expect automatic trust on the part of the patient, especially at the outset of treatment. If trust occurs, it develops *within the context of relational testing*. Trauma survivors, having been schooled in ways of betrayal and violation of personal boundaries, know little of trust. Few warning signs are more powerful to a trauma survivor than a clinician who asks or expects to be trusted, and/or who takes the client's mistrust personally rather than using it as a mechanism to understand the client's schema about self and others. Trust that arises in the therapy relationship is hard-earned and long in coming. Tests of trustworthiness are, at best, not failed, rather than passed. A client who claims to "trust you" early in therapy is likely to be placating you as a dangerous potential betrayer.

2. *Blame and behavior*: Safety grows when therapists do not blame clients for their troubles, problems, lifestyles, "choices," failings, symptoms, and behaviors that appear to be (or actually are) manipulative. These behaviors developed as protective strategies (survivor skills) and resulted from what the client learned and/or did not learn in formative relationships. Adult survivors of childhood trauma are used to being blamed for all bad things in their lives. They perfectly illustrate the admonition that if blaming someone for their problems would help, then they would have fully recovered years ago. This requires therapeutic steadiness and the ability to contain rather than react to client behavior.

3. *Shame and symptoms*: Therapists must not shame clients for their troubles, failings, symptoms, and behavioral repertoires. Trauma survivors, who already are shamed by how they have been treated, may engage in behaviors that reenact their shame. They require helpers who can be *sensitive to their shame* and help them to explore their negative self-worth and sense of being apart from/less than other humans, without adding to their shame.

4. *Consistency and connection*: The clinician must provide consistency with regard to his or her personal style and behavior, appointment times (start and finish), punctuality, and availability between sessions. Consistency applies to connection, to the therapist's willingness to engage in a close connection with the patient. Connection and support are essential elements of healing from trauma of any sort. In interpersonal trauma, real connection with others often takes a long time and much testing to develop.

5. *Humility*: The clinician must learn humility—the quality of not taking oneself too seriously. Competent clinicians acknowledge errors, blunders, and imperfections; are not afraid to express sorrow and regret; and work to repair damage to the therapeutic relationship when it occurs. Trauma survivors are not used to relationships with people who admit errors and foibles, which makes repair of therapeutic mistakes both difficult and incredibly helpful. Schore (2003b) comments on *relational repair as a core strategy in the development of secure relationships*. Competent clinicians maintain clear and firm boundaries, and reveal only a modicum of information about their personal lives (and then only when there is a clear therapeutic rationale for such disclosure), but they judiciously use and disclose their feelings and reactions within the treatment to be more transparent to the client, as a means of modeling collaborative problem-solving approaches and of negotiating relational impasses.

Dalenberg (2000) studied individuals who had completed trauma treatment. As patients, they felt they would have benefited had their therapists been more transparent with them regarding the rapist feelings "in the moment." Without this, they were left wondering about how their therapist felt and were anxious as a result. This was especially the case with therapist anger. Clients reported that if a therapist did not acknowledge his or her anger, the anger tended to get acted out, either passively or more directly, in ways that damaged rather than strengthened the relationship. This client feedback offers therapists important information about one of the most difficult emotions for trauma survivors. Therapist disclosure of personal history pales in significance to the therapist's ability to be present and mindful in the relationship, and to engage with honesty and directness.

6. *Demeanor*: Safety grows when the clinician's demeanor is warm, kind, calm, gentle, interested, and empathically attuned. Calm demeanor and empathic attunement contribute to a "holding environment" (Winnicott, 1965) within which the client is respected and validated as a unique individual. It contrasts with the ways abuse survivors are accustomed to being treated by others. Being treated with respect and attunement may initially be uncomfortable, and the client might even try to reject it; however, when accepted and internalized by the client, it provides conditions for personal growth and change.

7. *Awareness*: Safety grows as the clinician is aware (mindful) of his or her own emotional states, life stresses, and countertransference reactions, and is willing to talk with patients about these "awarenesses," when it is appropriate to do so. Therapist mindfulness is being promoted across all major treatment orientations, from psychoanalysis to cognitive-behavioral, to somatosensory treatment as a necessary component for client development (Fonagy, 1997; Linehan, 1993; Ogden, Pain, & Minton, 2006; Siegel, 2007; see also chapters in Parts II and III, this volume). Psychophysiological synchrony and relational attunement contribute directly to the client's well-being. In response to research findings that such attunement on the part of a significant other can lead to development of new neural pathways in the brain that, in turn, can lead

to changed behavior and a more secure attachment style, Schore (2003b) and Siegel (2007) have labeled the process *interpersonal neurobiology*.

8. *Professionalism*: Safety grows when therapist behaviors reflect professionalism. This includes articulated practice policies; defined and defensible billing practices; maintenance of a confidential setting and confidentiality of session content; open discussion of boundary crossings and their effects; records that the client can read and come away feeling respected; meeting the client within the established structure unless there is a well-planned and discussed reason for other arrangements, etc. In these ways, a professional frame increases a client's sense of safety. A dissociative client once transferred care to Kinsler because the prior therapist had moved and reconstructed her office four times in 1 year of treatment. The client asked, "Who in that relationship was really unstable?"

In summary, *the essential therapist task is to provide relational conditions that encourage the safety of the attachment between client and therapist*. It is through provision of such conditions that the therapy work can lead to a change in the client's attachment style. The client can move to what is termed an *earned secure* style within the therapy that then extends to extratherapeutic relationships (Valory, 2007).

Importantly, *relational attunement increases client self-regulation and self-development*. It includes the process of attending closely and reflecting upon the relational meaning of therapeutic events and reactions. Perhaps the most important question for the therapist to ask repeatedly is "How will this (considered) statement/intervention increase the client's *reflection on self-in-relationship*?" A safe relationship in which to explore self in relationship to others is the goal of the treatment process rather than insight or correct interpretation. Relational safety supports the client in learning new skills, especially new ways of coping. As the possibility of the safety and trustworthiness of others in the world is incorporated by the client, there is less need for dissociation and other defensive operations to self-regulate. The client's feelings and experiences are acceptable to the therapist and do not require exclusion from awareness, allowing an increase in personal coherence/personal narrative. There is less need for compartmentalization; rather than being overwhelmed by emotional reactions, the client begins to feel secure enough just to notice and experience emotions as they happen (labeled as increased capacity for self-reflection, reflective awareness, or mindfulness) (see Siegel, 2007). A clinical example serves to illustrate.

A client began therapy exceedingly sensitive to whether the therapist "cared." Any change in the established appointment times due to personal or professional obligations was personalized by the client and taken to signify that the therapist was indifferent to her. "You don't care. I'm just a marker in your book … another hour to fill … another paying customer. I'm always bad, wrong, the one no one gives a damn about!" The therapist had to work against feeling attacked or becoming defensive or reactive, instead responding with comments such as the following: "It's hard to believe anyone cares if

something that matters to you changes." Of particular importance were times when the treating therapist acknowledged his own mistakes in relationship management: "You're right. It was inconsiderate of me to wait too long to tell you I was going to be away. I apologize" or "I agree, I could have handled that better." This stance of nonretaliation toward the client's blame and attack was crucial. The client began to realize that she was important enough that the therapist took her position seriously and offered an apology. Making a mistake with her *mattered* to the therapist. Relational repair of this sort became major therapeutic change points for the client.

Another, more paradoxical change point came when the therapist expressed his irritation after the client made a series of repeated quasi-emergency and increasingly dependent calls in a short time period, straining the therapist's patience. After considering that the client had (he hoped) become strong enough to hear it, the therapist commented, "This is the third time you've called in 2 hours. You know, I'm *not* the endless source of peace and comfort!" By this time, the relationship was strong enough for the client to take this in, not as personal rejection or an indication that the therapist did not care but as an honest acknowledgment of the therapist's humanity and limitations. After acknowledging her initial hurt, she told the therapist in the subsequent session, "Sure I was taken aback, but it was good for me to realize you're human too. Sometimes you run out of patience, sometimes you get overwhelmed, just like I do." These comments communicated a marked increase in the patient's ability to obtain personal control over her initial emotional reactions, based in large measure on the long-term safety and holding environment of the relationship. A further example follows.

As the therapy moved toward the end, the client was able to incorporate the relational lessons she learned in the laboratory of therapy into important life relationships. She became capable of mutual, collaborative, give-and-take relationships with her children. She became able to set limits on and avoid exploitive relationships with men. She no longer "deserved" to be exploited. She asserted herself gently but firmly in her romantic relationships. For the first time in many years, she lived an organized, nonchaotic life. There was an increase in her ability to relate to others in healthy ways in all types of relationships: intimate, parenting, friendship, and colleagueship. These changes were enormously satisfying for client and therapist alike.

In summary, *changing the entire self-in-the-world schema, and how relationships and people work, is the goals of this therapy*.

AREAS OF RISK AND THEIR MANAGEMENT

Listed below is a series of the common relational "demands" often made by these clients, whether explicitly or implicitly, that often challenges therapists, along with considerations of how to manage ethically them in ways that simultaneously attend to the risk that mismanagement can create.

1. "*Re-parent/rescue me.*" Perhaps the most common mistake in this therapy is trying to become the good parent the client never had, by rescuing and attempting to meet all his or her unmet dependency needs. Such a strategy, instead of emphasizing the client's responsibility for self- and personal growth within and outside the therapy, often leads to increased demands and an entitled stance toward the therapist (e.g., needing more time, multiple crisis calls), and the therapist trying to do more in response. Therapists who do not communicate or address limitations can become entrapped in an impossible level of patient responsiveness and care. Examples include cards and phone calls while on vacation; nightly phone calls to assuage loneliness and to prove the therapist's caring; extended and extra sessions on an ongoing basis; and continuous crisis management, including suicidal crises and emergency hospitalizations. Therapists who engage in this way usually end up losing patience and tolerance, and taking such reactions out on the client—usually in a way that is blaming or hostile. Therapists learn that rescuing can boomerang as client demands and needs increase to the point that they become impossible to meet. Instead, the therapeutic task is to help the client learn self-responsibility and practice give and take with others. Therapists who maintain appropriate boundaries and limitations provide appropriate modeling. Clients learn that therapy does not exist "outside of the bounds of other human relationships," and that *their losses are not compensable by their therapist* and instead need to be grieved (Calof, cited in Courtois, 1999).

2. "*Promise you won't ever leave or hurt me.*" Clients who were seriously neglected in childhood understandably yearn for constancy and reassurance that they will not be abandoned or hurt by the therapist. They may test this out through hypervigilance, hypersensitivity, and/or acting-out behavior. The therapist must be empathic about the seriousness of these issues and help clients understand how they developed in the context of unpredictable, unresponsive, and chaotic relationships. Concurrently, the therapist must openly address this issue by not offering false reassurances and promises (i.e., "I will never leave you") and by assuring the client of his or her intention to remain available as long as the relationship is working, the treatment is progressing, and other life circumstances do not interfere. All relationships are conditional, and therapists cannot guarantee what they themselves are unable to control (e.g., their own health, the health and needs of members of their families, the stability of their practice, change in life circumstance or life plans, or that they will never make a mistake).

3. "*You will neglect me, or you have abused me.*" In a similar vein, it is inevitable that therapists will disappoint their clients by having other priorities and life vicissitudes. At times, they may be late, distracted, or overworked; the pager may go off; they may need to deal with an emergency, run late, or make a patient wait; and so forth. Therapists have their own life struggles that limit how much they can give. Therapeutic mistakes and limitations are "teachable moments" in which the lesson is "Yes, I am really tired today and maybe I have not been as present as we both wish—but I can and do still care about you.

This does not mean that I am going to abandon you." These moments teach the relational middle ground: Every letdown is *not* a prelude to neglect, abuse, or abandonment.

What has been identified as *traumatic transference* occurs when the survivor client expecting that the therapist will be yet another abuser, is ever vigilant to that likelihood. This can be a very difficult projection for therapists to understand, because they entered their profession to be helpers, not abusers. Therapists must work to not take this transference expectation personally, while helping clients to explore and understand its origin. They must also understand a relational paradox of betrayal-trauma and attachment insecurity (especially disorganized attachment) that is based on past abuse within relationships with others known to the client (e.g., family members, acquaintances, clergy, teachers). Often, the relationship was the context and conduit for grooming of the child victim, and role relationships and responsibilities were perverted: It was when the relationship became close that the abuse occurred. Thus, when the therapeutic relationship deepens, the client may become most fearful and vigilant, surprising the therapist who, in fact, may be feeling more connected. When therapists do not behave in abusive, exploitive, or retaliatory ways, and when they help clients to understand their fears as legitimate and as projections of past experiences, they provide a different model for relationships in which that abuse/exploitation is not the inevitable outcomes. Other people can be trustworthy.

4. "*How dare you have faults?*" A client once noted that Kinsler had a vanity license plate, and became so enraged at the "narcissism" of this that he left a nasty note under the therapist's windshield, and was extremely critical for several therapy sessions. The vanity plate was interpreted as an example of the therapist's personal aggrandizement, a belief that undercut the client's belief that to be helpful the therapist should be without flaws. Everyone wishes for a perfect father, mother, therapist, and so forth. The therapist's job is to help clients have more realistic expectations, and to grieve the faults of those who were self-centered, abusive, or neglectful in the past. As they let go of the wish, they are freer to accept what therapists *do have* to give, namely, themselves in relationship—imperfections, pettiness, and all. With this stance, therapists also model that the client need not be perfect to be acceptable, a belief held by many survivor clients (i.e., "I can be helpful to you even if I am imperfect, and will care even when you are").

5. "*Your boundaries are killing me. Make me special/get involved in my life (including sexual involvement in some cases).*" Clients raised with abusive/exploitive caregivers in the context of insecure–disorganized attachment experience a variety of boundary failures in these relationships. These may include stringent boundaries without flexibility on the one hand, lack of boundaries on the other, or boundaries that are ever-shifting and unpredictable. The fluidity of boundaries enables the development of dual relationships in childhood, and clients may be used to such relationships and try to establish them with the therapist. Understandably, abused and neglected clients yearn for the

"special-ness" they never had with their primary caregivers. Stable and predictable boundaries within the therapy work against the development of dual relationships and teach consistency, reliability, and trustworthiness. Although the client might experience boundaries as rejection, the therapist must make clear that a sexual or other dual relationship would not be in the client's best interests and would instead be unethical and retraumatizing: "Having a sexual relationship would not reassure you that you are special, but it would violate our relationship in many of the same ways your abusers did."

6. "*You solve this chaos/you make it all go away.*" Some clients have the expectation that it is the therapist's responsibility to "fix it." The therapist who takes on this expectation is likely inadvertently telling clients that they are incapable and not in charge of life decisions. Often, such a stance invites oppositional behavior on clients' parts. No one really wants to be taken over. Additionally, clients' resiliency and strength need to be supported and applauded, and built upon: "I know you wish I could just fix it. No one can do that. You have a number of strengths and things going for you. Let's find ways to help you build on those and learn some new skills as well."

7. "*You find my memories for me.*" Many clients enter therapy with the hope or expectation that the therapist will find their abuse memories for them (e.g., "My boyfriend/girlfriend was reading this checklist in a magazine and said I can't sleep and don't like sex because I was probably sexually abused. I want you to tell me if I was"). Without evidence, corroboration, or the client's autobiographical memory, no one can say for sure whether a person was or was not abused. There is no specific symptom that *proves* abuse (sexual or otherwise) or that arises *only* from sexual abuse. The therapist must start *with the patient's memories (if any are available) and symptoms as they are presented* (Courtois, 1999). Since it is not unusual for clients to want to "export the authority for memories to the therapist," rather than having to struggle with uncertainty and the possibility of real abuse and neglect in their backgrounds (Calof, in Courtois, 1999, p. 270), the therapist should not set him- or herself up as the arbiter of the patient's reality. Instead, the therapist can work to resolve presenting problems and provide an interpersonal context in which the client can explore the possibility of abuse without suggestion or suppression on the part of the therapist: "Without your remembering and without evidence, I have no way of knowing whether you may have been abused. You have mentioned problems in your upbringing that are worth exploring as to their personal meaning, and their possible influence on your sleep problems and sexual functioning. Let's see if we can work on these and help you manage these current problems."

8. "*Money: What am I worth to you?*" It is not unusual for severely abused clients to have poor financial management skills that leave some in dire financial straits. At the opposite end of the spectrum, others are scrupulous about money management, having vowed as children to become independent and never to have to rely on anyone for anything. Money can symbolize many

things for survivor clients. For the self-sufficient and untrusting client who views every relationship as a give-and-take transaction, each and every session might be paid for at the start of the sessions, "cash on the barrelhead." The therapist is promptly paid for services, and either party is then free to walk away *without owing anything*. For others, the therapy fee is yet another way they must "pay for" or be encumbered in the present by their past abuse. These clients are understandably resentful of the cost to them (financially and in other ways) and may resist paying for services, or may suggest that they are merely paychecks for the therapist. Still others may use money as a yardstick by which to measure the therapist's caring: If the therapist cares enough and the client is special enough, then he or she will not charge or will lower the standard fee in accommodation. To resist these treatment traps, and in keeping with professional standards, the therapist should have consistent fee setting and payment collection policies, and should not allow clients to build large back balances. We recommend carefully examining the relational meaning when a client fails to pay, falls seriously behind, and so forth. Often the latent meaning is a desire to be specially nurtured, a way to sabotage treatment, or a way to express anger or other emotions indirectly—issues that need to be made explicit and to be negotiated.

9. "*Emergencies: On call or on tap?*" In a population in which chaoic life and interpersonal revictimization might be the norm, at least toward the beginning of treatment, it is important to set clear standards regarding personal safety and how emergencies are defined and handled. It is optimal to have these detailed in the Informed Consent to Treatment Agreement given to the client at intake. Additionally, it is generally advisable to spend a certain amount of time toward the beginning of treatment conducting a risk and safety assessment and, for those clients in clear danger to themselves or others, to develop a plan of action (i.e., safety planning) that the client agrees to put into place in an ongoing manner, but especially in the event of an emergency. A wide variety of self-soothing and emotion regulation techniques should be taught to and implemented by the client in the initial stabilization portion of treatment. These form the foundation of self-management, and the therapist serves as a backup resource on an as-needed basis and when a given situation escalates. When clients do reach out for contact in dire circumstances, and in accordance with the agreements spelled out in the safety plan, the therapist must respond positively and in ways that reinforce honoring the plan before taking action. In Linehan's (1993) words, the therapist is then "reinforcing the right thing."

ADDITIONAL RISK MANAGEMENT TOOLS

We authors also recommend the following tools to aid in the management of risk, in what can sometimes be a challenging population.

Record Keeping

Treatment notes concerning the content of each session are generally required by professional ethics codes and can be used as an important risk management strategy. Many notes follow a format that resembles the following: (1) session content/topics/disclosures; (2) interventions; (3) client comments and behaviors; and (4) homework. This format is helpful in addressing two fundamental areas of compromise that many adult survivors of childhood trauma have undergone: self-reflexivity ("observing ego functions") and continuous memory. Both areas are addressed when the client is shown these notes, in the context of a treatment session covering topics that have been discussed on prior occasions. Review of the notes helps to reinforce memory. The "client comments and behaviors" section, which is a primarily record of things said/done by the patient, often clarifies the meaning to the client of material discussed, teaches, and reinforces an observing ego. Furthermore, this section can be extraordinarily helpful for documenting "boundary pushes" and how these are handled (e.g., a client may ask to be touched or held after a session in which an exposure treatment for flashbacks was done). The therapist makes a verbatim record of what the client said and the therapist's response. By documenting pushes and responses, the client (and, in the event of the need for any legal or regulatory body, reviewing personnel) knows that the therapist is aware of boundary issues and addresses them in ways consistent with the standards of care.

When Content Speaks Indirectly about Process

Process comments—comments by clinicians about what is transpiring in the therapeutic interaction—are a typical part of psychotherapy. A research findings in the treatment of trauma (e.g., see Dalenberg, 2000) is that adult survivors often have repeated experiences of disappointment, mistreatment, and victimization over the course of their lives, and also experience a range of feelings similar to those that occur in therapy—often ranging from disappointment and hurt to outright betrayal. At times, when clients are complaining about myriad episodes of mistreatment in their lives, it is a useful strategy to ask whether any of those complaints are applicable to their therapy. As noted earlier, it takes courage and commitment for clinicians to request this kind of feedback. There may be times when therapists may be surprised by something they said, or when something they did had a negative impact on a client, with intensity varying from mild to very strong. Making therapy safe enough for clients to disclose all feelings, including those of being misunderstood, let down, or betrayed, communicates respect and validation of the client's perspective.

Discussions of the Future

It can be very helpful to talk about the future in general and as it relates to the therapy relationship. In addition to avoiding impossible commitments (e.g.,

"I'll be your therapist for as long as you need me") these conversations open discussion about issues such as "How will I know I'm done with treatment?", "Will you tell me that it's time to stop?", "Will I be having flashbacks like this forever?", and so forth. These discussions address not only the therapist's view of the client's recovery but also his or her view of the client.

Management of the Therapeutic Impasse

Occasions arise in treatment of adult trauma survivors when an impasse is reached. One of the most helpful ways to manage an impasse is to acknowledge it and try to discuss what events or feelings have contributed to it. If a sense of goodwill remains between clinician and client (of course, this depends on the seriousness and intensity of the impasse), albeit with the feeling of being "stuck," it may be helpful to seek out the services of a consultant with expertise in the treatment of childhood trauma survivors and the negotiation of impasses. Depending on the consultant's standard of practice and assessment of the situation, the therapist–client dyad may meet together with the consultant, or there may be individual meetings to discuss each point of view, followed by conjoint meetings. The clinician's best approach to impasse consultation involves openness to understanding and appreciating all factors that may be at work, willingness to avoid blame or shame, and working toward a resolution that moves treatment either forward or toward a decision (gently, the therapist hopes) to terminate the treatment and make referrals as needed.

As an alternative to a consultant, some dyads may decide to begin recording sessions—either audio- or videotapes—so that perceptions of the process may be measured against the "reality" offered by the recording. Again, the willingness to avoid a stance of blame or shame and to work toward a resolution of the stalemate is essential.

Ending the Relationship on a Positive Note

Powerful connections develop in relationship-based therapy. The end of treatment may activate or recapitulate feelings associated with past abandonment or other losses. Termination needs to be handled carefully, because inattentive management can undo some of the gains of "earned-security." Generally, termination should be discussed as the client naturally begins to reconnect to the outside community and to reestablish a life that is less encumbered by the effects of the past trauma. The client may begin to cancel appointments to attend other activities, change appointment times, reduce frequency of sessions, and ask for telephone check-ins as opposed to in-person sessions. As therapy winds down, enough time should be given for discussion of the impact and the feelings that leave taking elicits. The relational lesson is "I and our work will always be with you as you move on." For some clients, we have discussed this as being analogous to the time a child is ready to go off to college, with the same hopes for the future and feelings of sadness and loss.

Sometimes, the client cannot take leaving this way, and he or she manufactures a reason to storm out and slam the door. Our experience has been that such clients often continue to function much better in their lives, and that they are ending a significant relationship in the best way they can manage. Therapists may need to cope with being left in an incomplete or less than optimal way, just as parents cope when an adolescent distances in terms of achieving independence. Leaving home—or a safe haven—is difficult. As with other issues in relational treatment, it is best if the issue is discussed, mutually decided, and undertaken with preparation, but that is not always the way it happens. The question of termination, of course, raises the question of what the outline may be for a posttherapy relationship, if any.

Posttherapy Contacts

Therapists have different values and policies regarding posttherapy contact. Some accept phone calls, e-mails, and visits, possibly even a meeting for coffee or lunch, as an extension of their ongoing concern for the now ex-client. Others are uncomfortable with maintaining any form of contact: They may endorse a therapeutic orientation that such contact is invariably infantilizing and calls up transference feelings. Whatever the therapist's stance, it should be based on a careful assessment with the former client about whether it is in the individual's best interest, whether it will be manageable, and whether it will interfere with the ending itself and the client's newly developed independence. An extratherapeutic relationship may make a needed return to therapy for additional treatment difficult, if not impossible, so the situation calls for caution and informed consent.

Although some professional ethics codes allow the establishment of romantic or sexual relationship with past clients several years posttherapy (American Psychological Association, 2002), others strictly forbid such a relationship. Due to the potential for retraumatization that characterizes this treatment population, and due to the power dynamics involved in the relationship between therapist and client, the development of a romantic/sexual relationship is fraught with the potential to damage the ex-client. For this reason, such a relationship with complex trauma survivor clients is inadvisable under any circumstance and patently unethical in some instances.

The Outcome

When this therapy works, changes can be dramatic. A client can move from a life completely centered on trauma, flashbacks, fear of abandonment, self-harm, and tolerance of exploitation to relative stability, coherence, safety, warmth, and human connection. Kinsler had the challenge and privilege to work for years with a woman who had previously spent a quarter of a million dollars on psychiatric hospitalizations. Multiple prior therapies had failed. In establishing therapy goals at the beginning, the client was quite frustrated and

blurted out, "I just want to have *normal person problems*." Years later, the client had not been in hospital for 5 years. The chronically dysfunctional relationship with her husband had become a working partnership. Two children with previously chaotic lives had become honor students. Therapist and client noticed that they had spent three or four sessions discussing where one child was applying to college, whether another would get into a prep school, and whether the client's (formerly chronically unemployed) husband would get a promotion. Therapist and client looked at each other in recognition and mutually realized that the client had achieved "normal person problems." They proceeded to a smooth, kind, and warm ending. This kind of therapy can achieve profound and long-lasting changes.

In this chapter, we have discussed the relational "teachings" that can occur for clients with multiple traumatizations in childhood, and have presented a therapy method based on the relational healing of such relational injuries, along with the parameters for conducting such a therapy, and for managing the risks of this deeply interconnected therapy method.

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