

Relational Healing in Complex PTSD

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More and more traumatology pundits see attachment disorder as one of the key symptoms of Complex PTSD. In the psychoeducational phases of working with traumatized clients [outlined in my article: “Managing Emotional Flashbacks in Complex PTSD”], I typically describe attachment disorder as the result of growing up with primary caretakers who were regularly experienced as dangerous – dangerous by contemptuous voice or heavy hand, or more insidiously, dangerous by remoteness and indifference. Recurring abuse and neglect habituate children to living in fear and sympathetic nervous system arousal, which over time creates in them an easily triggerable abandonment melange of overwhelming fear, shame and depression.

A child with parents, who are unable or unwilling to provide safe enough attachment, has no one to whom she can bring her whole developing self. No one is there for reflection, validation and guidance. No one is safe enough to go to for comfort or help in times of trouble. There is no one to cry to, to protest unfairness to, to seek commiseration from for hurts, mistakes, accidents, and betrayals. No one is safe enough to shine with, to do “show and tell” with, to be reflected as a subject of pride...to even practice the all-important intimacy-building skills of conversation. In the paraphrased words of more than one of my clients: “Talking to Mom was like giving ammunition to the enemy. Anything I said could and would be used against me. People always tell me that I don’t seem to have much to say for myself.”

Those with Complex PTSD-spawned attachment disorders never learn the communication skills that engender closeness and a sense of belonging. When it comes to relating, they are typically plagued by debilitating social anxiety, and social phobia when they are at the severe end of the continuum of PTSD. Many of the clients who come through my door have never had a safe enough relationship. Repetition compulsion has compelled them to unconsciously seek out relationships in adulthood that traumatically reenact the abusive and/or abandoning dynamics of their childhood caretakers. For many such clients, we are their first legitimate shot at a safe and nurturing relationship; and if we are not skilled enough to create the degree of safety they need to begin the long journey towards developing good enough trust, we may be their last.

As the importance of this understanding ripens in me, I increasingly embrace an Intersubjective or Relational approach. I believe that it is the quality [rather qualities] of the clients’ relationship with me that can provide a corrective emotional experience that saves them from being doomed to a lifetime of superficial connection, or worse, social isolation and alienation. Moreover, I notice that without the development of a modicum of trust with me, many of my PTSD clients are seriously delimited in their receptivity to my guidance, as well as to the ameliorative effects of my empathy. In this regard then, I will describe four key qualities of relating that I believe are essential to the development of trust and subsequent relational healing. These are Empathy, Authentic Vulnerability, Dialogicality and Collaborative Relationship Repair.

1. Empathy. I used to assume that the merits of *empathy* were a given, but I have sadly heard too many stories of empathy-impoverished therapy. In this regard, I will simply say here that if we are hard and unsympathetic with our clients, we trigger the same sense of danger and abandonment in them that they experienced with their parents. In terms of a definition, I especially like Kohut's statement that: "Empathy involves immersing oneself in another's psychological state by feeling one's self into the other's experience." When I delve deeply enough into a client's experience, no matter how initially off-putting or bizarre, I inevitably find psychological sense in it, especially when I grok its flashback components.

Empathy, of course, deepens via careful listening and full elicitation of the client's experience, along with the time-honored techniques of mirroring and paraphrasing which show the client the degree to which we get her. Noticing, and when appropriate sharing my subjective free associations – especially when they are my own emotionally analogous and autobiographical reverberations - often enhances my empathic attunement and ability to reflect back to her in an emotionally accurate and validating way.

2. Authentic Vulnerability. The process of emotional reflection is part of a second quality of intimate relating: authentic vulnerability. I have found emotional reflection to be irreplaceable in fostering the development of trust and real relational intimacy. I came to value this the hard way via its absence in my first personal experiences with therapists who were of the old, "blank screen" school – who were distant, laconic and over-withholding in their commitment to "optimal frustration." Therapy was actually counter-therapeutic and shame exacerbating for me as we co-created and reenacted a defective child/perfect parent dynamic. Gratefully, I eventually realized that I had unresolved attachment issues, and sought out a Relational therapist who valued the use of her own vulnerable and emotionally authentic self as a tool in therapy. Her temperate and timely self-disclosures - "God, the holidays can be awful;" "Sorry I missed what you said, I got a little distracted with anxiety about my dental appointment this afternoon;" "I feel sad that you're mother was so cold;" "It makes me angry that you were so bullied;" - helped me to deconstruct a veneer of invincibility I had built as a child to hide my pain. Her modeling that anger, sadness, fear, and depression were emotions that could be healthily felt and expressed rather than buried in shame and "gotten over" helped me to renounce the pain-repressing, emotional perfectionism that I had adopted in the hope of being loved. I needed this kind of modeling, as so many of my clients have, to begin to emerge from my fear of being attacked, shamed or abandoned for having dysphoric feelings. In order to let go of my Sisyphian salvation fantasy of achieving constant happiness, I needed to experience that all the less than shiny bits of me were acceptable to another human being. Seeing that she was comfortable with and accepting of her own unhappy feelings eventually convinced me that she really was not disgusted by mine.

The therapist's judicious use of vulnerable self-disclosure helps the client move out of the shame-lined slippery pit of emotional perfectionism. Here are some examples that I use: "I feel really sad about what happened to you;" " I feel really angry that you got stuck with such a god-awful family;" "When I'm temporarily confused and don't know what to say or do, I...;" "When I'm having a shame attack or feel suddenly triggered into fear, I..." "When my inner critic is overreacting, I remind myself of the Winnicottian concept that I only have to be a 'good enough person;'" My most consistent feedback from past clients is that responses like these - especially ones that normalize fear and depression -

helped them immeasurably to deconstruct their perfectionism, and open up to self compassion and self acceptance.

What guidelines, then, can we use to insure that our self-disclosure is judicious and therapeutic? I believe the following five principles help me to disclose therapeutically and steer clear of unconsciously sharing for my own narcissistic gratification. First, I use self-disclosure sparingly. Second, my disclosures are offered primarily to promote a matrix of safety and trust in the relationship. In this vein my vulnerability is offered to normalize and de-shame the inexorable, existential imperfection of the human condition, i.e., we all make mistakes, suffer painful feelings, experience confusions, etc. Third, I do not share vulnerabilities that are currently raw and unintegrated. Fourth, I never disclose in order to work through my own “stuff,” or to meet my own narcissistic need for verbal ventilation or edification. Fifth, while I may share my appreciation or be touched by a client's attempt or offer to focus on or soothe my vulnerabilities, I never accept the offer; I gently remind them that our work is client-centered, and that I have an outside support network.

Emotional self-disclosure and the sharing of parallel trauma history. Since many of my clients have sought my services after reading my autobiographical book on recovery from the dysfunctional family, self-disclosure about my past trauma is sometimes a moot point. This condition has at the same time helped me realize how powerful this kind of disclosure can be in healing shame and cultivating hope. Over and over clients have told me that my vulnerable pragmatic stories of working through the traumatizing effects of my parents varied abuse and neglect has given them courage to engage this long difficult journey. Now whether or not someone has read my book, I will – with appropriate clients - judiciously and sparingly share my own experiences of dealing with an issue they have currently brought up. I do this both to psychoeducate them and to model ways that they might address their own analogous concerns. One common example sounds like this: “I hate flashbacks too. Even though I get them much less than when I started this work, falling back into that old fear and shame is so awful.” Occasionally, I match them and let myself tear up with authentic commiseration while relaying this experience to them. Here is another example: “I really reverberate with your feelings of hopelessness and powerlessness around the inner critic. In the early stages of this work, I often felt overwhelmingly frustrated. It seemed that trying to shrink it actually made it worse. But now tens of thousands of repetitions of thought-stopping and thought-substitution have very gradually reduced it to a mere shadow of its former self.” [See “Shrinking The Inner Critic in Complex PTSD”.]

3. Dialogicality. Dialogicality occurs when two people move fluidly and interchangeably between speaking [an aspect of healthy narcissism] and listening [an aspect of healthy codependence.] Such reciprocal interactions energize both participants. Dialogical relating stands in contrast to the monological energy-theft that characterizes interactions whereby a narcissist pathologically exploits a codependent's listening defense. In therapy, dialogicality develops out of a teamwork approach - a mutual brainstorming about issues and concerns that cultivates full exploration of ambivalences, conflicts and other life difficulties. Dialogicality is enhanced when the therapist offers feedback with a take-it-or-leave-it intent. Dialogicality also implies respectful mutuality. It stands in stark contrast to the blank screen neutrality and abstinence of traditional psychodynamic therapy, which all too often reenacts the verbal and emotional neglect of childhood -

flashing the client back into feelings of abandonment, and triggering them to retreat into “safe”, superficial disclosure, ever-growing muteness and/or early flight from therapy. All this being said, extensive dialogicality is often inappropriate in the early stages of therapy especially when the client’s normal narcissistic needs have never been gratified, and remain developmentally arrested. In such cases, clients need to be extensively heard. They need to discover through the agency of spontaneous self-expression the nature of their own feelings, needs, preferences and views. This is the work of giving the as yet, unformed ego room to grow and break free from the hegemony of the traumatically inculcated superego [See again: “Shrinking The Inner Critic in Complex PTSD”.] This does not mean however, that the client benefits when the therapist retreats into extremely polarized listening. Most benefit, as early as the first session, from hearing something real or “personal” from the therapist. This helps overcome the shame-inducing potential inherent in the “One-seen [client] / Unseen [therapist]” dynamic. It is interesting to note in this regard that CAMFT surveyed California therapists about fifteen years ago concerning their therapy preferences, and upwards of ninety percent emphasized that they did not want a blank screen therapist, but rather one who occasionally offered opinions and advice. For twenty years, I have been routinely asking clients in the first session: “Have your previous experiences in therapy given you any sense of what you want... and what you don’t want to happen here with me?” How frequently they have responded similarly to the therapists in the survey. Experience has taught me that such clients typically benefit markedly from early psychoeducation about Complex PTSD.

I sometimes wonder whether the rise in popularity of Coaching has been a reaction to the various traditional forms of therapeutic neglect – none worse than when the therapist fails to notice or challenge a client’s incessant, self-hating diatribes. This, I believe, is akin to tacitly approving of and silently colluding with the inner critic. Perhaps therapeutic withholding and abstinence derives from the absent father syndrome that afflicts so many American families. Perhaps traditional psychotherapy overemphasizes the mothering principles of listening and unconditional love, and neglects the fathering principles of encouragement and guidance that coaching specializes in.

Too much coaching is, of course, as counter-therapeutic and unbalanced as too much listening. Just as it takes fathering and mothering to raise a balanced child, mothering and fathering principles are needed to meet the developmental arrests of the attachment-deprived client. The sophisticated therapist values both and intuitively oscillates between the two, depending on the developmental needs of the client in the moment – sometimes guiding with psychoeducation and active positive noticing, and sometimes receptively nurturing the client’s evolving practice of her own spontaneously arising self-expression. Finally, I often notice that the last phase of therapy is characterized by a true, increasing dialogicality – a balanced fluidity of talking and listening. This conversational reciprocity is a key characteristic of healthy intimacy, and when therapy is successful, progress in mutuality has already begun to serve the client in creating healthier relationships in the outside world.

Dialogicality and the Four F’s. [The Four F’s refers to four different defensive styles in Complex PTSD: Fight, Flight, Freeze, and Fawn, which correspond respectively with Narcissistic, Obsessive-Compulsive, Dissociative, and Codependent defensive styles (see “The Four F’s: A Trauma Typology in Complex PTSD”).]

While childhood abandonment, compounded by repetition compulsion in later relationships, leaves all untherapized Four F types dieing - or rather starving - to be heard, their dialogical needs in therapy vary considerably over the course of therapy. The *fawn* or codependent type, who discovered ersatz and pathological attachment in childhood by becoming a parent's sounding board or shoulder to cry on, may use his listening defense to prematurely elicit dialogicality, and may even invoke the careless therapist into narcissistically monologing herself. This type and the *freeze* type, who learned early to seek safety in the camouflage of silence, often have to be persistently encouraged to discover and talk about their own inner experience to discover that their healthy narcissistic needs can be met in the process of relating. It is also important to note here that freeze types – as they struggle to learn to talk about themselves - can easily get lost in seemingly relevant free associations, that on closer observation turn out to be flights of fantasy and dream elaboration that are merely manifestations of their dissociative defense – unconsciously constructed to keep them buoyant above their undealt with emotional pain.

On the other hand, the *fight* or narcissistic type - often already habituated to holding court in a desperate attempt to attain connection – may have her talking-defense exacerbated by months of uninterrupted listening. I remember one man early in my career whose barely extant ability to listen reciprocally to his wife virtually disappeared, as my fifty minutes of uninterrupted listening became his new norm and expectation in relationship. A therapist, who is a fawn type herself, may be prone to countertransferentially disappearing into a listening and eliciting defense to avoid the difficult, and sometimes scary work of gradually insinuating herself into the relationship and nudging it towards dialogicality.

Finally *flight* or obsessive-compulsive types sometimes look more dialogical than other types, but if we do not steer them into their deeper, emotionally based concerns, they may remain stuck and floundering in obsessive perseverations about superficial worries that are little more than left brain dissociations from repressed pain.

All types of course use left or right brain dissociative process to avoid feeling and grieving their childhood losses. Dialogicality then can be oriented toward helping them to uncover and verbally and emotionally vent their ungrieved hurts.

4. Collaborative Rapport Repair is the capacity to not only survive but also grow closer from the inevitable breaks in attunement that are existential to every relationship of substance. Rapport repair is probably the most transformative, intimacy-building process that a therapist can model. I guide this process from a perspective that recognizes that there is almost always a mutual contribution to any misattunement or conflict. Consequently, a mutually respectful dialogical process is typically needed to repair rapport. I often initiate the repair process with two contiguous interventions. First I identify the misattunement [e.g., “I think I might have misunderstood you”], and then I model vulnerability by describing what might be my contribution to the disconnection. Abbreviated examples of this are: “I think I may have just been somewhat preachy...or tired...or inattentive...or impatient...or triggered by my own transference.” Owning one's part in a conflict validates the normality of relational disappointment and the art of amiable disagreement. It also helps to deconstruct the client's tendency to project his own need for perfection onto the therapist, while at the same time modeling a constructive approach to conflicts outside the therapeutic relationship. I believe one of the most

common reasons clients terminate prematurely is the gradual accumulation of dissatisfactions that they do not feel safe enough to bring up or talk about. How sad it is that all kinds of promising relationships wither and die for want of the ability to safely work through differences and conflict.

Earned Secure Attachment is a newly recognized category of healthy attachment. Many attachment therapists believe that efficacious treatment can help a Complex PTSD client “earn” at least one truly intimate relationship - a good enough and intimacy-rich attachment. I sometimes tell clients they are intimacy-rich to the degree that they can connect with another and communicate authentically from all of their experiences: success or failure; happiness or depression; love or alienation; trust or fear; peace or anger, etc. I believe the principles outlined in this article are keys to achieving earned secure attachment, and that the intimacy-modeling relationship with the therapist can become a transitional relationship that leads to the attainment of at least one good enough relationship outside the therapy. I have repeatedly seen this result with my most successful clients, and I am grateful to report that I have experienced this myself through the agency of my own personal therapy.

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