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An investigation into what "best practice" entails with adolescent survivors of prolonged child abuse

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ABSTRACT

This theoretical study explored the differences between narrative therapy (White, 2007a) and the family contextual model (Gold, 2000) in the treatment of adolescent survivors of prolonged childhood abuse (PCA). The aim of this research was to contribute to defining "best practice" with this population.

Narrative therapy and the family contextual model were selected for this research because they are primarily client directed and trauma responsive as opposed to trauma focused. These were important considerations given the differences between the treatment needs of survivors of long-term childhood trauma, which are inevitably intertwined with development and attachment, and those of single-incident trauma survivors. Content analysis was then conducted within and across bodies of literature on PCA survivorship, Complex Posttraumatic Stress Disorder (which describes difficulties that PCA survivors frequently experience), narrative therapy, and the family contextual model. This analysis found that narrative therapy and the family contextual model each lend different strengths to clinical practice with adolescent PCA survivors and that their differing strengths have the capacity to complement one another. Suggestions for clinicians on how to integrate these two treatment philosophies were therefore proposed in an attempt to offer more comprehensive and effective treatment options for practice with this population, although much further research is needed.

AN INVESTIGATION INTO WHAT "BEST PRACTICE" ENTAILS WITH ADOLESCENT SURVIVORS OF PROLONGED CHILDHOOD ABUSE

A project based upon independent investigation,
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CHAPTER I

INTRODUCTION

> Many clinicians do not find the existing PTSD research literature or treatment guidelines helpful in their day-to-day treatment of traumatized individuals. The disparity between existing treatment research samples and actual clinical populations may account for the fact that many clinicians treating patients with complex presentations continue to adhere to treatment models that are not supported by empirical research, but rather, are based on accumulated clinical experience (see Ford et al., 2005). Of necessity, clinicians have learned to focus more on issues of patient safety, affect regulation, coping and self-management skills, as well as on the therapeutic relationship itself, rather than on the processing of traumatic memories, the focus of most empirical research with PTSD patients (van der Kolk & Courtois, 2005).

Given the above, one must ask how clinicians go about constructing a treatment framework for practice with survivors of complex trauma. What defines "best practice" with this population? There is a dearth of literature in the field for developing any kind of comprehensive framework in dealing with the complexities of practice with survivors of multiple and complex trauma. Thus, there is also a lack of applicable treatment outcome research in this area. In great measure this is due to unresolved debates in the field regarding diagnosis and how the experiences and treatment needs of survivors of complex and prolonged trauma (especially in childhood) differ from those who have experienced single-incident trauma.

This study therefore looked at what is in fact written about these differences and conducted an exploration of narrative therapy (Denborough, 2006; Freedman & Combs, 1996; White, 1995, 2004, 2007a, 2007b) and the family contextual model (Gold, 2000) in

an attempt to understand how they do or do not and can or cannot meet the treatment needs of survivors of complex trauma. The goal of the study was to help to define what "best practice" should look like with this population.

Since there is immense variability among experiences of "multiple and complex trauma," this inquiry focused specifically on treatment with adolescent survivors of prolonged childhood abuse (PCA), where the experience of prolonged trauma in childhood is inevitably intertwined with the process of development and where criteria for the proposed diagnosis of Complex PTSD (Herman, 1992, 1999; Roth, Newman, Pelcovitz, van der Kolk, & Mandel, 1997; van der Kolk & Courtois, 2005; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005) are often met. Adolescent survivors were chosen for this study because they are at a stage in their development where there is greater potential for treatment to be effective (discussed in Chapter III). That said, the available research on this topic stems from and can also be applied to work with adult PCA survivors.

The Issue of Diagnosis and Outcome Studies

A complicating factor in the clinical conceptualization of work with PCA survivors is the fact that due to the lack of a more comprehensive diagnosis in the current *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV*), PCA survivors are frequently diagnosed with Posttraumatic Stress Disorder, often along with a host of other diagnoses. However, results from the *DSM-IV* Field Trial for PTSD established that trauma -- especially early chronic interpersonal trauma -- "can have significant effects on psychological functioning above and beyond PTSD symptomatology" (van der Kolk et

al., 2005). After studying 400 treatment-seeking traumatized individuals and 128 community residents, it was found that:

> …victims of prolonged interpersonal trauma, particularly trauma early in the life cycle, had a high incidence of problems with (a) regulation of affect and impulses, (b) memory and attention, (c) self-perception, (d) interpersonal relations, (e) somatization, and (f) systems of meaning (van der Kolk et al., 2005).

The problems identified above were subsequently listed as "Associated and Descriptive Features" of PTSD in the *DSM-IV* (American Psychiatric Association, 1994) but were not deemed to constitute a separate diagnosis. Collectively, however, they are generally referred to in the literature as either "Complex PTSD" or Disorders of Extreme Stress Not Otherwise Specified (DESNOS) (Allen, 2001; Courtois, 2004; Ford, Courtois, Steele, van der Hart, & Nijenhuis, 2005; Gold, 2000; Herman, 1992, 1999; Kilpatrick, 2005; Pearlman, 2001; Roth et al., 1997; van der Kolk & Courtois, 2005; van der Kolk et al., 2005).

The presence of Complex PTSD symptoms in trauma survivors have been shown to be negative prognostic indicators of the effectiveness of standard PTSD treatments (Ford et al., 2005; van der Kolk et al., 2005) and therefore have important implications for practice. However, there exists an abundance of research and evidence-based practices geared toward working with 'standard' PTSD, while much less attention is given to complex trauma presentations and the ways the difficulties of complex trauma survivors subsume the PTSD diagnosis. Since survivors of complex trauma are often given multiple diagnoses, including PTSD, experienced clinicians are left with a limited and scattered research base from which to draw regarding comprehensive treatment with this population, while less experienced clinicians can be misled into simply combining

evidence-based treatments for PTSD and other diagnoses, inadvertently putting their clients at significant risk of retraumatization.

Choice of Treatment Approaches

The family contextual model (Gold, 2000) and narrative therapy (Denborough, 2006; Freedman & Combs, 1996; White, 2004, 2007a, 2007b) were chosen for this inquiry into what might constitute "best practice" with adolescent PCA survivors because they provide both a comprehensive philosophy or treatment structure and specific practices to address many core areas of difficulty that PCA survivors frequently struggle with, *including* PTSD, while also being trauma-responsive instead of trauma-focused (Denborough, 2006; Gold, 2000; White, 2004, 2007b).

A widely accepted tri-phased treatment structure exists and is often used with survivors of complex trauma (Courtois, 2004; Ford et al., 2005; Gold, 2000; Pearlman, 2001). However, this structure is very general and leaves much unarticulated. It is also still quite trauma-focused, meaning that it still centers around the "abuse trauma" model rather than priming the "much more pervasive childhood atmosphere of coercive control, contempt, rejection, emotional unresponsiveness, and lack of training in fundamental abilities necessary for effective daily living" (Gold, 2000) that often describes the childhood environment of PCA survivors.

In the case of the family contextual model (Gold, 2000), its entire framework was created specifically for work with adult PCA survivors, drawing its principles for practice from multiple theoretical foundations. This model overlaps significantly with the tri-phased treatment structure mentioned above. In addition to being much more

comprehensive and specific, however, it goes further in asserting that survivors do not necessarily need to engage in trauma-focused work. Rather than seeing overt abuse as central to the difficulties of PCA survivors, it emphasizes the detrimental effect of the general family and/or social context. It also articulates many intervention strategies to teach clients a variety of life skills that they were frequently not taught due to their "ineffective" socialization context (Gold, 2000).

Narrative therapy (White, 2007a), on the other hand, is more of a worldview supported by specific collaborative practices (Freedman & Combs, 1996). It was chosen for this inquiry because it offers different strategies and strengths for working with complex trauma survivors than those of the family contextual model. These include an emphasis on promoting personal agency, on re-developing meaning and a sense of connection, and on helping people create "subordinate storylines" (White, 2007a) that can eventually overshadow the negative, "dominant storylines" (White, 2007a) of their lives (detailed in Chapter IV). A discussion of the manner in which each of these treatment approaches meets (or does not meet) the needs of adolescent PCA survivors presenting with Complex PTSD will be articulated in this study's final chapter.

Summary

The research question examined in this inquiry was: How well do the family contextual model and narrative therapy meet the treatment needs of adolescent PCA survivors presenting with Complex PTSD? The purpose of this study was to inform and shape effective or "best" practice with this population.

Chapter II gives an overview of the conceptual framework for this study, including how the "goodness of fit" between each approach and the treatment needs of adolescent PCA survivors was evaluated. Chapter II also includes definitions of terms used throughout this report, along with a discussion of potential biases and the study's strengths and limitations.

Chapter III gives an overview of the commonly accepted framework for treating survivors of complex trauma (Courtois, 2004; Ford et al., 2005; Gold, 2000; Pearlman, 2001). It also goes into detail regarding the ways in which the difficulties frequently experienced by survivors of prolonged childhood trauma transcend traditional symptoms of PTSD. Finally, a brief overview of the developmental stage of adolescence is discussed. These sections are all in the service of providing increased understanding of the treatment needs of the population in question toward defining best practice. This chapter concludes with an amalgam case example of "Deanna," an adolescent survivor of prolonged childhood abuse, which is used in subsequent chapters for illustrative purposes.

Chapter IV explains the rationale for creating the family contextual model (Gold, 2000), introducing its aims for treatment and detailing its structure and practices. Where necessary, it uses the case of Deanna to expound upon examples of specific practices.

Chapter V describes the basic worldview, theoretical foundation, and practices of narrative therapy (White, 2007a); describes its aims for treatment, and again uses the case of Deanna to illustrate what practice might look like from this perspective.

Finally, Chapter VI compares and contrasts the narrative and contextual approaches as they do or do not apply to the treatment of adolescent PCA survivors. It

discusses what each has to offer to this population and presents implications for practice. This last chapter also provides recommendations for future research on this topic and offers an overall conclusion.

CHAPTER II

METHODOLOGY

This chapter articulates the conceptual framework used to structure this research, which explored what "best practice" entails with adolescent survivors of prolonged childhood abuse. This study was designed to address the question of which theoretical frameworks and practices are complex enough to both meet PCA survivors' varied treatment needs and to provide a more general, comprehensive structure within which these difficulties can be addressed.

In this study, I attempted to extend the limited and often scattered research on this topic by exploring the application of both the family contextual treatment model (Gold, 2000) and narrative therapy (Denborough, 2006; Freedman & Combs, 1996; White, 1995, 2004, 2007a, 2007b) to clinical work with adolescent PCA survivors. I used content analysis within and across related bodies of literature to compare and contrast how well these treatment approaches meet the needs of this population.

Definition and Discussion of Terms

Although there are many different types of complex trauma, this study specifically addresses treatment with survivors of *prolonged childhood abuse* (PCA), where trauma and development are inevitably intertwined. For the purposes of this study, prolonged childhood abuse includes ongoing or prolonged traumatic circumstances,

whether consisting of neglect, abuse, or a combination of the two, where a child is left unprotected. Implicit in these circumstances are the familial and/or societal factors that allow ongoing abuse or neglect to occur in a child's life, which often precede discrete incidents of abuse (Gold, 2000).

The term *PCA survivor* is used throughout this study to speak about the general population with whom this research is relevant in clinical practice. I use this term as a short-hand way of referring to people coming to treatment with a history of prolonged childhood abuse and with a number of difficulties that overlap with the Complex PTSD diagnostic construct (van der Kolk et al., 2005). While the use of the term *PCA survivor* has been helpful for the sake of clarity and brevity in this study, it is not necessarily a term that should be used in practice with clients. Although the term "survivor" may be empowering to some, it can also privilege the fact that a person has been through traumatic experiences as central to that person's identity, thereby opposing the aims of treatment (Gold, 2000). For this reason, terms such as *survivor* or *PCA survivor* should only be used in practice if clients identify these terms as helpful to them in some way.

In terms of gender pronouns, I use s/he throughout this report to include people who identify as male or female as well as those who do not identify as existing within either of these binary gender categories (Goldson & Wells, 2008).

Conceptual Framework

The previous chapter provided an introduction to this study, while this chapter speaks to the types of analysis and the conceptual framework used to structure this research. This chapter also articulates the potential biases, strengths, and limitations of

this report. Chapter III will describe the generally accepted, albeit non-specific, "meta-model" (Courtois, 2004) frequently used in working with complex trauma survivors, which has evolved out of the realization that there are immense differences between the treatment needs of people who have undergone extensive, prolonged, developmental trauma and those who have endured single-incident trauma. In using the term "meta-model," I am referencing the tri-phased framework for working with complex trauma that stresses the importance of first building a foundation of engagement, safety, and stability in treatment before moving on to process traumatic experiences (Courtois, 2004).

It was the intent of this study to use what is known about the differences between complex developmental trauma (often found in PCA survivors) and standard PTSD to further evaluate and articulate what effective treatment or "best practice" might look like with adolescent PCA survivors. Since the difficulties many PCA survivors experience are often best described by the proposed diagnosis of Complex PTSD (Herman, 1992, 1999; van der Kolk et al., 2005), Chapter III also goes into detail about the six major areas of difficulty found in Complex PTSD that transcend standard posttraumatic symptomatology. These areas of difficulty are then used in later chapters to evaluate the abilities of narrative and contextual therapy to meet the needs of PCA survivors with Complex PTSD (van der Kolk et al., 2005).

Chapter III also provides a brief overview of the developmental stage of adolescence in order to integrate considerations specific to work with adolescent PCA survivors into the discussion. Finally, an amalgam case example is presented in order to ground the application of the philosophies and practices discussed in Chapters IV and V.

Chapter IV will detail the framework and practices that comprise the family contextual model (Gold, 2000), which was created specifically for the treatment of PCA survivors. This model has been described as "the first in a series of efforts to clearly articulate the best ways of helping the traumatized survive and thrive" (Gold, 2000). The contextual model draws from a number of theoretical orientations for its variety of practices and articulates an overarching framework for the complexities of work with this population. It was chosen for this study because of its comprehensiveness, specificity, client-directed orientation, consideration of context, and because it grows out of years of clinical experience with this population. Chapter IV therefore consists of a description and analysis of what this model offers PCA survivors in treatment.

Chapter V gives an overview of narrative therapy (Freedman & Combs, 1996; White, 1995, 2007a). Narrative therapy was chosen for this study because of the different strengths it offers from that of the contextual model, which overlaps in many ways with the currently accepted meta-model for the treatment of complex trauma. Narrative therapy, however, is based on a completely different set of assumptions (Freedman & Combs, 1996; White, 1995, 2007a). An overview of the philosophy behind narrative therapy is included in this chapter, along with specifics about its practices and how it applies to work with adolescent PCA survivors. Again, the case amalgam is used to ground practice examples.

Finally, Chapter VI presents a content analysis that compares and contrasts how well contextual (Gold, 2000) and narrative (White, 2007a) therapy each apply to and meet the treatment needs of adolescent PCA survivors. At the end of that discussion,

implications for practice are presented, followed by recommendations for future research and a conclusion.

Potential Biases

Potential biases I bring to this theoretical study include my own experiences, albeit limited, of working with adolescents and young adults who have histories of prolonged interpersonal childhood trauma and the impact of these experiences on my perceptions of what this kind of work looks like. I also chose narrative therapy (Denborough, 2006; Freedman & Combs, 1996; White, 1995, 2004, 2007a) as one of the approaches from which to examine practice with PCA survivors because it has been a major part of my work with young people who have endured prolonged trauma, and because these experiences have inspired my faith in peoples' abilities to transform their lives when they are first supported in developing a stronger sense of self, meaning, and connection.

In contrast, the family contextual model (Gold, 2000) is newer to me, although many of the bodies of literature it draws from are not. I was drawn to this model because of its dedication to furthering the mental health field's understanding of the PCA survivor population and its emphasis on creating a comprehensive framework within which to be able to conduct very complex and varied work, while still having some sense of structure and direction.

Finally, both narrative and contextual therapy's treatment practices aim to keep the person coming to treatment in the "expert" role. Because this is something I value in an approach to treatment, this also influenced my choice of these theories for this study, and thus is also a personal bias.

Strengths and Limitations

By choosing these two approaches, I inevitably left out many other treatment options. Similarly, while I was able to draw from a wide variety of resources in order to build the content of this study, the research on these topics is not exhaustive and was limited by the time and scope of this project, as well as by my own research methods.

Another limitation is the fact that because this study focused on the ways being a PCA survivor may have influenced people coming to treatment, it failed to examine the ways in which the multitude of other identities and contextual factors that people bring to treatment intersect with this background. Further, because of the lack of empirical research in treating this population with these approaches, this theoretical study lacks data about actual treatment outcomes when these approaches are used.

A strength of this theoretical study, however, is its ability to provide an extensive consideration of PCA survivorship in order to analyze how well the two approaches studied meet the treatment needs of this population.

Conclusion

In this chapter, I gave an overview of the conceptual framework used in this study, provided definitions and considerations around the use of specific terms, defined how the usefulness and "goodness of fit" of narrative and contextual therapy to work with adolescent PCA survivors was evaluated, and reviewed the potential biases, strengths, and limitations of this research. The next chapter goes into more depth on current practices with PCA survivors and the major areas of difficulty they often experience that

transcend the standard PTSD diagnosis, thus creating much different and more complex treatment needs than people only meeting standard PTSD criteria.

CHAPTER III

CLINICAL TREATMENT WITH ADOLESCENT SURVIVORS OF PROLONGED CHILDHOOD ABUSE

This chapter first looks at the currently accepted phase-based model for the treatment of Complex PTSD (otherwise known as *DESNOS*, or *Disorders of Extreme Stress Not Otherwise Specified*) (Courtois, 2004; Ford et al., 2005; Gold, 2000; Pearlman, 2001), the diagnostic construct - although not an officially recognized diagnosis (American Psychiatric Association, 2000) - that best describes the difficulties commonly experienced by PCA survivors (Courtois, 2004; Gold, 2000; Herman, 1999; van der Kolk & Fisler, 1994; van der Kolk, 1996; van der Kolk & Courtois, 2005; van der Kolk et al., 2005). It then provides a brief review and analysis of the strengths of this model and argues that more comprehensive models are still needed. In the next section, this chapter gives an overview of the major categories of difficulty described by Complex PTSD (van der Kolk et al., 2005) in order to later compare the effectiveness of the theoretical approaches described in Chapters IV and V in meeting the treatment needs of adolescent PCA survivors. Next, a brief overview of the developmental stage of adolescence is offered. And finally, a case amalgam is presented to ground practices described in later chapters involving work with adolescent PCA survivors. This chapter is so organized in order to support an inquiry into the use of narrative therapy (Denborough, 2006; Freedman & Combs, 1996; White, 2004, 2007a) versus that of a family contextual model

(Gold, 2000) with PCA survivors meeting criteria for Complex PTSD, with the aim of contributing to what best practice entails with this population.

The Evolution of a Phase-Based Model for Treating Complex PTSD

Many evidence-based practice models have been published for use in the treatment of standard PTSD, and many support the gradual exposure to and the processing of discrete traumatic events. This perspective assumes, however, that discrete incidents of abuse lie at the core of the client's difficulties, and that the client has the necessary self-capacities to handle the processing of traumatic events. Neither of these assumptions are often true for victims of chronic interpersonal trauma.

> Posttraumatic stress disorder as the central psychological consequence of traumatization implies treatment that focuses on the impact of specific past events and the processing of specific traumatic memories. In contrast, in traumatized patients with histories of early abuse and DESNOS, the treatment of other problems, such as loss of emotion regulation, dissociation and interpersonal problems, may be the first priority because they cause more functional impairment than the PTSD symptoms (van der Kolk et al., 2005).

Over time and through clinical experience, clinicians realized that treatment with the PCA survivor population needs to address the client's difficulties within the Complex PTSD/DESNOS spectrum before it can even assess the potential relevance of and need for the processing of discrete traumatic incidents. Without an adequate foundation of interpersonal and emotional regulation skills, the processing of traumatic events can easily be re-traumatizing. Being coerced into examining traumatic memories without the necessary support and skills to do so safely can engender renewed feelings of helplessness and victimization that can parallel the original traumatic event(s) or circumstances. Although PCA survivors may frequently be diagnosed with PTSD, van

der Kolk cites a number of diverse studies in which "the presence of DESNOS has been shown to be a powerful negative prognostic indicator of PTSD treatment outcome and behavioral disturbance (Ford & Kidd, 1998; McDonagh-Coyle et al., 1999; Zlotnick, 1999)" (2005, p. 396).

Further, it has been found that the existence of comorbid trauma-related psychiatric problems (as almost always exist in PCA survivors) is a frequent cause for exclusion of traumatized individuals from PTSD treatment outcome studies (Spinazzola, Blaustein, & van der Kolk, B., 2005). Due to the fact that these outcome studies are therefore unrepresentative of work with a Complex PTSD population, many of the existing empirically-based PTSD treatment models should be limited to use with survivors of single-incident or short-duration trauma, where the difficulties described in the DESNOS construct are not a concern.

Although there are as of yet no empirically validated treatment approaches for use with individuals meeting Complex PTSD criteria, a phase-based "meta-model that encourages careful sequencing of therapeutic activities and tasks, with specific initial attention to the individual's safety and ability to regulate his or her emotional state" (Courtois, 2004, p. 418) is currently considered the treatment frame of choice for most practitioners working with this population, although there are still many differences between models operating within this general framework (Courtois, 2004; Gold, 2000; Herman, 1992, 1999; Pearlman, 200; Pearlman & Courtois, 2005; van der Kolk, McFarlane, & van der Hart, 1996).

Although specific interventions are left up to the clinician and depend on individual client presentations, this tri-phased framework "serves as a general guideline

for the therapist that emphasizes safety, security, and affect regulation as core foundations of treatment" (Courtois, 2004, p. 418). Courtois (2004) discusses the complexities involved in constructing a cohesive, individualized treatment approach:

> Findings…have suggested that many treatment approaches and strategies from a variety of theoretical perspectives apply to the treatment of the CPTSD [Complex PTSD] population. Treatment is therefore multimodal and transtheoretical, necessitated in large measure by the multiplicity of problems and issues presented by these clients and by the fact that, CPTSD, like PTSD, has biopsychosocial and spiritual components that require an array of linked biopsychosocial treatment approaches. Moreover, CPTSD clients suffer from developmental/attachment deficits and issues, a situation that requires treatment strategies that are focused on ameliorating these deficits in order to advance the rest of the treatment (p. 417).

This phase-based approach therefore conceptualizes the treatment of Complex PTSD as occurring in three stages, which will be outlined below.

Stage One

Stage One tends to be the longest phase of treatment, as it is the foundation upon which the rest of treatment depends. This foundation is needed before any survivor should proceed to do the kind of work normally involved in 'simple PTSD' treatments (if this is even deemed necessary later in treatment), as it consists of building the kinds of self-regulation skills usually acquired in early development given the availability of adequately secure attachment relationships. Without adequate capacities for self-regulation, "trauma-focused" work will often be retraumatizing and will further dysregulate the survivor. Further, trauma-focused work is not always indicated for PCA survivor populations (Gold, 2000). Ford et al. (2005) therefore conceive of the first stage of treatment as primarily involving "engagement, safety, and stabilization" (p. 438), a definition which is fairly consistent across predominant descriptions of this phase in the

field (Courtois, 2004; Ford et al., 2005; Gold, 2000; Herman, 1999; Pearlman, 2001; van der Kolk, 1996). Safety and stabilization here involve "enabling the client to gain control of overwhelming affect, impulsive behavior, and self-destructive thoughts and behaviors by anticipating and replacing them with self-management strategies" (Ford et al., 2005, p. 438). Working toward these aims often involves the use of psychoeducation, safety planning, and skills building, all within the context of a relational approach.

The relational piece is essential, as it is within the context of the therapeutic relationship that an opportunity is provided to "rework attachment difficulties from the past…in order to develop greater self-capacities and specific personal and interpersonal skills" (Courtois, 2004, p. 419). It is predominantly through the experience of a supportive, stable, and secure relationship that interpersonal skills and self-regulation can develop (Allen, 2001; Fosha, 2003; Karen, 1994). Attainment of this kind of a therapeutic relationship – a monumental achievement in and of itself for this population - is often a long process with PCA survivors. This is because it contradicts many of the core beliefs and cognitive schemas they have developed based on years of maltreatment:

> Resolving long-standing feelings of mistrust – which often are grounded in a legitimate sense of betrayal and violation in formative relationships that were traumatic or trauma-affected – requires reliability, clarity of therapeutic focus, and good boundaries on the therapist's part. The most difficult barrier to a working alliance in many cases is that the client has had very few and highly erratic experiences in which she or he could learn how to safely "join" with a caregiver without becoming enmeshed and over-dependent, or detached and both rejecting and rejected. Most fundamentally…clients may not have experienced caregivers who consistently self-regulated their own emotions and bodily reactions…Therefore, the client may approach the therapeutic relationship in an apparently "disorganized" manner – alternately demanding and withdrawing, pleading for and rejecting help, being in crisis or being indifferent – that can be understood as an expression of an inability to regulate intense and often contradictory feelings and impulses in early attachment relationships (Ford et al., 2005, p. 438).

Efforts to help clients stabilize, enhance self-care, self-regulate, and to plan for safety are therefore intertwined with the construction of a secure therapeutic alliance and occur on a variety of levels. Planning for crises that result from overwhelming affect or other triggers, and which lead to dysregulation, is often a big part of the early work (Courtois, 2004; Linehan, 1993). Their successful resolution, through safety planning, enhanced self-management strategies, enhanced supports, and appropriately boundaried assistance on the part of the therapist, helps to build a collaborative and predictable relationship.

Psychoeducation and "co-regulation" aid in this process. Providing the client with information about complex trauma, its effects, and the processes by which it is resolved helps to normalize and make sense of survivors' reactions, assisting them in gradually observing and tolerating rather than fearing their body's responses.

> The client can learn that traumatic memories or affects are not necessarily toxic or overwhelming when modulated with self-regulation skills. The therapist also may comment on trauma-relevant themes (e.g., being or feeling trapped, helpless, blocked, stigmatized) when they are evident in the client's spontaneous disclosures…Thematic comments [by the therapist] in this early phase do not encourage a deeper delving into the details of trauma memories, but instead assist the client in self-regulation and gradually tolerating self-awareness (Ford et al., 2005, p. 439).

Education and transparency around the process of psychotherapy itself also help to put the client in greater control and contribute to a therapeutic relationship defined by collaboration.

Stage One continues until the client feels some sense of enhanced self-regulation skills such that they may be able to safely tolerate the gradual processing of traumatic memories and their respective symptoms. At this point, clients' general level of daily functioning should have dramatically improved (although this may take years) due to the

construction or reconstruction of regulational capacities which they had either lost or had never developed. Before moving into Phase Two work, the extent of the client's current posttraumatic symptoms should be assessed. Details of traumatic events should only be processed to the extent that they are interfering with the survivor's current functioning and well-being.

Stage Two

Stage two begins to have much more in common with "simple PTSD" treatment models. This is because adequate coping resources and supports, both internal and external, have been built to enable the survivor to safely tolerate gradual traumatic memory processing, along with making connections between these memories and current posttraumatic symptoms. The major difference that remains between Complex PTSD and standard PTSD, however, is the fact that for PCA survivors, traumatic experiences have often been experienced as more of an ongoing process or a general sense of "how the world is" than as discrete "events" per se. In either case, though, treatment is guided by what the survivor defines as most troublesome in his/her life.

Opinions in the field about how traumatic memories should be processed are quite varied, as there are a wide range of possibilities accompanied by an ever-widening research base. The two general techniques commonly used in some form are exposure and narrative-based strategies, with careful attention paid to the pace at which these are carried out. The main objective is to allow the client to process parts of the trauma(s) while remaining within a "window of safety" where they are able to use newfound self-regulation and co-regulation (with the therapist's assistance) skills to keep themselves

from becoming overwhelmed and resorting to maladaptive defenses (Courtois, 2004). More specific techniques or approaches frequently used in this stage are eye movement desensitization and reprocessing (EMDR) (Shapiro & Forrest, 2004), narrative telling or writing (Child Welfare Information Gateway, 2007; Medical University of South Carolina, 2008), and/or sensorimotor approaches (Eckberg, 2000; Levine, 1997). It may be just as common, however, for clinicians to assist clients in processing traumatic memories or cognitions as they naturally arise in treatment. Ford et al. (2005) speak to one such approach:

> Phase 2 does not necessarily involve repeated recollection of traumatic memories, but may alternately take the form of interventions that assist the client in recognizing the "imprint" of past trauma in current experiences and posttraumatic symptoms. Because intrusive memories occur in and dramatically alter the meaning of ongoing life experiences, a careful therapeutic examination of current stressful events can be the basis for teaching clients how to become aware of unwanted memories in tolerable doses – rather than simply trying unsuccessfully to avoid intrusive reexperiencing. The key to such a "present-centered" model of trauma processing is the provision of cognitive schemas and a practical vocabulary that enable clients to recognize the trauma imprint in current experiences while maintaining bodily and affective self-regulation (p. 440).

It is important to recognize that Stage Two work does not only involve the recounting of traumatic memories, but necessitates the processing of the trauma-related cognitions and emotions that arise in the process (e.g., self-blame, shame, rage, loss, betrayal, grief, etc.) so that some level of resolution is reached. The recounting of traumatic memories is never an end in itself, and should only be entered into in the service of processing and decreasing the trauma-based symptoms and beliefs survivors' lives are negatively affected by.

Finally, the processing of traumatic memories in Stage Two also serves to integrate traumatic experiences into a more complete narrative of the survivor's life.

When traumatic memories can become one aspect of a survivor's life and no longer *define* his or her life, survivors can move on with a more balanced self-concept and can begin to make meaning of trauma's place in his or her life.

Stage Three

Stage Three work typically involves enhancing daily living (Courtois, 2004; Ford et al., 2005), although the work of both previous stages often continues to arise (albeit in more manageable amounts and enhanced by the client's increased self-regulation skills). "In this phase, the quality and balance of the client's life (i.e., work, play, rest, relationships) is the focus. Self-management skills taught in Phase 1…can be refined, strengthened, and more broadly applied in Phase 3" (Ford et al., 2005, p. 440). Areas of development often needing attention in this phase include establishing healthy intimate relationships, parenting issues, creating goals, making healthy decisions, and confronting the fear of change itself.

> The goal is for the client to acquire experiential evidence of safety and empowerment, and to thus gradually replace constricted or self-defeating beliefs, schema, and goals that have resulted in a constricted lifestyle with a more flexible, specific, and self-enhancing personal framework (Ford et al., 2005, p. 441).

Courtois (2004) adds that: "In this stage, as in others, the clinician continues to provide the secure base from which the client does the work and provides ongoing facilitation of relational learning" (p. 422). As the client takes risks to expand various parts of his/her life, the clinician remains a constant attachment figure and continues to facilitate the processing of any disruptions within the therapeutic relationship. Thus, the therapeutic relationship continues to model how healthy relationships can be negotiated through

communication, with the idea that these skills can in-turn be applied to other relationships in the client's life.

At some point, and ideally through collaborative and well-planned efforts, termination will be discussed. The length of treatment often varies considerably between clients initially presenting with Complex PTSD and should respond to their individual needs and rates of progress. Termination usually stirs up many trauma-related issues such as abandonment, loss, fear, etc. (Courtois, 2004), and these need to be given ample time to be worked through. Courtois (2004) also recommends that "the option should be left open for a return, whether for a check-in, booster, or a return to more sustained treatment" (p. 422). This recommendation is consistent with that of many clinicians working with attachment issues in the long-term (Brisch, 2002).

Review of the Phase-Based Meta-Model

Great strides were made in clinical practice with PCA survivors when this tri-phased model was introduced as an alternative to standard PTSD treatments. Most notably, this model recognized the importance of clients feeling safe, feeling stabilized, and having a sound foundation in self-regulation skills before delving into detailed processing of traumatic experiences (Courtois, 2004). In terms of its overall structure, there is significant overlap between this model and the family contextual model (Gold, 2000) that will be introduced in Chapter IV. However, this tri-phased model leaves much unarticulated both in terms of its specific practices and its overall philosophy beyond this tri-phased framework. Further, it is somewhat ambiguous about the extent to which it still centers around the idea that discrete traumatic events lie at the core of the client's

difficulties. The contextual (Gold, 2000) and narrative (White, 2004, 2007a, 2007b) approaches that will be applied to work with PCA survivors in Chapters IV and V both see PCA survivors' presentations through a much wider lens than through "abuse trauma" alone. Further, they both provide comprehensive philosophies and frameworks for practice with PCA survivors without being rigid or prescriptive. Lastly, they both articulate specific practices that help to support their respective treatment philosophies, giving clinicians a better sense of what treatment might look like. It is for these reasons that the contextual (Gold, 2000) and narrative (White, 2004, 2007a, 2007b) approaches are being looked at in this study, with the goal of furthering what best practice involves with adolescent PCA survivors.

In order to be able to gauge what best practice with the PCA survivor population entails, the difficulties that separate Complex PTSD from standard PTSD must be understood, as these difficulties are often at the heart of treatment with PCA survivors (Courtois, 2004; Gold, 2000; Herman, 1999; van der Kolk & Courtois, 2005; van der Kolk et al., 2005).

Complex PTSD: Categories of Difficulties in Functioning

For organizational purposes, I will use the six categories of psychopathology outlined by outcome studies from the *DSM-IV* Field Trial on the DESNOS/Complex PTSD syndrome to explore the difficulties often experienced by the PCA population. These are: "problems with (a) regulation of affect and impulses, (b) memory and attention, (c) self-perception, (d) interpersonal relations, (e) somatization, and (f) systems of meaning" (van der Kolk et al., 2005, p. 389). It should also be noted that in the same

trial, the constellation of symptoms listed above was rare in participants who did not also suffer from PTSD (van der Kolk et al., 2005). Thus it was found that in the majority of Complex PTSD cases, the 'standard' PTSD symptoms of re-experiencing, numbing, and hyperarousal are intertwined among the symptoms listed above.

Problems with the Regulation of Affect and Impulses

It is within the context of primary attachment relationships that children develop the ability to soothe themselves and to regulate their emotions.

> [T]he infant's capacity for physiological self-regulation depends on synchrony with a caregiver… [T]he precursors of attachment in mother-infant interaction that initially foster *physiological* regulation lay the foundation for attachment relationships that subsequently promote *emotional* regulation. What begins as a sensorimotor relationship that modulates physiological arousal evolves into an attachment relationship that regulates emotional arousal through psychological attunement…(Allen, 2001, p. 45).

When a caregiver regularly supports a child in handling overwhelming emotions and distress by accurately responding to that child's needs, the child eventually internalizes these capacities and gradually learns how to soothe him/herself. In being able to rely on the support of a primary attachment figure, the child develops a sense of the world as a safe and predictable place and develops confidence in his/her ability to handle stressful situations. PCA survivors with Complex PTSD have either never experienced such a relationship and have thus failed to develop affect and impulse regulation skills, or have been chronically traumatized at a young age without access to a secure relationship such that they often lose the affect and impulse regulation skills they may have originally acquired.

These children soon come to learn that the world is often a terrifying, unpredictable place, and frequently feel overwhelmed. Not only do they end up lacking emotion regulation skills, but they are regularly left alone to handle potentially traumatizing situations. The experience of disrupted or impaired attachment can add marked distress to already traumatic experiences, as "the child is left psychologically alone to cope with his or her heightened and dysregulated emotional states" (van der Kolk & Courtois, 2005, p. 387). Thus insecure attachment relationships and traumatic experiences are inevitably intertwined, and both contribute to the dysregulated states PCA survivors often experience.

A lack of responsiveness or maltreatment by attachment figures has also been found to negatively affect neurophysiological development, "leading to restricted capacities and somatic and emotional dysregulation as well as [affecting] psychosexual development, especially identity formation, affective competence and regulation, and ability to relate to others" (Pearlman & Courtois, 2005, p. 451). The combination of weak neurological capacities for affect regulation and impulse control and a lack of secure attachments to help them build these skills force PCA survivors to attempt to cope with overwhelming emotions and/or trauma in any way they possibly can. This is one reason why people who meet criteria for Complex PTSD are often considered to have "co-morbid conditions," conditions which actually arise out of attempts at coping and regulating intense emotions. These disorders are often highly resistant to typical treatments when their etiologies are not considered and when they are viewed solely as co-morbid conditions (van der Kolk & Courtois, 2005).

Problems with Memory and Attention

Dissociation begins as an attempt by the body-mind system to defend itself from intolerable affects and trauma when action is not plausible. It is a way of detaching oneself from direct experience and "turning off" self-awareness (Allen, 2001). It helps people to survive in the moment. There are, however, numerous consequences afterward. As hard as a person may try to fight off and detach from traumatic memories, they have ways of reemerging. As re-experiencing of the trauma often occurs and greater and greater energies are required to contain or ward off these memories, as is certainly the case when a child is forced to continually experience extreme trauma, the dissociative response becomes chronic and intensifies. Symptoms must become all the more extreme in order to contain the increasingly fierce energy and memories of overwhelming experience (Levine, 1997). It is here that some of the more severe dissociative symptoms and disorders begin to be seen. Memory and attention are disrupted to varying extents along a spectrum of dissociative severity.

Neurobiological research has also found that trauma interferes with memory and attention according to the process by which overwhelming experiences are stored in the brain. Traumatic experiences are often not able to be fully processed, and trauma survivors are frequently left without words to describe or to integrate the fragmented memories that arise (Allen, 2001). Because these memories are not fully processed, unintegrated traumatic sensations can arise at any time, with or without triggers recognizable to the survivor. This creates a constant state of hyperarousal and unpredictability. The survivor is left in a state of intense vulnerability to re-experiencing

of the trauma and subsequent re-traumatization, which often exacerbates the need for dissociation as a form of coping.

Problems with Self-Perception and Interpersonal Relations

Self-perception and self-worth are inextricably linked, especially in youth, to attachment relationships and to Bowlby's (1973) concept of an internal working model, which guides one's expectations of interpersonal relationships (Allen, 2001).

> Parental approval plays a major role in global self-worth throughout childhood and adolescence, and early experience often establishes a foundation of global self worth that is highly resistant to change…As Bowlby (1973) recognized, the internal working model of the self is congruent with treatment by caregivers (Allen, 2001, p. 93).

If children are valued by their caregivers, they will come to see themselves as worthy of positive attention and care; they will come to expect to be treated with respect and kindness and will learn to assert themselves if they feel they are being violated or treated unfairly. But the opposite is just as true. It is very common for PCA survivors, as victims of interpersonal maltreatment, to think of themselves as unlovable, worthless, bad, undeserving, hopeless, weak, damaged, or shameful. Often, the need to make sense of the world takes precedence over the victim of PCA's sense of self-worth. Allen (2001) states that it is "preferable to see the self as bad, blameworthy, and deserving of maltreatment and neglect than to face meaninglessness – irrationality, unpredictability, and uncontrollability" (p. 95). Accordingly, PCA survivors are often diagnosed with "co-morbid" depressive disorders.

Herman (1992) also talked about the way a child's internalized sense of "badness" (that can carry on well into adulthood) preserves the attachment relationship and loyalty

to caregivers. These children (and later adolescents/adults) therefore develop the sense that they do not deserve positive treatment or regard, and frequently fall into interpersonal relationships where they are again abused and/or neglected. These relationship patterns serve to confirm their beliefs of the self as bad, undeserving, and somehow damaged. With the expectation that others will always abandon, reject, or abuse them, PCA survivors often lack any sense of basic trust. These expectations and schemas emerge in the therapeutic process and are part of the long-term work with this population. PCA survivors need to be supported in developing both an increasingly positive and consolidated self-identity and the capacity for supportive and stable interpersonal relationships.

Somatization

"The clinical literature consistently emphasizes the relation between somatization and a failure to experience and express emotion" (Allen, 2001, p. 156). Because of the interrelationship between chronic childhood trauma and dissociation (including the subsequently impaired storage of traumatic event memories), intense amounts of terror, rage, shame, and resultant physiological activation are "short-circuited" in the body. These powerful energies do not simply disappear, however. This acute and persistent activation is stored in the body, and if it cannot be released through expression in symbolic form (i.e., through words, images, etc.), it will often manifest as somatic symptoms or in some for of 'acting out.' Van der Kolk (1996) explains part of this complex process:

> [Partially due to the way traumatic experiences are imprinted in the brain, people who have undergone trauma often] experience intense emotions without being

> able to name their feelings. Their bodies are aroused, and fragments of memories may be activated, but they are unable to form a clear mental construct of what they are experiencing. Needing to reestablish their internal homeostasis, they use their muscles. Discharge via the smooth muscles leads to psychosomatic reactions, whereas discharge through the striated muscles leads to action. Both of these solutions are likely to have adverse consequences…(p. 296).

When trauma is repeated and ongoing, as is the case in the histories of PCA survivors, physical symptoms with no medically diagnosable cause are common. Unfortunately, PCA survivors often have the experience of being invalidated by the Western medical community due to this frequent presentation of physical symptoms that cannot be "seen" or "proven." Some progress has been made in this area as Western medicine slowly begins to recognize trauma theory and the significance of the mind-body connection, but there is still a long way to go. Trauma survivors, and especially those who have endured chronic abuse, need to be educated about the interaction between traumatic stress and ill health (Allen, 2001; Levine, 1997; van der Kolk, 1996) so that this is not yet another area where they perceive themselves as "crazy" and so that they have some understanding of their bodies as reactive to outside circumstances rather than simply being "irreparably damaged" and "completely unpredictable."

Problems with Systems of Meaning

Chronic interpersonal trauma, especially for children - who are inherently dependent on caregivers for protection and care - can easily destroy any semblance of order and meaning in the world if one ever existed to begin with.

> In general, childhood traumatic experiences contribute to a schematization of the world, especially of security, safety, risk, injury, loss, protection, and intervention. The importance of traumatic memories lies in their role in shaping expectations of the recurrence of threat, of failure of protective intervention, and/or of

> helplessness, which govern the child's emotional life and behavior (Pynoos, Steinberg, & Goenjian, 1996, pp. 349-350).

Spiritual beliefs are often compromised as well. Chronic abuse and neglect often have a devastating impact on

> …meaning and hope, transcendence, openness to all aspects of life, and one's relation to nonmaterial aspects of life. This damage may be reflected in cynicism or despair; a narrow focus on self or victimhood; irreverence for nature, humanity, or life; materialism; and inability to experience love, joy, awe, wonder, gratitude, passion, or community (Pearlman, 2001, p. 219).

Later aspects of the therapeutic work with PCA survivors must often include some form of meaning-making of their childhood experiences which allows for them to exist within the scope of a larger sustaining belief system.

The Developmental Stage of Adolescence

Adolescence, which roughly occurs between the ages of 12 and 19 (Lesser & Pope, 2007), is a time of immense change. Holmbeck et al. (as cited in Lesser & Pope, 2007) refer to this developmental stage as a time "when one's developmental trajectory can be dramatically altered in positive or negative directions" (p. 293). It is therefore an important stage of development to understand in considering when and how therapeutic interventions geared toward PCA survivors may be most effective.

The biological, psychological, and cognitive transformations that occur within the adolescent not only influence how they experience the world, but just as greatly affect how the world interacts with them. This is a time when puberty and general growth spurts initiate significant biological changes; when formal operational thought, abstraction, and more sophisticated self-reflection become possible; and when identity formation is thought to emerge as the major task at hand (Erikson, 1959). It should be

noted, however, that Erikson's definition of identity formation as the major task of adolescence has been recognized as culture-bound (Lesser & Pope, 2007). Consistent with adolescence corresponding to the developmental stage of identity development in many Western cultures, adolescence is also a time when many teenagers begin to exert greater autonomy, "trying on" being less dependent on previous caretakers and/or attachment figures. In this way, it has actually been conceptualized as a second "separation-individuation" phase (Lesser & Pope, 2007).

Generally, adolescence involves a heavier emphasis on peer relationships and school functioning, since this is where and with whom many adolescents (in many Western cultures) spend large amounts of their time. Their social context begins to widen as they often become more involved in their community and as they begin to attempt constructing attachment relationships with their peers, which eventually hope to meet the attachment needs previously met by parents or primary caretakers.

Attachment style is thought to stabilize (or, in other words, to become internalized) sometime within the window of adolescence through reflective processes brought on by formal operational thought.

> …something else is also emerging – an integrated strategy for approaching attachment relationships that is highly predictive of future behavior in new attachment (and caregiving) relationships…This in turn implies a degree of generalization and abstraction that permits the emergence of a generalized stance toward attachment from the multiple models held of different attachment relationships in infancy and childhood (Allen & Land, 1999, p. 320).

With the help of new reflective and abstract cognitive functions, however, adolescents also have an opportunity to alter what would otherwise become an internalized attachment style. The "recognition that parents can (and perhaps should)

behave differently also implies that other relationships may meet attachment needs better than current relationships with parents may" (Allen & Land, 1999, p. 320). This recognition can lead to an unhelpful preoccupation with "deficient" parents, or, through processing and support, it can lead to "greater openness, objectivity, and flexibility in reevaluating past attachment relationships – characteristics that mark the presence of secure attachment organization in adolescence and young adulthood" (Allen & Land, 1999, p. 320). This kind of processing and reworking of attachment styles falls within the realm of Complex PTSD treatments. Enhanced reflective and cognitive abilities and their intersection with the primacy of identity development in adolescence therefore make this time a unique opportunity to intervene therapeutically in the lives of PCA survivors.

The Case of Deanna

Deanna, a 17-year old female, was referred to an outpatient mental health setting by the local probate court when her mother attempted to regain custody. Deanna had dropped out of numerous treatment programs over the past two years and had a history of cutting, aggression, and suicidal ideation. The probate court decided that it would only consider granting Deanna's official reunification with her mother if Deanna would attend treatment to eventually include her mother. Deanna reluctantly agreed and made it very clear in her initial clinical interview that she did not want to be in treatment.

Deanna was originally removed from her mother's care when she was five years old for both physical abuse and neglect. Reports indicate that she was physically abused by her mother's live-in boyfriend at the time (who was also violent toward her mother), and that her mother used to lock her in the closet for multiple hours at a time. She was

the last of five children, born to a mother who had a history of severe childhood abuse herself and who had her first child at age 15. At the time Deanna was removed from her mother's home, it was just she and her older brother in the house. The family was of a low socioeconomic background and Deanna witnessed many acts of community violence in her inner-city neighborhood from the time she was very young.

When she was removed from her mother's care, Deanna was sent to live with her father (who was not also her brother's father, and the two were thus separated). At her father's home, she grew accustomed to taking care of herself, as her father was often absent – physically and/or emotionally – due to his struggle with alcoholism. Deanna lived among a number of step-siblings and a step-mother who did not welcome her presence. She recalls the house feeling "like a boarding home," with different people constantly coming and going, and with some staying for months at a time. From the ages of 7-12, she was intermittently sexually abused by a male relative of the family who would often stay at the house. By the time she finally told a school counselor about the abuse, she had developed a reputation at school as a "difficult student," receiving multiple suspensions for numerous physical altercations with her peers. She also began cutting herself around this time, and was hospitalized a year later for reportedly attempting suicide, although she denied this intention at intake. She received little emotional support at home after revealing the abuse and developed a toughly independent persona, claiming she "didn't need anyone." Deanna also acknowledged being raped twice in her early teens, but at the time of our meeting had as of yet been unable to speak about the circumstances and details involved in these incidents.

The local school system transferred her to an alternative educational setting, where she continued to get into fights with others. Deanna described how tension would build with a peer, and before she knew it, she would black out; when she came-to, the other person would be lying on the ground. She did not get along well with peers, and did not trust anyone, although she became a devout protector of a younger cousin of hers who was growing up in circumstances that were unfortunately quite familiar to her.

When she came into treatment, she was two grade levels behind in school, was on the verge of dropping out, and presented with the following symptoms: "angry outbursts" (low impulse control and frequent aggression), unstable interpersonal relationships, dissociation and "numbness," depression, frequent stomach pains and headaches, (very) low self-esteem, frequent marijuana use, insomnia, and a history of cutting and suicidal ideation that had only recently slowed down. She continued to technically live with her father and his family, but had an extensive history of running away and staying with others (friends/boyfriends/extended family) for significant periods of time. Upon my meeting with her for the first time, she had her arms crossed and rolled her eyes when I called her name in the waiting room. She presented as incredibly guarded.

I will refer to Deanna's case in subsequent chapters in order to ground the comparison of working with adolescent PCA survivors using a family contextual model (Gold, 2000) to that of coming from a narrative perspective (Freedman & Combs, 1996; White, 2004, 2007a, 2007b).

CHAPTER IV

THE FAMILY CONTEXTUAL TREATMENT MODEL

The family contextual treatment model (also referred to as contextual therapy or the family/social context model) (Gold, 2000) was created specifically for adult survivors of prolonged childhood abuse based on socio-political analysis (see, e.g., Alexander & Lupfer, 1987; Williamsson, Borduin, & Howe, 1991), and extensive clinical observations in work with this population (Gold, 2000). Although this model overlaps significantly with the tri-phased treatment framework detailed in Chapter III, it decentralizes the client's "abuse trauma" and emphasizes the effects of clients' home and social environments in childhood (Gold, 2000).

In this chapter, I give a brief overview of the rationale for the creation of this model and its views on the aims of treatment with PCA survivors. I then detail the structure of treatment and use the case of Deanna to explicate this where necessary, while also giving examples of specific interventions often used. It should be noted that the case of Deanna is less prevalent in this chapter than in Chapter V because many of contextual therapy's practices do not necessitate grounding in case examples or come from more of a traditional paradigm, which it is assumed that readers will be familiar with. Lastly, I conclude this chapter with an account of how the family contextual treatment model conceives of the various roles of the therapist.

The Creation of the Contextual Model

Far too frequently, PCA survivors have been told that the only way to transcend the effects of a history of abuse is to endure intensive trauma-focused treatment (Gold, 2000). This belief may, at least in part, stem from a concept of catharsis as a healing element, but more predominately, it is the result of new research on effective treatments for posttraumatic stress disorder (commonly referred to as PTSD). The findings of that research have established that many individuals with PTSD are able to return to their prior level of functioning once traumatic material has been confronted and processed. However, people manifesting signs of complex trauma (as PCA survivors often do) - such as suicidal ideation, characterological issues, and/or difficulties with impulse control - are routinely excluded from PTSD research (Spinazzola et al., 2005). The fact that PCA survivors frequently meet the criteria for and/or are diagnosed with PTSD can therefore create dangerous assumptions, because trauma-focused treatment is likely to be re-traumatizing and damaging with clients whose symptomatology significantly transcends that of standard PTSD. The originator of the family contextual model (Gold, 2000) recognized this and sought to create a model specific to clients presenting with histories of ongoing childhood abuse. In so doing, he found that discrete incidents of abuse, in these cases, were reflective of a much more pervasive "ineffective" family and social context. These contexts not only failed to protect clients from repeated abuse, but also failed to transmit adaptive living skills and to provide adequate opportunities for healthy attachment. In this way, the family contextual model's (Gold, 2000) conceptualization of the etiology of PCA survivors' difficulties emphasizes the environment in which PCA survivors were raised rather than focusing exclusively on discrete incidents of trauma:

> …adult [PCA] survivors are affected not only by the abuse-trauma, but also by the family and social contexts that surround such abuse…[T]hese contexts may be much more subtle and less evident to the observer (i.e., emotional neglect and maltreatment involving the lack of a secure base due to interpersonal chaos and involving rejection, abandonment, unresponsiveness, belittlement, contempt, coercive control, lack of training in life skills and lack of training in essential self-regulation skills) than more frank abuse (i.e., physical and sexual abuse) but…their potential for damage is enormous and should not be minimized…Thus, the multitude and complexity of problems manifested by adults abused as children and brought to treatment are cumulative and developmental within this family context, rather than only the result of distinct and identifiable incidents of abuse (p. xvi).

The family contextual treatment model (Gold, 2000) was therefore created as an alternative to trauma-focused treatment and reflects the complex and multiple causes of the difficulties often experienced by PCA survivors. It focuses on the crucial tasks of developing a collaborative therapeutic alliance, assisting clients in constructing contextualized conceptualizations of their lives, and helping clients to learn effective daily living skills not transmitted in childhood. Specific traumatic events are only processed if clients still deem it necessary once other adaptive capacities have been learned. Further, even if this processing is decided upon, it is only done so in service of improved current functioning.

The Aim of Treatment

According to Steven Gold, Ph.D. and founder of contextual therapy (2000), "…the ultimate aim of treatment is not merely to resolve problems, but to teach clients methods for adaptation and problem resolution that will lead to continued gains long after formal therapy ends" (p. xxiii). These skills, such as the capacity to tolerate distress and regulate one's emotions or to employ critical reasoning skills, are frequently taken for granted by people who have been raised in supportive, effective environments. Gold

contends that in the case of PCA survivors such skills often need to be taught explicitly to make up for their lack of earlier transmission.

Along with the teaching of adaptive living skills, it is also hoped that through the therapeutic alliance clients will gain experiential knowledge of both healthy attachment and effective skills in interpersonal relating. Additionally, it is hoped that through collaborative inquiry and client-directed conceptualization of one's historical context, PCA survivors will learn to critically question and redefine destructive beliefs.

As a general guide to the aims of treatment, "The only justification for targeting a response for modification or elimination is that it propagates distress or interferes with adaptive living…" (Gold, 2000, p. 157). No goals are therefore undertaken in this model unless they are ultimately in service of the client's achieving better functioning and decreased distress in the present. In other words, clients should never be pushed to process details of traumatic incidents merely for processing's sake.

The Structure of Treatment

Contextual therapy (Gold, 2000) defines three intersecting "contexts" that constitute the three primary aspects of the treatment model: the interpersonal context, the conceptual context, and the practical context. The alliance between therapist and client is considered the interpersonal context, and aims to experientially teach interpersonal skills and to facilitate movement in the client toward secure attachment. The interpersonal context, otherwise known as the therapeutic alliance, is also the foundation on which successful treatment is thought to be built.

Within the conceptual context, clients are supported in building an "understanding of self and others based on recognition of the influence of family, trauma, social and other contexts" (Gold, 2000, p. 132). The conceptual context therefore includes deconstructing and reexamining faulty and negative beliefs (especially about oneself) that may be the result of trauma, an invalidating environment, or any of a number of other influences. The conceptual context also helps clients to distinguish skills deficits that may be the result of growing up in an unsupportive and abusive environment from performance deficits that are likely to be the result of trauma (Gold, 2000). Finally, the conceptual context eventually serves to guide treatment by using clients' new understandings of themselves and their needs. Based on this new conceptualization of themselves, a prioritized list of goals toward which they and their therapist will work is collaboratively constructed.

Last, the practical context involves the transmission of adaptive living skills "such as the capacities for security, focus, reasoning, coping, and liberation from traumatic impact" (Gold, 2000, p. 132) from the therapist to the client as is necessary and according to the prioritized treatment goals described above. In any given session, constant shifting and interplay between these three contexts takes place. Below I will describe each of these contexts in greater detail, along with their function in the greater structure of treatment with PCA survivors. The case of Deanna will be integrated throughout these descriptions where specifics are needed to ground the material.

The Interpersonal Context

Gold (2000) describes the collaborative alliance, or the relationship between therapist and client, as being primary – "a higher priority than treatment goals" (p. 133). The reason for this is twofold; first, the teaching and transmission of effective skills for daily living is likely to be ineffective if it is not grounded in a solid collaborative alliance, and second, the establishment of a healthy, collaborative relationship is often considered a major goal of treatment in and of itself for PCA survivors.

> For someone who grew up in a family marked by emotional disengagement, vehement conflict, and interpersonal control, the capacity for attachment is at best tenuous and the patterns of social relating that have been learned are likely to foster conflict rather than affiliation. In these cases one of the cornerstones of efficacious psychotherapy, the formation of a collaborative working relationship between client and therapist, is itself a central challenge (Gold, 2000, p. 86).

Equipped with knowledge about why PCA survivors may present with a variety of initially challenging interpersonal styles, it is the therapist's job to remain consistent, reliable, receptive, and empathic, modeling effective interpersonal skills and adhering to the boundaries of a mutually constructed general treatment structure. This stability and predictability on the part of the therapist is a piece of what will eventually help to erode the client's deeply held mistrust of others.

In this sense, the clinician needs to maintain awareness of the fact that

> …they [PCA survivors] have little reason to expect interpersonal relationships to be marked by cooperation and good will, have had minimal if any experience of being nurtured and supported, and have developed an interpersonal style and a set of beliefs about interpersonal relationships that are likely to work against the formation of a collaborative partnership (Gold, 2000, p. 87).

Further, "The expectation of abandonment is largely constructed from real life experiences of being deserted and rejected when unmet dependency and affectional needs

overwhelm others and lead them to cut off interaction" (Gold, 2000, p. 88). Given the prior experiences of PCA survivors with primary caregivers and other attachment figures, it is no wonder that the possibility of an attachment relationship in therapy is frequently met with trepidation, mistrust, and fear, accompanied by all of the protective behaviors survivors have used to cope with these emotions.

> …the interacting forces of a loathsome self-image, fear of being rejected and abandoned, and excruciating feelings of dependency constitute pivotal influences on the PCA survivor's perception of and interactions with the clinician throughout much of the course of treatment. Appreciation of this configuration of experiences can be an invaluable aid to the clinician in avoiding misinterpretations of the intentions behind the client's interpersonal behavior (Gold, 2000, p. 93).

Due to the many complexities and barriers inherent in forming a collaborative alliance with many PCA survivors, the family contextual treatment model (Gold, 2000) considers it of utmost importance for clinicians to take as much time as is needed at the beginning of treatment to form a collaborative relationship before beginning to address other treatment goals. Clinicians can support the gradual establishment of a healthy working alliance by allowing the clients to guide the pace and direction of sessions, thereby focusing on listening, validating, and encouraging that which is meaningful to clients. It is also helpful for clinicians to actively support the clients' identification and expression of feelings, as well as to provide clients with opportunities to sort out, make sense of, and gain perspective on their life experiences (Gold, 2000). This client-directed stance is especially important with clients whose experiences, thoughts, and feelings have repeatedly been invalidated and belittled or who have been abandoned due to expressing their own needs. Because of this history, these clients may unknowingly adhere to what they sense the clinician's expectations of them are instead of learning how to value their

own perceptions, judgments, and feelings. Depending on whether or not the client has had *any* experience with healthy attachments (e.g., a teacher, a neighbor, a family member, etc.), this process of building a collaborative working relationship can take anywhere from a few sessions to many months or even years in the most extreme cases.

Given Deanna's history, this process in her case would probably take a number of months. She has some memories of a healthy attachment relationship with her grandmother, and also began to develop a sense of trust with a counselor in middle school, but otherwise has predominately experienced relationships characterized by conflict, instability, and betrayal. She entered treatment with a deep mistrust of others and without models of healthy communication. Although she states that her closest relationship is with her boyfriend, she also reports that they are in constant conflict. Establishing a collaborative working relationship with Deanna would need to emphasize respect for her personal definitions of her experiences, validation of her struggles and accomplishments, and a non-judgmental, supportive stance. Her right to control the pace and direction of treatment would also need to be paramount. In many ways, the type of space being constructed here between therapist and client is similar to that of the concept of a "holding environment" in object relations theory (Winnicott, 1953) in that it is a consistent, structured, nurturing space that clients can use to eventually proceed in their development. The difference, however, is the need for more explicit methods of "teaching" interpersonal skills that were never developed:

> A family and social context-based formulation reveals the need for a very different approach to the formulation of a collaborative therapeutic relationship than would a trauma-centered model. If the capacity for productive interpersonal relating were present but for some reason dormant, providing a therapeutic atmosphere that promotes a sense of safety and security could realistically be

> sufficient to allow these resources to surface. However, if these social competencies were never fully developed to begin with, then no amount of support and reassurance will lead to their emergence. What PCA survivors need, in conjunction with a reliable and secure therapeutic environment, is a structure that will foster the remediation of deficient interpersonal relationship skills, while simultaneously correcting distortions created by invalidating and abusive familial and extra-familial interpersonal contexts (Gold, 2000, p. 102).

The following two sections will detail further aspects of this structure.

The Conceptual Context

As was stated previously, the conceptual context is defined by Gold (2000) as the construction of "an understanding of self and others based on recognition of the influence of family, trauma, social and other contexts" (p. 132). One of the outcomes of this process of understanding is the formation of treatment plans geared toward developing skills that were not transmitted or modeled for clients in childhood.

Clients are asked to be the leaders in the assessment of both their needs and the contributing factors to what they define as their current problems, guided by the inquiry of the therapist. In this way, clients educate the therapist about their life experiences, as clients are the experts in this realm. At the same time, however, it is also the job of the therapist to take on a neutral, open-minded, and inquisitive orientation geared toward examining other possibilities based on the information the client presents. This is done via the types of inquiry s/he provides, which need to be of a specific quality:

> …questioning [by the therapist] will be most productive when the therapist does not have any particular (i.e., "correct") answer in mind, and instead maintains the mindset of dispassionately seeking information and wanting to be enlightened by the client…What is [also important]…is for the practitioner to introduce, by virtue of her or his line of inquiry, the possibility that alternate views on the same situation might exist, and to model for the client the dispassionate examination of the facts and various ways of construing them (Gold, 2000, p. 115).

An example of this kind of inquiry in Deanna's case might consist of the following questions in response to her repeated, self-blaming claims that she has "anger problems":

- Can you tell me more about these "anger problems"?
- When did these "anger problems" begin?
- What were the circumstances surrounding their development?
- Are there circumstances that allow these "anger problems" to fade?
- What circumstances make these "anger problems" worse?
- If you could place someone else in these same circumstances, do you think that these "anger problems" would have an influence over them as well? How so?
- If these "anger problems" could have a voice of their own, what do you think they would say?
- Do others have any responsibility for their actions in these circumstances?
- What purpose do you think anger serves in the circumstances you've described?
- Is anger always a problem? How is it helpful and how is it hurtful?

The construction of a conceptual framework for treatment based on exploration and definition of difficulties the client has articulated is therefore a collaborative process between client and therapist and supports the client in deconstructing the "truth" of what are often very old, ingrained and destructive beliefs.

> …the very process of addressing these questions often functions as a mode of intervention in and of itself. Frequently, illuminating the myriad of influences that contribute to the PCA survivor's current difficulties engenders a reformulation of their understanding of the problems being examined. The recognition that gaps and warps in functioning are attributable to factors such as a

> history of deprivation of learning or to the disruptive effects of maltreatment helps to make them comprehensible to clients. In turn, this often effectively diminishes the client's tendency to find fault with themselves for having these difficulties. They grow less inclined to see their problems as a reflection on them, or as insurmountable obstacles. Instead, they are more able to appreciate that their difficulties are a consequence of their life circumstances, and that they are reparable (Gold, 2000, p. 117).

There are a number of other reasons why the ongoing process of collaborative conceptualization is so central to treatment. First, for the PCA survivor, "…recognizing her or his unique contribution to this endeavor as the sole source of the data from which the conceptual framework is constructed is implicitly validating and empowering" (Gold, 2000, p. 117). Second,

> Active participation in the enterprise of conceptualization promotes the acquisition of skills in critical judgment and reasoning, and transmits the more circumscribed ability to deduce the nature, source, and causes of difficulties in order to develop a strategy to resolve them (Gold, 2000, p. 117).

In this way, skills being taught in the practical context of treatment are used, reinforced, and integrated into the client's own skill set. Additionally, collaborative conceptualization serves an important organizational purpose:

> Initiating the conceptualization process by identifying goals establishes focal areas around which the complex and extensive life histories and current circumstances of PCA survivors can be organized. In this way, exploration is guided and structured by an effort to achieve a particular objective, rather than proceeding as an expansive, haphazard search for information…Rather than examining one aspect of the client's background (such as a childhood abuse history or an inadequate family context) exhaustively and exclusively, this strategy encourages the consideration of the contribution of a range of factors to the evolution of each targeted area (Gold, 2000, p. 116).

Finally, the process of collaborative conceptualization of a framework for treatment serves to strengthen the alliance between therapist and client by communicating mutual respect. Work toward subsequently defined treatment goals is much more meaningful when clients have predominately been able to define these goals themselves.

In the next section, I describe the process of defining goals for treatment and deciding on the most effective ways these goals can be accomplished.

Once a current area of functioning has been identified by a client as needing to undergo change, the therapist supports the deconstruction and exploration of the problem by "gathering relevant information about the onset, surrounding circumstances, course, and contingencies of each problem being addressed" (Gold, 2000, p. 107), where inquiry is always guided by data provided by the client. As described above, this exploratory and deconstructive process is what supports the opening up of alternate understandings of the roots of clients' difficulties.

Next, clients are asked to define what it is that they would like to accomplish with respect to identified areas of difficulty. Once an initial goal is articulated, exploration focuses on the nature of the issue involved, i.e., "Does the goal pertain to behavior, thoughts, feelings, sensations, circumstances, or some combination of these? Is it centered around the reduction or elimination of existing behaviors, thoughts, feelings, etc., the development of new ones, or both" (Gold, 2000, p. 115)? From these questions, a clearer picture of the specific changes involved in the attainment of the goal emerges. With regard to Deanna's self-identified difficulties with anger, a therapist would wonder with her what a positive change with regard to anger might look like. Would it be that she would be better able to sit with her anger, understanding it and expressing it in healthier ways? Would it be that anger would have less of an ability to overpower her feelings and actions? Would it be that she might learn to channel her anger into more effective ways of altering her circumstances? Once Deanna's goals in terms of anger had

been explored and identified, this process would be started anew for other changes the she might want to make.

Beyond identifying treatment goals, however:

> The ultimate aim of conceptualization is to point to appropriate methods for achieving treatment goals. Where deficits appear to be a consequence of never having learned essential living skills, training in those abilities is indicated. In instances where capacities appear to have at one time been established but were derailed by the traumatic impact of abuse, trauma-focused interventions may prove to be more effective. In areas where the client's perspective has been shaped by the restrictive and disempowering influence of ethnic, racial, gender, or other forms of discrimination, identification and challenging of internalized social prejudices may be called for. In these respects, the content yielded by exploration serves as a foundation for developing interventions that are logically grounded in an understanding of the nature, roots, and causes of problem areas (Gold, 2000, p. 116).

Specific interventions and areas for change are prioritized, again in a collaborative process between client and therapist, and a plan is made to begin working on treatment goals. The following section will detail the methods by which the skills that inform or constitute treatment goals are learned, otherwise called the practical context.

The Practical Context

The practical context of contextual therapy supports the client in mastering "practical," or adaptive living skills "such as the capacities for security, focus, reasoning, coping, and liberation from traumatic impact" (Gold, 2000, p. 132). These skills are learned by the client under the direction of the therapist, thereby putting the therapist in more of a "teaching" role in this context. Here, the therapist is seen as providing the kind of structure and guidance necessary for adequate transmission of these adaptive living skills to the client as a means of remediating deficits the client experiences as a result of growing up in an ineffective familial and social context. The sequence and substance of

the treatment goals attempted will vary from client to client depending on individual needs and preferences, and are determined through a collaborative process between client and therapist. Regardless of the sequence of prioritized treatment goals the client and therapist come up with, however, these are never seen as "fixed," and some amount of shifting and overlapping between the various objectives is expected as various issues arise in treatment and in clients' lives. In the end, "…it is the conceptual framework that ultimately guides the treatment process, rather than any particular order of goal setting and attainment" (Gold, 2000, p. 122). Therapists are told to use their own judgment and to seek cues from clients when it comes to the prerequisite skills needed to address certain goals. Addressing traumatic material is a great example of this, as it would be wise for clients to be equipped with a certain level of distress tolerance capacity and a variety of adequate coping skills before taking on the processing of overwhelming traumatic experiences, if this is indicated.

In addition to this openness to flexibility in treatment structure, the family contextual treatment model (Gold, 2000) does propose a general guideline for the prioritization of treatment goals that reflect frequent deficits in adaptive living skills experienced by PCA survivors presenting for treatment. While this guideline is merely a suggestion and is intended to provide a template for the prioritization of treatment goals, it is logically ordered in that the skills later in treatment build off of those constructed earlier on. This general structure is therefore helpful in adapting individualized client goals to a plan that will help the client to succeed, and provides specific intervention strategies toward achieving each general skill category. This structure is detailed below.

Managing and modulating distress. Assisting the client in building the capacity to tolerate, manage, and decrease his/her own level of distress is given first priority in this suggested treatment structure, as these skills are often a prerequisite for being able to focus on any other aspect of treatment. For example, "…proficiency in the management of affect allows the development of the capacity for cognitive processing to benefit from the information provided by feelings, without allowing judgment and reasoning to be overpowered by the immediacy or intensity of emotions" (Gold, 2000, p. 122). The ability to tolerate distress also steers people away from resorting to what are often maladaptive coping strategies such as addictions, compulsions, dissociative reactions, and other potentially self-harming patterns. In this way, the client's ability to tolerate distress allows treatment to move away from the realm of constantly managing (non life-threatening) crises and to focus on the remediation of adaptive living skills.

In order to maximize effectiveness, the family contextual model (Gold, 2000) suggests that the teaching of distress tolerance skills should only begin once the therapeutic relationship is stable and a healthy collaborative alliance has been established. The clinician can then gauge what level of self-sufficiency the client might be able to attain with regard to anxiety management techniques, wanting the client to be successful at the most independent level possible. Potential methods of anxiety management include: audio-taped guided imagery exercises, the "safe place" imagery technique, autogenic training, hypnotic induction, physical approaches such as progressive muscle relaxation and various breathing techniques, and any other types of healthy activities the client may already find to be stabilizing and relaxing (Gold, 2000). The process of finding out which methods work best for each individual occurs through both trial and

error and practice. While clients learn the techniques in session initially, they are asked to make them their own by using and practicing them repeatedly in their daily lives (during times when they do not necessarily *need* them so that they become very familiar should they need them in a time of great distress). They are given "assignments" to designate at least two times each day to practice the techniques of their choice, recording on a scale of 1-10 or 1-100 how anxious or distressed they felt before the relaxation practice and whether or not there were any changes in this level afterward. These daily charts not only point to the effectiveness of relaxation techniques and to what works best for each client, along with providing the client with a sense of accomplishment by completing them and reviewing them in session, but they also provide relevant information on any patterns of distress in the client's daily life. For example: Are there certain times each day that the client's stress level increases dramatically? What accounts for this? Or: What happened on a specific day that might have rendered certain relaxation techniques less effective? Is this part of any larger pattern the client can be aware of in order to prepare for its occurrence?

Once clients are familiar enough with a range of distress management techniques to have a sense of what works best for them, the family contextual model (Gold, 2000) suggests that clients keep a list of techniques to choose from them with them at all times (in a pocket, a bag, etc.) as a reference in the case their anxiety gets in the way of remembering the techniques they have practiced or what to do to help soothe themselves. It is not uncommon for PCA survivors to dissociate when triggered or stressed, thereby making it that much harder to initially follow through on the techniques that have been practiced without something to jog their memory.

Simple behavioral techniques can also be used at this point to help to decrease depressive symptoms that clients often experience in conjunction with high levels of anxiety, helping clients learn to have more control over the regulation of their emotions. A daily activity log can be used to examine and track daily patterns in the areas of sleep, eating, exercise, work, socializing, and recreation. Client and therapist can go over a typical day in the client's life in order to identify any habits that might be perpetuating the client's depression. They can then collaboratively consider each habit and can generate alternate possible behavioral patterns, setting goals in the format of a new daily activity log. Again, this log provides clients with a sense of structure and a sense of accomplishment as they work toward adhering to the goals that have been mutually generated. The log also helps clients to recognize how structuring their daily lives differently, a foundation that in most PCA survivors' cases was never transmitted or modeled in their upbringing, can help to improve their mood and to accomplish a greater number of goals.

Fostering experiential presence and continuity. This goal entails assisting clients in building the capacity to remain present in the "here and now," again as a prerequisite to learning other skills. It follows the general accomplishment of distress tolerance skills in the suggested list of priorities because it is often distress, or overwhelming emotion, which leads clients to dissociate or to lose contact with the present in some form. Dissociation is not always detrimental, however, and this should be carefully assessed before making it a target of intervention. "Contextual therapy aims to provide the client with the option to control dissociative experiences when they arouse emotional upset or interfere with effective functioning, rather than imposing on her or him the goal of

eradicating these experiences" (Gold, 2000, p. 157). Emphasis is placed on expanding the client's capacity to maintain attention and awareness rather than on eliminating dissociative tendencies, which have played a very important part in many PCA survivors' ability to cope with horrific circumstances. If it is decided that involuntary dissociative tendencies are detrimentally interfering with a client's life, s/he can also be taught alternate strategies for increasing feelings of safety and security, thereby decreasing the fear or overwhelming emotional discomfort that often leads to dissociation.

Major methods for maintaining experiential presence and continuity are called *grounding techniques*. These are defined as "methods of resisting the pull to drift into a dissociated state by intentionally experientially anchoring one's attention in the here and now" (Gold, 2000, p. 164). There are a number of ways to go about doing this, but the use of tactile sensations is often suggested first. In terms of teaching these techniques:

> A useful way to begin to familiarize the client with grounding skills is to identify, immediately following an episode of absorption, the behavioral concomitants of dissociation she or he is displaying, and to explain how these responses help to sever awareness of the surrounding environment…This establishes the rationale for purposefully reversing these behaviors as a means of modulating the dissociative experience. Placing feet on the floor, lowering arms to one's sides, and attending to the tactile sensations of being supported by the floor and the furniture help one to experientially reconnect with one's surroundings. If these steps do not sufficiently diminish the dissociative stupor, then standing up, moving around, and walking around the room while focusing on the tactile sensations these actions evoke will substantially amplify the grounding process" (Gold, 2000, p. 165).

The therapist can help the client become more curious and less ashamed about the presence of these experiences by providing psychoeducation on the reasons these tendencies are so often found among PCA survivors. By taking away the pressure clients often feel to "hide" the existence of these experiences, room can be opened up for clients

to learn more about the early warning signs (e.g., triggers, prodromal signs) of their dissociative episodes, thereby allowing them to learn how to disrupt the sequence that often leads there.

Finally, clients can also learn how to directly modulate their level of absorption, taking much of the fear out of the experience by teaching clients to have some control over it. Techniques such as imagining shifting a dial from a low degree of absorption to a high degree, when practiced, can create quite successful results.

All of these techniques, while initially taught by the clinician, should be turned over to the control of the client as soon as is possible. Just as is the case with regard to other skills being taught, the therapist should be constantly trying to help the client develop a sense of personal agency and control in the various areas of his/her life.

Learning to exercise judgment and critical thinking. Critical reasoning skills can most effectively be transmitted by applying them throughout treatment with the client to the analysis and resolution of various problematic situations as they occur, with the clinician structuring his/her inquiry in such a way that the client is assisted in coming up with his/her own deductions and conclusions (Gold, 2000). In these scenarios, clinicians' inquiries are based on a number of principles that underlie critical reasoning skills. In order to support clients' abilities to exercise judgment and critical thinking, these principles can also be taught more systematically. In this process, emphasis should be placed on the fact that critical reasoning skills are learned, not inborn, and that survivors "can't be expected to know what [they've] never been taught" (Gold, 2000, p. 182). Below is a list of these principles, to be taught and discussed with the client so that the

process of applying each of these principles becomes engrained into the client's thought process:

1. The purpose of thinking is to increase future *effectiveness*.
2. Identify, acknowledge, and find a *balance* between emotional pulls and logical consequences.
3. Weigh the relative *costs and benefits* of immediate relief and long-term gains.
4. Develop an expanded perspective in order to find the "*middle ground*" between extremes.
5. Identify a *range of choices* including several falling within the "middle ground."
6. *Weigh* the alternate choices and *select* a course of action (Gold, 2000, pp. 183-187).

Each one of these principles is geared toward alleviating maladaptive tendencies PCA survivors often employ because of the lack of guidance they received in these areas when growing up. For example, the family contextual model (Gold, 2000) gives the following context and explanation with regard to Principle 1:

> An integral component of early family life for many PCA survivors was being criticized and berated for having made poor decisions about a situation…despite the fact that no one offered them guidance on how to handle the situation in advance or provided constructive advice about how it could have been better managed in retrospect. Consequently, survivors are disposed to engaging in protracted, unproductive second-guessing and self-denigration for missteps in hindsight, without being oriented toward learning from and preventing similar outcomes thereafter. In effect, they carry out an inner dialogue that recapitulates the type of destructive, debilitating condemnation that they frequently heard from family members during their formative years. Cognitive processing is routinely used to engage in destructive self-criticism, rather than to promote effective functioning. Therefore, survivors need to be directed toward developing the habit of stopping and thinking through situations more extensively before the fact and of restricting the unproductive habit of replaying them in their minds after the fact. They need to come to see post-hoc analysis as being justifiable only if it is conducted in the spirit of constructively learning from past errors in order to avoid similar future outcomes (p. 184).

Similarly, Principle 2 emphasizes building the capacity to refrain from acting on the intensity of fleeting emotions and impulses that are not tempered by logical reasoning. It promotes learning to modulate feelings, to think difficulties through in order to generate productive response options, and to see nuances or "grays," allowing oneself to use both emotions (as information) and logical reasoning in decision-making (Gold, 2000). These capacities can all be practiced in session and applied to situations the client encounters as they arise. The therapist can also be the supportive other, helping the client to think through a situation before it happens or to reflect productively on his/her actions and decision-making process afterward.

Another aspect of critical thinking that frequently needs to be taught in the case of PCA survivors is the ability to critically examine and revise erroneous convictions, assumptions, and cognitive distortions. Here again, these skills can be transmitted through the line of inquiry practitioners use to support clients in deconstructing these assumptions and beliefs.

> [Practitioners] need to collaboratively join with survivor clients in order to facilitate the process of helping them to identify and articulate their implicit assumptions. Then, by asking them to explain how they arrived at these conclusions, [practitioners] can assist them in considering whether their core beliefs are consistent with logic and evidence (Gold, 2000, p. 190).

This process may take a considerable amount of time and repetition, along with patience on the part of the therapist, as it is especially important that any revised beliefs or conclusions come from the client through the process of this exploration and not via the suggestion of the therapist. For many PCA survivors, relinquishing even the most negative core beliefs can be incredibly frightening and disorienting, as these beliefs are still what have provided some sense of predictability in the world. The process of

allowing these beliefs and assumptions to change needs to happen at a pace that is under the control of the client. It is therefore the therapist's job to "display constructive curiosity" (Gold, 2000, p. 190) regarding the client's beliefs using "an open-ended Socratic method of inquiry…grounded in the assumption that the client's innate judgment is usually the best guide to the rate and direction in which exploration should proceed" (Gold, 2000, p. 191). Because opportunities for this type of exploration emerge sporadically, these skills are pursued intermittently and are integrated throughout treatment.

Breaking and replacing maladaptive patterns. It is rare that PCA survivors enter treatment without either an ongoing or a prior struggle with some type of a maladaptive behavioral pattern in the form of addictions and/or compulsions. This is because these frequently are the only methods survivors have found to cope with difficult, overwhelming, and unpleasant emotions under the circumstances in which they grew up. The family contextual treatment model (Gold, 2000) attempts to illuminate the origins of these behaviors in order to provide a sense of understanding as to how these behaviors have functioned in survivors' lives and to open up the option for survivors of learning alternate strategies for coping with intensely difficult feelings. Armed at this point in treatment with at least a basic level of distress tolerance skills, some ability to modulate dissociative experiences, and an emerging ability to exercise critical judgment, these skills "can be applied to the investigation, evaluation, understanding, disruption, and ultimately, elimination of self-damaging patterns of behavior" (Gold, 2000, p. 200). The order in which these processes are listed is very important, as this model advocates for the exploration of the purposes the behaviors serves, without judgment, before attempting

to simply give up the behavior all together. (An exception here is when behaviors are life-threatening and thus need to be directly addressed before any other mode of treatment can proceed. This model is contraindicated when clients are exhibiting behaviors so severe that they require attention to the exclusion of all other treatment goals.)

In order to explore the various elements comprising and surrounding the client's maladaptive behavior pattern, therapist and client collaborate in conducting a functional behavioral analysis. In this procedure, specifics such as when the pattern started, the circumstances surrounding the first occurrence, the specifics of the behavior itself, the frequency of the behavior, and how the behavior has changed over time are recorded and analyzed. This is done collaboratively at first between the therapist and client, but over time is transferred to a log for the client to keep for him/herself. In this way, the client learns to recognize precursors or triggers to the maladaptive behavioral sequence and to stop it before it starts. After practice and effort in short-circuiting this pattern, its pull will begin to lose its intensity and the client will no longer need to attend so closely to it.

Toward this end, the client may also be asked to describe a specific incident involving the use of the behavior in order to assure that no details of the behavioral sequence are overlooked. Specifics elicited in this case are often the sequence of thoughts, feelings, actions, sensations, and events involved in an episode. As the client begins to notice and understand more about the nature, function, and significance of these behaviors in his/her life, the power of the behavior or the behavioral sequence over him/her decreases (Gold, 2000).

> By correcting misunderstandings, misinterpretations, and misattributions about the compulsion, she or he comes to realize that the actual intention behind the behavior is reasonable and comprehensible, rather than depraved or bizarre. Identification of the real rather than apparent function of the activity is reassuring to the client and usually prompts her or him to seek out or develop more effective strategies for achieving the same objective (Gold, 2000, p. 208).

It is not uncommon for clients to sporadically discover other ways to achieve these same objectives once the maladaptive patterns lift, although clients will often need some guidance from the clinician in "accessing, developing, or strengthening and maintaining these new resources" (Gold, 2000, p. 208). One example might be that instead of taking anger out on her/himself, a client might address the issue with the person that s/he is angry with. As this kind of assertiveness will be quite unfamiliar to the client, however, support from the therapist and a place to process these new experiences is often needed, especially in the beginning stages of this transformation.

As new ways of behaving and getting their needs met begin to open up, clients often feel a rush of positive change. A different kind of a life than they may have thought possible often opens up. At this point, clients will typically need simple support and validation from the therapist in integrating new realizations, abilities, and experiences. The stability of the therapist may also be needed when setbacks arise and clients occasionally resort to old habits. Here, clients need to be assured that this is often part of the process and that they can continue to move forward and to build on the changes they have made despite occasional setbacks by simply using them as further learning opportunities to better understand the compulsion or addiction. The occasional setback does not negate the progress they have made.

Expanding adaptive living skills. With the ability to modulate distress and dissociation, to exercise critical reasoning skills and judgment, and to understand and replace maladaptive behavioral patterns with healthier ones, clients are freed up enough to begin making progress on general areas of adult life. These areas might include improving their parenting skills, obtaining stable employment, engaging in an emotionally intimate relationship, improving relationships with friends, family, and community, engaging in comfortable and rewarding sexual experiences, and maintaining stable finances (Gold, 2000). "The clinician's major role at this point is to assist the survivor in adopting a productive problem-solving perspective when confronting obstacles such as these" (Gold, 2000, p. 210). The primary method for assisting the client in this way is to reinforce the application of the principles of constructive reasoning skills, which the client has already learned, along with advocating for the continual examination of assumptions and beliefs that may be faulty and that may be more reminiscent of his/her history than his/her present.

Resolving trauma. This is the final suggested treatment goal on the list for working with PCA survivors, as it is likely to be most safely and effectively accomplished, if even needed, once other basic skills have been mastered. By this point in treatment, the reality is that many of the effects of prolonged abuse have probably come up in one way or another as they have pertained to pursuing other treatment goals.

> Clinical experiences…led specialists in the field to the general conclusion that collaborating with PCA survivors in order to understand their current erroneous beliefs, disturbed feelings, or dysfunctional cycles of behavior would lead us back to a connection to traumatic experiences where one existed and needed to be resolved, without needing to expressly encourage extensive exploration of the abusive incidents themselves. Acknowledging and exploring this link was almost invariably constructive, particularly when we were careful to explicitly place the

> timing, pace and depth of examination of the traumatic material under the control of the client. Under these conditions, what we generally found was that with some monitoring and guidance by the therapist, the client could be trusted to effectively judge when and in exactly how much detail it was necessary to process the traumatic experience in order to benefit without becoming overwhelmed or destabilized (Gold, 2000, p. 217).

Considering that many aspects of traumatic material that needed to be processed have probably already been addressed to some extent, it should be completely up to the client to assess whether or not they need to further confront specific incidents of the abuse they have endured. Steven Gold (2000) speaks about his own experiences in his work with PCA survivors around this issue when he writes, "I found that when we entrusted our clients to direct the course of therapy and to educate us about their needs and concerns, specific instances of abuse became an increasingly peripheral focus of attention" (p. 215). This work should therefore only be pursued to the extent that the client feels that specific memories of abuse continue to interfere with his/her functioning or sense of well-being in the present.

If clients do report – on their own volition – continuing to experience what are often symptoms of standard PTSD (intrusions, hypervigilence, nightmares, etc.) as connected to a particular abusive incident, however, highly structured methods can be used at this point to decrease the impact of this memory. For this to safely take place, both client and therapist need to agree that the prerequisite skills to handle this exposure are soundly in place. Processing methods should then be planned and discussed in advance, and should be carried out according to their respective intervention protocols.

While exposure methods such as prolonged exposure (PE), eye movement desensitization and reprocessing (EMDR), or stress inoculation training (SIT), might

often be indicated here, the family contextual model recommends an approach to processing trauma called Traumatic Incident Reduction (TIR) (Gold, 2000). This approach is considered to be the most client-directed, and is suggested for this reason. Although aspects of this approach are similar to other exposure methods, as in the way it consists of having the client recount a traumatic incident repeatedly, it diverges from common exposure methods in the following ways:

1. It is the client, without influence by the practitioner, who selects the event to be reviewed.
2. Retelling and processing of the incident by the client proceed without interpretation, reframing, interruption, or other forms of interference by the therapist.
3. Once the processing of a particular incident is initiated, it continues, without a predetermined session time limit, until resolution is achieved (Gold, 2000, p. 220).

Because of the primacy placed on the client's own judgment and his/her ability to sort through the abusive experience under his or her own direction, this approach "bolsters the client's sense of empowerment and promotes the capacities for self-sufficiency that are integral to the contextual approach to treating PCA survivors" (Gold, 2000, pp. 220-221).

One of the most important guidelines for clinicians to keep in mind in regard to work with PCA survivors is that trauma-focused approaches play a very minimal role, if any role at all, in the overall framework for treatment with this population. "[W]hen distress is reduced and functioning is strengthened by the acquisition of adaptive coping skills, the debilitating effects of trauma are often adequately resolved so as to render direct confrontation of these episodes unnecessary" (Gold, 2000, p. 221). Providing PCA clients and the clinicians working with them with an alternative to trauma-focused treatment is one of the major aims and accomplishments of contextual therapy.

The Role of the Therapist

In the family contextual model (Gold, 2000), the clinician takes on various and constantly shifting roles over the course of treatment depending on the type of work being done at the time. S/he often is alternately: a collaborator around building a treatment alliance and supporting clients in broadening their conceptual frameworks; a teacher in the transmission of daily living skills; a learner with regard to clients' life experiences and beliefs; a model of self-regulation, critical thinking, and interpersonal skills; and a witness to clients' stories.

Contextual therapy as a whole emphasizes the importance of the clinician's role in assuring that PCA clients end up defining their own goals, course of treatment, and choices in general, while also making certain that treatment remains within an appropriate and helpful framework.

> Ultimately, the *clients* must identify which life experiences contributed to the problems that led them to seek treatment, and they must come to these conclusions in their own time, based on the strength of their own judgment. Otherwise, particularly because of their previous interpersonal experiences of subjugation and the resulting self-doubt, therapy can easily lapse into being one more in a long line of instances of passively bending to someone else's authority…Some survivors are so unsure of themselves and so fearful of being attacked that they are unable, at least in the early stages of treatment, to take the lead…With clients such as those, the therapist has to be even more vigilant to refrain from inadvertently deciding for them what is worth attending to, and to guard against unwittingly shaping the conclusions at which they arrive (Gold, 2000, pp. 50-51).

In order to support this kind of an environment, the family contextual model (Gold, 2000) suggests that clinicians employ a "curious stance" in their interactions with clients, which can serve to implicitly communicate a number of important messages:

> A demeanor of receptivity on the part of the clinician implicitly and powerfully communicates a position of respect, regard, and valuation that is likely to be more

> affirming and empowering than any direct, deliberate intervention…Participation in this type of interaction requires the practitioner to have a solid appreciation of the critical role the survivor client's expertise plays in the ultimate success of the therapeutic enterprise. While the clinician must bring extensive professional knowledge and skill to the treatment situation, her or his failure to recognize and respect the preeminence of the survivor's lived experience is at best misguided and at worst arrogant and destructive. In brief, we cannot possibly know how to productively intervene until we have adequately understood the background, experiences, and perspective of the individual we are seeking to help (Gold, 2000, p. 97).

In this way, one of the major roles of the clinician in contextual therapy is that of a learner and a witness in regard to the client's life experiences. Simultaneously, the clinician is modeling a way of relating interpersonally that PCA survivors may have never or have rarely experienced before.

There are also times in contextual therapy (Gold, 2000) where it is necessary for the clinician to be an educator, as mentioned above. One such major instance is in the teaching of adaptive living skills. This role as an educator is specific, however, and is aimed at allowing clients to make new skills their own as soon as they are able to. The clinician's role is therefore to teach methods appropriate to the highest level of self-sufficiency clients can attain, and then to gradually support clients in integrating these skills independently into their lives. Part of this process entails the clinician's modeling of these same skills in session when appropriate, such as providing questions to help clients deconstruct faulty assumptions or beliefs and thereby modeling constructive reasoning skills. Collaboration in this process is stressed, and clients' input is always used to the greatest extent possible.

Another way that clinicians in this model also act as educators is by providing psychoeducation around issues frequently effecting PCA survivors. Normalizing a

client's tendency to dissociate under certain circumstances, for example, and explaining why this is so common among PCA survivors, can help the client to feel both less alone in these experiences and to better understand their origins so that s/he does not blame him/herself to the same degree around this issue.

Throughout treatment, clinicians additionally act as models of skills for adaptive daily living (e.g., emotional regulation, interpersonal skills, critical thinking skills, etc.) and the qualities inherent in a healthy attachment relationship.

> The therapeutic relationship in contextual therapy is not merely the medium through which interventions occur, but is in itself an important corrective for the attachment difficulties experienced by the survivor (Gold, 2000, p. 132).

In order to sustain a position that communicates respect and care for clients despite the many challenging behaviors PCA survivors can exhibit, clinicians need to have a deep understanding of the origins of many of these behaviors, respecting their role in clients' protection of themselves.

> Many of these interpersonal difficulties are not performance deficits – capacities that are present but are not being manifested or have been disrupted due to interfering influences – as an abuse trauma model might suggest. Instead, they represent skill deficits – abilities that were never satisfactorily developed in the first place (Gold, 2000, p. 101).

By conveying compassion for clients and seeking to understand the purposes of specific behaviors, clinicians model interpersonal skills and can implicitly teach clients about the foundations of healthy attachment relationships.

The balance between teaching skills and providing the client with the necessary level of support on the one hand, and promoting the client's capacity for self-sufficiency on the other, can be complex. Thus:

> It is imperative…when responding to dependency, that the practitioner be clear on the distinction between empathic acknowledgement of dependent urges, and efforts to ease these feelings by unwittingly treating the client as someone who is incapable of self-soothing and self-reliance. This is a difficult balance to maintain. It requires that the practitioner listen to, witness, and share in the pain, thereby demonstrating caring *for* the client, while resisting the temptation to try to soothe that pain by attempting to do things for the client, thereby taking care *of* her or him (Gold, 2000, p. 97).

In contextual therapy, the clinician therefore seeks to promote the client's sense of self-sufficiency, accomplishment, and personal agency as much as is possible by supporting him/her in taking care of him/herself, while still expressing empathy toward him/her. One example of a suggestion this model makes toward this end is the following:

> It is incumbent upon the clinician to provide specific instructions on who to contact and how to proceed if an emergency situation arises. However, it has been my observation that when individuals and agencies other than the therapist – such as friends, relatives, crisis hotlines, day treatment facilities, or hospital emergency rooms – are identified as the ones to seek out in these circumstances, crises occur extremely infrequently (Gold, 2000, p. 100).

In Gold's own practice, he found that "…when the terms under which the therapist will be available between scheduled sessions are kept relatively restricted and meetings do not occur more than once weekly, the client's self-sufficiency and security are usually augmented" (2000, p. 100). In this sense, clinicians should be aware of how to be a support to clients without reinforcing already common feelings of inadequacy in many survivors, providing just enough support for them to move toward independence constructively.

Conclusion

The purpose of this chapter has been to outline various aspects of the family contextual treatment model (Gold, 2000) in order to compare its approach to treatment with PCA survivors to that of narrative therapy (White, 2004, 2007a, 2007b). The

contextual model (Gold, 2000) pulls from many different theoretical sources and integrates many different practice methods to create a model specific to adult survivors of prolonged childhood abuse. Over time, proponents of this model have found that treatment is often most successful when, within a general structure, flexibility is used and:

> …a pattern of alternately concentrating on acquisition of remedial living skills, examination and progressive fortification of the therapeutic alliance, exploration of the influence of the family-of-origin environment on present-day functioning and beliefs, investigation and amelioration of the impact of abusive experiences on current adjustment, and analysis of the relationship between these various domains can be allowed to emerge. The sequence of fluctuating emphasis on these tasks will vary considerably from one client to another, and from one point in treatment to another. It will follow a logic that is determined by the needs and circumstances of each individual, and will unfold primarily under her or his direction (Gold, 2000, p. 120).

This is a brief overview of the complexities of this model and of the broad range methods it has been designed to incorporate, all grounded in a deep respect for PCA survivor clients.

CHAPTER V

NARRATIVE THERAPY AND WORK WITH PCA SURVIVORS

In this chapter, I will first present a brief overview of narrative therapy in order to articulate its applicability to therapeutic work with PCA survivors. I will then speak to the role of the therapist in this practice, followed by the general structure of this kind of work and the major techniques often used. The case of Deanna will be used to provide examples of what the major techniques used in narrative therapy might look like when applied.

Rather than being considered a theory or an approach, narrative therapy consists of practices that are first and foremost reflective of a certain worldview or attitude about reality (Freedman & Combs, 1996; White, 1995, 2007b). This worldview can be described as a postmodern philosophy based on social constructionist theory and narrative metaphor, as opposed to a modernist worldview which believes in the existence of an objective, essential reality or "truth" (Freedman & Combs, 1996). According to this postmodern worldview, realities are socially constructed, are constituted through language, and are organized and maintained through narrative. Thus, there are no essential truths (Freedman & Combs, 1996).

Given these basic assumptions, preferred realities can be developed through narrative and social interaction, which is one of the major aims of narrative therapy. Its practices often help people to deconstruct how "modern power structures" (using ideas

borrowed from Michel Foucault) and/or more powerful others contribute to the creation and maintenance of "problem-saturated," "dominant" storylines and negative identity conclusions, thus opening up space for "re-authored" identities reflecting a positive sense of self and personal agency (White, 2007b). Narrative therapy therefore has the potential to be incredibly powerful for PCA survivors, who often present with very fragile, tentative, and negative self-concepts. By fostering the "redevelopment and reinvigoration" (White, 2004, p. 45) of what Michael White calls a "sense of myself" in therapy with people who have undergone significant trauma, development that reflects a preferred and strengthened sense of self can proceed. People can begin to act on a foundation of what they value and on an enhanced self-concept.

This process is seen as the foundation of narrative therapy and evolves through the social collaboration between the therapist and the person seeking his or her consultation. Below, I will give an overview of the role of the therapist in this work and of the major practices stemming from a social constructionist/narrative worldview as they relate to work with PCA survivors. I will use the case of Deanna to ground these descriptions and to give examples of this type of work.

The Role of the Therapist

In narrative therapy, the clinician's roles vary from that of a witness to a social collaborator (via editorializing or reflecting back to the person what the therapist has heard him/her say), and from an "investigative reporter" to a facilitator (White, 2004, 2007b). Clinicians operating out of a narrative worldview are careful about refraining from using traditional affirmations (i.e., "that's wonderful!") so that they are able remain

in the role of a collaborator as much as is possible, allowing clients to define and make meaning out of their own experience. Similarly, it is the therapist's job to ask the kinds of questions that will help people to deconstruct and reconstruct their own stories, and not for the therapist to do this for them. The stories, the words, and the deductions of the people coming to therapy are always the ones that are privileged. Given that they are the ones who are most knowledgeable about their own lives, people coming to therapy are thus put in the "expert" role when it comes to understandings about their lives, thereby displacing more traditional hierarchies of power. This shift is reflected in the language narrative therapists use to speak about the people with whom they work, referring to them as "people seeking consultation" rather than as "clients" or "patients." This shift can begin to alter the self-perceptions of people coming to therapy, and especially PCA survivors, who often have had to endure roles where they have no sense of power or where their sense of personal agency is purposefully targeted and diminished.

Narrative therapists listen to both the story the person consulting them originally presents, which in the case of PCA survivors is often a problem-saturated narrative containing negative conclusions about who they are, and for untold or "thinly known" stories which are exceptions to or in opposition of the dominant narrative this person carries about their identity. Michael White (2004) talks about "doubly listening" or "listening for two stories" as a therapist. In using these terms, he was specifically referring to trauma work, where the therapist needs to make space for both the witnessing of untold stories of the trauma itself, to the extent that the person needs to tell them, and also for the person's responses to the trauma, and specifically what values they were able to hold onto despite enduring abuse and/or trauma. An example might be a person who

reports feeling despair with regard to an upbringing characterized by abuse and neglect, who tells his or her story through this lens of despair. In this case, a narrative therapist might end up asking how this person knew to feel despair over these circumstances (did they ever experience circumstances different from these?), what this feeling of despair in response to this history says about how this person feels about his or her history, and what this says about what he or she values in life (White, 2007b). In this way, the person's response to the trauma is highlighted and the development of a subordinate storyline can begin. Personal agency is also implicitly reflected by this line of questioning, as it emphasizes that whether the person's response to trauma occurs in the form of thoughts, feelings, or actions, no one is a passive recipient of trauma.

This idea of "doubly listening" and the type of inquiry that follows can also be applied in a much larger sense to the work of a person practicing narrative therapy, since the difficulties PCA survivors initially present with may or may not be obviously connected to the trauma they have endured. In this way, Michael White's description of "doubly listening" overlaps with the narrative stance of listening for the "absent but implicit" in people's stories (White, 2007b).

The important pieces for practice, therefore, are (a) that the therapist bear witness to any material the people consulting him/her might need to share about their experiences, including traumatic material; (b) that s/he assist people with questions that help to "unpack" certain negative conclusions they may have drawn about their lives or identities, looking at how they were "recruited" into these beliefs and "checking back" or reflecting for them what s/he has heard from him/her; and (c) that the therapist listen for and inquire about the "absent but implicit" material in people's stories, looking to thicken

a sense of what people give value to in their lives and to assist the person in building an alternate storyline of their life that reflects personal agency. In this way, the negative, dominant storyline they currently carry around with them is diminished. These three aspects of practice correspond to the roles of witness, investigative reporter, and social collaborator/facilitator that the therapist often plays in narrative conversations.

Thus, if Deanna had, through previous narrative conversations, described her daily experience as "dealing with self-hate," the therapist might ask questions about what voices have supported self-hate throughout her life, about where self-hate gets its power from, and about what voices weaken or have protested the power of self-hate. These questions would help Deanna to begin to deconstruct how self-hate came to be a major presence in her life, along with the history and politics that have contributed to this. Once the "hate" Deanna described was more accurately understood (perhaps at her mother for not protecting her, at either of her parents for not being able to care for her, etc.), the therapist might ask what this feeling of hate, or other identified feelings underneath it, says about what Deanna values in life. This, in turn, could lead to a discussion of the importance Deanna places on the protection of children or it might be an expression of Deanna's sense that she deserved love as a child. Whatever the outcome, it is this story that would be richly attended to and thickened by the therapist's inquiry. In this process of "thickening" subordinate storylines, the therapist acts as a social collaborator, trying to assist the person in moving from what is known and familiar to what is possible (White, 2007b).

In order to develop alternate storylines, therapists often engage in a process known as "scaffolding" with the people consulting them. This process, based on Russian

psychologist and developmental theorist Lev Vygotsky's ideas about how learning takes place, allows the therapist to assist the people consulting him or her with negotiating, in manageable steps, the process of gaining distance from what is familiar to them (dominant narratives) and crossing into territories of what might be possible (subordinate narratives) (White, 2007a).

> It is in traversing this gap between the known and the familiar and what is possible that people experience a newfound sense of personal agency: a sense of being able to regulate one's own life, to intervene in one's life to affect its course according to one's intentions, and to do this in ways that are shaped by one's knowledge of life and skills of living (White, 2007a, pp. 263-264).

Unfortunately, the "inability" to traverse this gap and to influence the shape of one's life on one's own is often storied as a validation of a person's inadequacy or incompetence in many dominant cultural narratives. What does not get talked about in these stories is how power and privilege operate in keeping people from being easily able to shape and to feel good about their own life. For this reason, it can be incredibly empowering for people to have a context in which to question and address how power is operating in the definition and narrative of their lives. This process is part of "separating from the familiar," and is arrived at through the types of questions the therapist (or others, in certain narrative practices which will later be discussed) asks and when he or she asks them. In this way, therapists' questions and reflections help to "scaffold," or structure, conversations so that the people consulting them can distance themselves from familiar narratives in which they often feel "stuck" and can begin to develop alternate narratives according to what they value and what might be possible in their lives. People can then move toward developing or re-developing a sense of personal agency and the sense that they have the ability to address the changes they feel need to be made in their lives. The

following section will further detail the kinds of conversations that help to structure this journey.

The Structure of Therapy

In his book, *Maps of Narrative Practice* (2007a), Michael White details major types of narrative conversations used to structure the work of many narrative practitioners. In the interest of clarity, I will give an overview of these in order to describe what therapy might look like with PCA survivors when the social constructionist/narrative worldview is used as a guide. Although these "types" of conversations are listed separately for explanatory purposes, they are often interwoven in practice.

Externalizing Conversations

Externalizing conversations "employ practices of objectification of the problem against cultural practices of objectification of people" (White, 2007a, p. 9). By separating the problems people struggle with from their identity, people then can choose what kind of a relationship they want with that problem or how and when they want to go about keeping it from exerting its influence.

Externalizing conversations begin with a detailed and "experience-near" description of the identified "problem." In Deanna's case, she came into treatment talking about how she has "anger problems." The therapist might ask how she knows when she is under the influence of anger, what her body feels like, and in what kinds of situations it is most likely to manifest. Once the problem is clearly and specifically defined, the next step is to detail its effects. How has anger affected her life? How does it help her, and

how does it hurt her? Are there times when she appreciates its influence? When does she most wish she could keep it at bay? Does it ever get in the way? Third, an evaluation of the effects of the problem takes place, followed by a justification for this evaluation (White, 2007a). Are the ways that anger influences Deanna's life okay with her? Why or why not? Is there a story she might be able to share from her life that would shed some light on why these effects are or are not okay with her? Through this line of questioning, it is possible that Deanna might come to see anger's effects as both positive and negative in her life. In looking at times when she appreciates its influence (usually the more thinly-storied of the two), she might come to see that it allows her to stand up for herself occasionally - perhaps when, deep down, she doesn't feel that she deserves a certain kind of maltreatment. This realization might lead into a discussion of the part of her that doesn't believe she is worthless, unlovable, and inherently problematic. Getting in touch with the side of anger that doesn't let her completely believe she is deserving of maltreatment might also help Deanna to investigate how she might use this knowledge (of justified anger) toward more helpful and proactive actions in her life. Deanna's therapist might also ask questions to wonder with Deanna about what this kind of anger might be renamed. This would be articulated by Deanna but might end up being something like "protest" regarding the way she was being treated, or a "reminder that she deserves better."

Re-Authoring Conversations and Highlighting Unique Outcomes

In re-authoring conversations, people are asked to look at some of the moments or stories of their lives that have not been assigned particular significance and that do not play a part in the storyline they currently carry about themselves.

> Re-authoring conversations invite people to continue to develop and tell stories about their lives, but they also help people to include some of the more neglected but potentially significant events and experiences that are 'out of phase' with their dominant storylines (White, 2007a, p. 61).

In this way, narrative therapists use specific types of questions to search for "unique outcomes" or "exceptions to the dominant storyline" in peoples' lives. Examples of this type of questioning in Deanna's case might include: Has there ever been a time when self-hate was not present in Deanna's life, even for a moment? Or, in the case of the 'problem' of anger described above, Deanna's therapist might ask what this anger or 'protest' regarding the way she was being treated might say about her beliefs about what she deserved? How did she know to get angry in these circumstances? What does this anger or "protest of maltreatment" say about what she believes in and values? These neglected or "thinly remembered" stories can provide starting points for re-authoring conversations, as they begin to build subordinate storylines that can eventually call into question and even overpower previously destructive dominant storylines.

Another possible line of questioning to bring about unique outcomes (and to break down the power of dominant storylines) might include asking Deanna questions that portray someone else's life that might be similar to hers. In Deanna's case, she had a cousin who was being brought up under circumstances that were familiar to her, and of whom she was very protective. The therapist might ask if Deanna felt her cousin did

something to deserve the kind of treatment she was being subjected to. Deanna's therapist might also ask why Deanna did or did not think that her cousin deserved this kind of treatment. Depending on Deanna's response, a follow-up question might be: How did Deanna know that her cousin was lovable and important despite what was being communicated to her by her cousin's mother? If Deanna had an older cousin like herself, what might that older cousin say about Deanna? Would she say she deserved the kind of treatment she received? Why or why not? Without a specific inroad to this line of questioning such as Deanna's relationship with her cousin could have been, a therapist could also use a photo of a five-year old child and could simply tell a story about them. Looking at this five-year old child, what does Deanna believe this child deserves? These are just a few possibilities as to how to develop storylines that highlight unique outcomes.

Questions that are intended to bring about the storying and "thickening" of unique outcomes are called *landscape of action* questions. Here, the therapist is looking for more details and additional stories that strengthen the subordinate storyline that has started with the identification of a unique outcome. How did this "exception to the rule of the person's dominant storyline" even become a possibility? Are there any prior experiences this person can think of that might have opened him or her up to this possibility? Why did this person not just ignore it or shut it out? Expanding on the conversation about anger or "protest" described above, Deanna's therapist might ask questions about possible experiences in her life that might have taught her that being maltreated was not a given in life, and that she had a right to protest this? How did she know that she could or that she had a right to get angry under these circumstances? Who

was involved in these experiences? What about these experiences was different than how she had otherwise been treated?

Along with *landscape of action* questions, re-authoring conversations also include *landscape of identity* questions. Michael White (2007a) speaks of having drawn significantly on the work of Jerome Bruner (1986) to guide him in the process of helping people engage in meaning-making activities that support the development of subordinate storylines:

> Bruner, borrowing significantly from the literary theorists Griemas and Courtes (1976), proposed that stories are principally composed of two landscapes – a 'landscape of action' and a 'landscape of consciousness' [renamed the 'landscape of identity' by Michael White]. The landscape of action is the 'material' of the story and is composed of the sequence of events that make up the plot and the underlying theme. The landscape of consciousness is composed of 'what those involved in the action know, think, or feel, or do not know, think or feel (pp. 77-78).

In this way, *landscape of identity* questions ask people to draw new conclusions about their identities based not only on the unique outcomes and exceptional stories being developed in therapeutic conversations, but also on the intentions and values they hold in their lives. A narrative therapist might ask Deanna what it might say about her own life that she does not believe that the child in the photo could have done anything to deserve being abused or unloved. If Deanna had been able to recall any experiences, however small, where she had felt even somewhat lovable, questions would be asked to thicken the story of these experiences and would be followed by *landscape of identity* questions, asking her to draw new conclusions about herself based on what she felt under these other circumstances. What did she recognize in herself or what was it that this person

recognized in her that let her know she was deserving of love? What does it say about who she is that she or this person was able to recognize these qualities in her/herself?

> Another characteristic of landscape of identity questions is the use of the subjective stance…characterized by terms like *as if, perhaps, maybe, might be, possibly*, and so on"…"this subjective stance displace[s] the mood of certainty and inevitability" that is often a pervasive part of people's self-descriptions (White, 2007a, p. 100).

In Deanna's case, these kinds of questions might include the following: If you could have had X (a figure already identified as viewing Deanna in a positive light, or even herself) as a parent instead of growing up under the circumstances you did, how do you think you might see yourself differently today? Another question that takes into account the effects of intergenerational trauma clearly seen in Deanna's family history might be: If your mother had been protected and loved as a child, how might this have changed the way she parented you? How might this have changed the way you see yourself?

Yet another major way to assist the development of new identity conclusions is to ask about a person's values, beliefs, aspirations, hopes, goals, purposes, and/or commitments. Working as a narrative therapist, I could have asked Deanna what her 'protest' around the maltreatment she was subjected to says about her hopes and beliefs, or what her protectiveness over her younger cousin says about what she values, believes, hopes for, and what she is committed to in her life. What do these commitments, hopes, beliefs, and values say about who she is as a person? What kinds of things might her cousin say about who she is as a person? If a stranger were in the room now observing this conversation, what kinds of conclusions might they draw about what Deanna stands for? And moving forward with this storyline in time: What further kinds of actions might Deanna take in her life that would be in line with these hopes and values?

In many Western cultures, people often make identity conclusions about themselves and others based upon the idea of a "core" or "essential" self. This perspective tends to lead to fixed ideas about who one 'really is,' where the outer world and one's experiences are merely a reflection of these internal characteristics. Michael White refers to this concept of there being an "essential self" within each person as reflecting *internal state conceptions* of peoples' lives and identities.

> Internal understandings tend to: diminish the sense of personal agency (according to internal understandings, people's lives are lived by the elements and essences of the self, not shaped by actions taken under the influence of the intentions and values that one is embracing); be isolating (according to internal understandings, human expression is conceived as one of a singular self, not as an expression of life that is the outcome of the story of one's life being linked with stories of the lives of others around shared and valued themes); discourage diversity (internal understandings are shaped by global norms about life that promote a modern ideal of the 'encapsulated self' – one that valorizes notions of self-possession, self-containment, self-reliance, and self-actualization) (White, 2007a, pp. 104-105).

Because of the limitations of this perspective in allowing for change or alternate meanings, narrative therapy tends to emphasize and to believe in *intentional state understandings*, or conclusions drawn about a person's identity that are based on a person's hopes, purposes, values, beliefs, aspirations, goals, and commitments (White, 2007a). In this way, people are seen as active, fluid beings whose "selves" are continuously created and recreated.

> In contrast to internal state conceptions, intentional state conceptions of identity are distinguished by the notion of 'personal agency.' This notion casts people as active mediators and negotiators of life's meanings and predicaments, both individually and in collaboration with others. It also casts people as the originators of many of the preferred developments of their own lives: People are living out their lives according to intentions that they embrace in the pursuit of what they give value to in life; they are going about the business of actively shaping their existence in their effort to achieve sought-after goals (White, 2007a, p. 103).

In this way, people can engage in self-definition. Looking at identity from this perspective makes it much harder for PCA survivors to be defined by what happened *to* them, and opens space for them to be defined by their reactions to things they have had no control over and by what they have continued to stand for and to assign value to in their lives. In Deanna's case, she came into therapy being obviously defined by an internal state understanding of herself as someone who was inherently worthless, unlovable, and deserving of maltreatment. This story was created and reinforced by extremely damaging external influences in her life, and her behaviors then reflected what she believed was the "truth" about herself. Using an intentional state conception of identity, however, Deanna could be asked questions that might lead her to come to different understandings about who she is. She could be asked questions about what her actions to protect her younger cousin say about what she stands for, about what it says about her that she is able to love and protect someone else despite the fact that she often had to feel unloved and unprotected, and about how she was able to hold onto these values despite the trauma she has had to endure in her life. She could also be asked questions about what hopes, values, and beliefs are connected to her tendency to protest being maltreated personally.

Finally, storying a sense of continuity of self despite traumatic experiences is important for the PCA survivor population. In this way, people's self-definitions can be based on their purposes, values, and hopes in life rather than on what has happened to them. The consistent thread is not what they have had to endure, which they had no control over, but rather the values and commitments they have been determined to hold on to throughout their lives *despite* what they have had to endure. This sense of identity

and personal agency can also help PCA survivors to imagine what actions they might take in the future that are in line with this new understanding of themselves. Living out of an understanding of herself as a person who is determined not to let anything or anyone take away her capacity to love others and to provide protection to those who most need it would give Deanna a very different sense of herself. This self would be one who is in control of how she defines herself and what she values. By further developing her understanding of her role in the protection of her younger cousin, she might also come to revise whether or not she believes she deserved to be maltreated as a child. This new understanding might eventually rid Deanna of the need for the self-destructive, self-blaming, self-injurious actions that had characterized her younger adolescent years, and might instead lead her to feel a greater sense of purpose in standing up for those who have endured circumstances similar to hers.

Re-Membering Conversations

Re-membering conversations (a term Michael White derived from Barbara Myerhoff, a cultural anthropologist) "are shaped by the conception that identity is founded upon an 'association of life' [or a "club of members"] rather than on a core self" (White, 2007a, p. 129). Identity, then, is seen as "multi-voiced" and constructed. Another way of saying this is that we all have relationships with significant figures and past, present, and potential future identities (members of what makes up our "association of life") that play a role in and make up the "voices" from which our current identities are constructed. Through re-membering conversations, people are offered the chance to decide which voices they are going to empower in the construction of their identity, and,

alternately, which voices they might choose to demote or to disregard altogether. "Re-membering conversations provide an opportunity for people to engage in a revision of the membership of their associations of life, affording an opening for the reconstruction of their identity" (White, 2007a, p. 136).

Michael White (2007a) describes re-membering conversations as "not [being] about passive recollection but about purposive reengagements with significant figures and with the identities of one's present life and projected future" (p. 129). These reengagements do not have to be with people one knows personally, although they can be. But they can also be, among other examples, reengagements with a character in a book, a pet, a famous singer, a writer, someone who has since passed away, a historical figure, or even a spiritual figure.

Once a figure who might reflect an aspect of a person's preferred identity has been named, the areas of inquiry that often define and shape re-membering conversations can be broken down into four parts. The first part focuses on what a given significant member contributed to this person's life. In Deanna's case, she might have named her grandmother as a figure around whom she can remember feeling somewhat special. Her grandmother passed away when Deanna was young, so that Deanna did not have many specific memories of her, but had a vague sense of how she felt in her presence. After much questioning, it became apparent that Deanna considered her relationship with her grandmother to be a significant relationship in her life. In terms of thinking about what her grandmother contributed to her life, Deanna might say that her grandmother was the only one in growing up who ever really paid attention to her. Deanna can remember her

grandmother smiling at her and playing with her, along with giving her hugs and affection when she would visit.

The second area of inquiry often involved in re-membering conversations involves "witnessing his or her identity through the eyes of this figure" (White, 2007a, p. 139). What might Deanna's grandmother's engagement with her during her visits say about whom Deanna was to her or what she saw in Deanna? Posed with this question, Deanna might say that her grandmother saw something special in her, that she saw hope in the way Deanna was very opinionated and stubborn at that age – strong, even – and that Deanna might be able to do better for herself in her life than her mother or even she herself had; Deanna might not allow herself to be in an abusive relationship as they both had been. She might say that her grandmother could see the strength of her spirit inside of her. In his writings, Michael White (2007a) talks about how surprised the people consulting him often are that they have come up with such statements about themselves, but that this kind of questioning really allows space for different memories and identity conclusions to surface.

The third area of inquiry involved in re-membering conversations centers around the *person's* contribution to the *figure's* life (White, 2007a). This part of the conversation can often be difficult for people who do not see themselves as having much to give, but is all the more crucial for this reason. It is not uncommon for the therapist to engage in scaffolding this part of the conversation when the person consulting them has a hard time coming up with an answer or even imagining the possibility that they could have had a positive effect on someone else's life. If Deanna was not able to provide an answer to questions about what effect she may have had on her grandmother's life, questions to

break this down might potentially look like the following: Did you accept your grandmother's affection toward you, or did you run away from it or reject it? (Deanna might say that she hugged her grandmother back.) What do you think it might have been like for your grandmother to have you to accept her affection? (A possible response from Deanna might be that it made her grandmother feel good.) What message do you think that your response to her affection gave her? (Deanna might say that it let her grandmother know she loved her.) What do you think about what your responsiveness to her affection might have brought to her life? (Deanna might talk about how her grandmother and her mother always had a conflict-ridden relationship, and how Deanna's returned affection for her might have brought her joy and peace to know that Deanna – or someone - cared about her.) How might her life have been different because of your responsiveness? (Here, Deanna might talk more about the relationship between her mother and her grandmother, and how, with Deanna, her grandmother had a "second chance" to make a more positive impact on the family. Because of Deanna's ability to accept her grandmother's affection and her grandmother's ability to give it at that time, Deanna might say that she provided her grandmother with some hope for their family going forward.)

Finally, the fourth area of inquiry involved in re-membering conversations explores the "implications of this contribution for the figure's identity" (White, 2007a, p. 140), or how "this connection shaped or has the potential to shape this figure's sense of who he or she was and what his or her life was about" (White, 2007a, p. 139). Specific questions for Deanna might be: How do you think your connection with your grandmother might have shaped her sense of purpose in life? Do you have any ideas

about how your grandmother's sense of her own life might have been different because of knowing you the way she did? To these questions, Deanna might eventually be able to come up with a response having to do with her grandmother's struggle at watching Deanna's mother get into multiple abusive relationships, not respecting or standing up for herself (or her kids) at all. She might say something about how perhaps her grandmother saw potential in her (Deanna) to do something different in her life that would give all of the struggles her grandmother and mother had been through some kind of meaning.

If we look at what kinds of statements Deanna might be making toward the end of this conversation, it becomes obvious how powerful re-membering conversations can be for PCA survivors. In addition to enhancing positive connections in their lives, re-membering conversations also help PCA survivors to rebuild that crucial piece for survivors of complex trauma that Michael White talks about – a sense of themselves. This is evidenced above in the way "Deanna" characterizes herself as strong, opinionated, and having the potential to resist abusive relationships – all qualities she can identify as being with her from the time she was a child. By re-connecting with these qualities, Deanna has the chance to re-claim them as aspects of her preferred identity.

Definitional Ceremonies

Definitional ceremonies are another narrative practice that Michael White emphasizes in his discussions on working with those who have survived the consequences of multiple and complex trauma (2004). I will first describe them in order to then talk about their particular potential significance for PCA survivors.

In this ritual, a person is asked to tell their story, led by mutually pre-chosen questions asked by the therapist, in front of one or more "outsider witnesses" (another term White borrowed from Barbara Myerhoff). The outsider witnesses are told to stay in an audience position, never directly interacting with the person telling their story. Once the therapist feels that the person telling their story has been able to speak about much of what they wanted to present, and feels the outsider witnesses have sufficient information to respond to, he or she will ask the person and the outsider witnesses to switch positions. At this point, the therapist will interview the outsider witnesses about what they heard according to a very specific line of questioning, and the person whose story is at the center of the ceremony will now be in the audience position. Finally, once this line of questioning has contributed to the rich story development of the original person's story, and once the major categories of questions have been answered by all outsider witness participants, the therapist will again ask the outsider witnesses to return to an audience position as he or she now interviews the person whose story has been the focus of the ceremony about what they heard and responded to in the outsider witness retellings (although here the focus remains on what images, metaphors, etc. were evoked in regards to his or her *own* life by the retellings of the outsider witnesses).

The categories of inquiry the therapist uses to shape both the retellings of the outsider witnesses and the follow-up interview of the central person are "not so much about empathy and sympathy but about resonance" (White, 2007a, p. 188).

> It is not the place of outsider witnesses to form opinions, give advice, make declarations, or introduce moral stories or homilies. Rather, outsider witnesses engage one another in conversations about the expressions of the telling [by the person being interviewed] they were drawn to, about the images that these experiences evoked, about the personal experiences that resonated with these

> expressions, and about their sense of how their lives have been touched by the expressions (White, 2007a, pp. 165-166).

In order to assure these types of responses, the therapist plays an active role throughout the session and outsider witnesses are prepared in advance for what this ceremony will look like and what kinds of responses will be expected from them. The four main categories of inquiry used to shape the retellings of the outsider witnesses (and later to shape the central person's response to the retelling) are:

- What particular expressions (words, phrases, moods, sentiments) were you most drawn to in what you heard – what caught your attention? What expressions provided you with a sense of what this person accords value to in life?
- What images came to mind for you as you listened? (These images can be in the form of metaphors about the person's life, mental pictures of the person's identity or relationships, or any image or "sense" evoked from the person's story.) What might these images reflect about what this person intends for his or her life or what he or she accords value to? What might these images say about this person's life and identity?
- Why do you think you may have been most drawn to these particular expressions – what might they have connected you to in your personal history? What experiences in your own history came into memory on account of these expressions?
- How have you been moved by this experience you've had of being present to witness these stories of life? (Here, "moved" is meant to express any number

> of experiences, including movement of understanding, emotional movement, movement toward new ideas on how to take action, etc.) How has your life been "touched in ways that have contributed to your becoming someone other than who you were before you witnessed the person's expressions and had the opportunity to respond to them" (White, 2007a, p. 192)?

When the interview turns back to the central person's experience of the outsider witness retelling, the response is often quite profound.

> In these outsider witness retellings, what people give value to in their acts of living is re-presented in ways that are powerfully resonant and highly acknowledging. Additionally, it is through these retellings that people experience their lives as joined around shared and precious themes in ways that significantly thicken the counterplots [subordinate/preferred stories] of their existence (White, 2007a, p. 166).

For PCA survivors, feeling seen for what they value in life along with the experience of having a positive impact on others' lives is often overwhelming and new. Michael White uses a poignant quote from Barbara Myerhoff's writings about the aims of definitional ceremonies:

> Definitional ceremonies deal with the problems of invisibility and marginality; they are strategies that provide opportunities for being seen and in one's own terms, garnering witnesses to one's worth, vitality, and being (as cited in White, 2007a, p. 181).

If Deanna were able to participate in a definitional ceremony, there would undoubtedly be numerous aspects of her life that would probably resonate for others. Here, I will use the example of her protectiveness of her younger cousin – making sure she was always fed, staying at her cousin's house overnight when her aunt was out dealing and/or prostituting herself, encouraging her cousin in her schoolwork, and voicing her opinion about the conditions under which her aunt was forcing her cousin to

live because of her addiction. When an outsider witness (e.g., a female) to these stories was asked what stood out for her, she might point to the detail about Deanna's ability to voice her opinion about the conditions under which her cousin was being forced to live. She might speak about how this seems to strongly suggest the extent to which Deanna values the protection of children and their right to grow up under safe and loving circumstances. An image that might be evoked for her could be that of a shelter – a structure to protect children, with Deanna standing guard over the shelter, withstanding any storm that might go by. This image could be said to speak to Deanna's strength: to have been unprotected herself and to have weathered countless storms, getting knocked down over and over again, and yet to be determined to stand up for and to protect others who might be growing up under similar circumstances. When this outsider witness was asked why she may have been drawn to this particular expression and image, she might speak about her own experience of being in an emotionally abusive relationship where she kept getting metaphorically "knocked down" time and time again. She might comment on how many years it took her to exert any of her opinions at all – and how Deanna's actions of speaking up for her cousin took her back to that feeling of the first time she had the confidence to speak up for what she thought was right. When asked how her life has been touched or moved by being a witness to Deanna's story, this outsider witness might express renewed confidence in herself, looking back on how much she has grown since being in that abusive relationship, and in her right to have and express her opinions.

At this point, the therapist would either interview this woman about other expressions that stood out for her, would interview other outsider witnesses present at the

time, or would have Deanna and this woman switch positions again so that Deanna could be interviewed about what she was most drawn to in the outsider witnesses' retellings, what images came to mind for her (images that were evoked about her *own* life by the retellings), the personal experiences that the expressions within the retellings touched on, and "where these expressions of the outsider witnesses had taken [her] to in [her] thoughts on, understanding about, and perceptions of [her] own [life] and in [her] reflections on possibilities for action" (White, 2007a, p. 197). Depending on time, this retelling would either conclude the ceremony or another round of retellings might take place.

Conclusion

Narrative therapy is predominately shaped by postmodern philosophy, social constructionist theory, and narrative metaphor. In all of its techniques and practices, it is most important that the therapist operate out of this worldview as a whole. This can be challenging in many of today's environments, which necessitate the use of the medical model for purposes of reimbursement and where anyone operating out of this worldview is often surrounded by many others coming from internal state understandings of people and operating out of a belief in objectivity. For PCA survivors however, who frequently present with a multitude of diagnoses and years of treatment by the time they enter adolescence, the experience of working with someone who embraces this worldview can be a uniquely positive experience.

CHAPTER VI

DISCUSSION

In this inquiry, narrative therapy (Denborough, 2006; Freedman & Combs, 1996; White, 1995, 2004, 2007a, 2007b) and the family contextual treatment model (Gold, 2000) have been outlined in order to further analyze what "best practice" entails with adolescent PCA survivors. These "approaches" were chosen as candidates for articulating what constitutes "best practice" with this population because of their current broad and contextualized treatment emphasis as opposed to the more focused, evidence-based treatments typically associated with PTSD. In order to compare and discuss these two therapeutic philosophies and practices as they pertain to the treatment of adolescent PCA survivors, however, an important overarching distinction between them needs to first be reinforced. This is done in the next section. A discussion ensues on the important ways in which these approaches overlap and differ, followed by a presentation of implications for practice. Finally, the methodology of this research is reviewed, recommendations for future research are outlined, and an overall conclusion is offered.

Complexities of Generalization and Comparison

Being a worldview based on postmodernism (Bruner, 1986; Bruner, 1990; Foucault, 1980), social constructionism (Berger & Luckmann, 1966; Bruner, 1986; Foucault, 1965, 1980; Geertz, 1986; Gergen, 1985; von Glasersfeld, 1987), and the

narrative metaphor (Bruner, 1986; Geertz, 1986), narrative therapy (Freedman & Combs, 1996; White, 2007a) does not share a common language with practices stemming from more traditional psychotherapeutic theoretical roots (see, e.g., Berzoff, Melano Flanagan, & Hertz, 2002; Mitchell & Black, 1995). Further, the work of the narrative therapist reflects this postmodern, social constructionist worldview more than it adheres to any specific treatment model or structure (Freedman & Combs, 1996). Its practices are therefore difficult to generalize, and as a whole there are many complexities inherent in comparing it with concepts derived from psychodynamically inclined models. It is with these challenges in mind, however, that I compared it to the family contextual treatment model (Gold, 2000), which stems from a number of theoretical backgrounds, including psychodynamic (Alexander, 1993; Bartholomew & Horowitz, 1991), trauma (Finkelhor, 1980, 1990; Herman, 1992), systems (Friedman, 1997), and cognitive-behavioral thought (Beck, 1979; Hoyt, 1996; Linehan, 1993).

In order to avoid being overly cumbersome, I refer to narrative and contextual therapy here as approaches, although the narrative stance is more accurately a worldview and generally refers to itself as such (Freedman & Combs, 1996; White, 2007a).

Comparing Narrative and Contextual Therapy: Toward Defining "Best Practice" with Adolescent PCA Survivors

On a broad level, the narrative approach (White, 2004, 2007b) to working with survivors of multiple or prolonged trauma has much in common with the family contextual treatment model (Gold, 2000). The principles they share speak to their mutual understanding of the fundamental differences between working with survivors of single-

incident trauma and those with a history of prolonged childhood abuse. I will first speak to this and other major areas of overlap between these approaches, all of which should be carried over into any model of treatment with adolescent PCA survivors, and will then elaborate on where they part ways. Because a larger discussion on the differences between postmodern, social constructionist philosophy and psychodynamic thought is beyond the scope of this paper, I focus on areas of similarity and difference within these approaches that can help to ascertain best-practice implications for working with adolescent PCA survivors.

Important Parallels between Narrative and Contextual Therapy

Two related and important aspects of narrative (White, 2004, 2007b) and contextual therapy (Gold, 2000) as applied to work with PCA survivors are that they are trauma responsive without being trauma focused and that the exploration of any traumatic material or details within each is always client-directed. To be trauma responsive is to acknowledge and address the impact of trauma without assuming that it is at the core of treatment, while being trauma focused is to center treatment around the exploration of and gradual exposure to traumatic memories. Thus, in both narrative (White, 2004, 2007b) and contextual therapy (Gold, 2000), the people who enter treatment define the sources of their current problems and are considered the experts when it comes to their lived experience. Since it is more often the larger pattern of feeling unloved and unprotected that PCA survivors find most difficult in their lives rather than discrete incidents of trauma (Gold, 2000) processing specific traumatic memories will only occur if they feel it is necessary to improve their general functioning (e.g., experiencing

flashbacks). Further, this path will only be taken if and when clients are ready to do so (usually after a strong foundation has been built), and is always at their pace and discretion. These shared principles are essential to working with PCA survivors, because they allow clients to define their own experience and to be in control in a world where they otherwise often feel powerless. These aspects of the work (self-determination and self-definition within the therapeutic context) alone can begin to build the "sense of self" that prolonged trauma either breaks down or that prevents development in the first place. Further, by allowing clients to define the elements or experiences contributing to their current difficulties, discrete traumatic incidents emerge in titrated form and only as necessary (Gold, 2000). This significantly decreases the risk of clients becoming overwhelmed and re-traumatized by the treatment process and also lowers the chances of clients' defining themselves based on trauma.

A second important principle shared by the narrative (White, 2004, 2007a) and contextual (Gold, 2000) stances is that they do not pathologize clients. Both approaches see people in a larger social context that has failed them in fundamental ways, and both support people in deconstructing the negative beliefs about themselves and others as a result of these contexts. Again, these are pivotal components of therapy with PCA survivors. If practitioners cannot see the potential origins of the many types of behaviors that PCA survivors may present and how many so-called maladaptive patterns may have been essential for survival, treatment will at best be superficial and at worst reproduce traumatizing and blaming dynamics that are all too familiar to the client. Similarly, providing a context to question and "unpack" negative beliefs and identity conclusions is

essential to work with this population, because a sense of self as shameful, damaged, or essentially bad is often one of the core issues for PCA survivors (Allen, 2001).

Third, both approaches are conceptually-driven rather than driven by protocol. This allows each approach to have an overall philosophy from which to structure clinical work without being that structure being rigid. Further, they each offer specific practices that are congruent with those philosophies, giving clinicians a better guideline of how treatment should actually look.

Both approaches also emphasize collaboration between the therapist and the client, although it is within the particulars of this collaboration that they begin to differ considerably.

Applicable Differences between Narrative and Contextual Therapy

Although much could be said about the more general philosophical disparities between these two approaches, I will focus here on a few major differences that have concrete implications for practice with adolescent PCA survivors. The first is the structure or the "direction" of each approach.

General Approach: "Grass-Roots"/"Bottom-Up" Vs. "Top-Down." Narrative therapy (White, 2004, 2007b) can largely be considered a "grass roots" or a "bottom-up" approach in the way it conceives of treatment with survivors of multiple trauma. Instead of using a collaborative alliance to assess and alleviate symptoms or to build skills, its main focus is to help people reconnect to a sense of meaning, belonging/connection, personal agency, and self. This is the foundation of treatment, and it is from this altered

and strengthened sense of self that the person coming to treatment can later evaluate and work on difficulties (i.e., "symptoms" or "skills deficits").

The family contextual model (Gold, 2000), on the other hand, can be considered more of a "top-down" approach to treatment. Although it also focuses significant attention on the therapeutic relationship itself and the conceptual realm, one of its primary goals is to transmit effective skills for daily living to clients. This, therefore, involves "teaching" techniques and skills to clients and supporting them in making these skills their own. A strengthened sense of self (e.g. as capable, effective, and as having a sense of personal agency) is expected to develop as people learn and apply these skills to their lives.

Going back to the six areas of difficulty commonly experienced by people meeting the criteria for Complex PTSD in the *DSM-IV* Field Trial (van der Kolk et al., 2005), narrative therapy (White, 2004, 2007a, 2007b) seems to primarily target systems of meaning, self-perception, and interpersonal relations, seeing changes involved in these realms as fundamental to treatment. The idea is that if people can begin to redefine and to ground their sense of self according to what they value in life and to reconnect with a sense of personal agency, this sense of self, sense of meaning, and sense of connection with one's intentions and with others will foster further changes that are in alignment with this altered and preferred identity. Development according to hopes, values, and intentions will proceed, and a fuller storyline of the past is built to emphasize personal agency where someone may not have recognized himself or herself as having had any autonomy. Further, instead of coming from an outside source (i.e. a therapist), they come

from the client precisely because they are a product of increased personal agency and sense of self.

As opposed to narrative therapy's focus on systems of meaning, self-perception, and interpersonal relations as a foundation for the work with PCA survivors (White, 2004, 2007b), the contextual treatment approach (Gold, 2000) maintains an emphasis on interpersonal relations via the relationship between therapist and client throughout treatment and also expends considerable energy helping people to deconstruct negative or faulty beliefs about themselves or others whenever they arise. However, there is no rebuilding process here; rather, negative beliefs are simply deconstructed so that space is made for more accurate and healthy beliefs. There is no structure in contextual therapy for the "thickening" of these new beliefs and for a focus on building a stronger sense of self and meaning. What is provided, however, are techniques to learn skills for daily living that were never transmitted to them in "ineffective" socialization environments (Gold, 2000). In this way, alternate difficulties frequently experienced by PCA survivors are focused on, such as problems with (1) regulating affects and impulses, (2) memory and attention, and (3) perceptions of self and others. Examples of the life skills taught (see Chapter IV) are (1) the ability to regulate affects and impulses, (2) continuity of presence and attention, and (3) critical thinking and judgment. In this therapeutic model, a strengthened sense of self can be expected to emerge as clients learn targeted life skills and begin to experientially feel more in control of their lives. Similarly, a sense of meaning may evolve out of clients' experiences later in treatment, but this is not defined as an area of explicit intervention.

One major difference between the two general approaches, therefore, seems to be that narrative therapy (Denborough, 2006; Freedman & Combs, 1996; White, 2004, 2007a, 2007b) focuses on helping clients to build a preferred sense of self and meaning, trusting that other necessary changes will grow out of this foundation, while contextual therapy (Gold, 2000) emphasizes the teaching of effective skills for daily living such as relational skills, distress tolerance, affect regulation, impulse control, grounding techniques, and critical thinking – all with an expectation that an enhanced sense of self will grow out of successful implementation.

A related aspect of treatment where differences between these two approaches can be found lies in the varying roles that therapists often play. These are discussed below.

The "Role(s)" of the Therapist. As stated earlier, the role of the therapist is both similar and different between the two approaches studied for this thesis. Both approaches see the role of the therapist as facilitator. In narrative therapy, it is the practitioner's job to structure questions to help clients move from the known and familiar, or the dominant storyline they arrive with, to what is possible for their lives (White, 2007a). In doing so, the therapist's inquiry is wholly dependent on the content provided by the client. Contextual therapists also help to facilitate client development by asking questions to assist clients in deconstructing faulty beliefs and by structuring learning tasks appropriate to the skill level of the client, constantly moving the client toward self-sufficiency in each skill area or technique being taught (Gold, 2000).

However, the contextual therapist is intermittently put in the position of being an expert or teacher, even if the client is supported in attaining self-sufficiency within these

skill sets as soon as is possible. In contextual therapy (Gold, 2000), therefore, the client is a collaborator in his/her own treatment process. In narrative therapy, the client is more of a director, even though that direction is being shaped to some extent by the inquiry of the therapist (White, 2007a). While it is not outside the realm of the narrative approach to provide psychoeducation or helpful information, this therapist would do so with constant attention to opportunities to "level the playing field" in terms of power and privilege in the therapeutic relationship. On the whole, therefore, narrative therapists tend to take a slightly more active role in seeking opportunities to subvert "traditional power relations" (White, 2007a, p. 267) that are institutionalized in local culture, such as the language and power relations around disadvantage, race, gender, sexual orientation, disability, culture, etc.

In both approaches the therapist also takes on the role of "investigative reporter," although this descriptor is specific to narrative therapy (White, 2007a). Still, in contextual therapy (Gold, 2000) the therapist provides inquiry that allows the client to deconstruct negative or faulty beliefs. The narrative therapist, however, goes further in this realm. Amidst helping to deconstruct peoples' negative conclusions about themselves, s/he focuses the inquiry on *re-constructing* peoples' "subordinate storylines" (White, 2007a) as they develop, acting as an "editorializer" at times to reflect back what s/he has heard from the client in order to “thicken” (i.e., strengthen) preferred narratives. In this way, narrative therapy directly supports an expansion of the client's inner life and sense of self.

Last, the family contextual model (Gold, 2000) emphasizes the role of the therapist as a corrective attachment figure, helping to build and negotiate a collaborative

and trusting relationship with a client. While the narrative approach does not use this same language and does not explicitly conceive of the treatment relationship as corrective, it too aims to provide a normalizing context (White, 2007a). Thus, if the most significant condition in helping to bring about a secure attachment is the presence of a warm, sensitive, responsive, and dependable "other," (Karen, 1994), then it can be argued that both approaches meet this need.

Applicability to Crises. Finally, neither of these approaches are crisis models; the work of each tends to be more long term. That said, aspects of each have the potential to be help construct models for handling crises. The family contextual treatment model (Gold, 2000) is not very well suited to crisis work, however, because its entire foundation is based on the collaborative/attachment relationship between therapist and client, which can take months or even years to build. Still, the specific interventions used to teach skills, such as distress tolerance, can be quite helpful in building a crisis model. Alternately, the overall structure of narrative therapy (Freedman & Combs, 1996; White, 1995, 2007a) tends to be less defined. There are descriptions of single sessions that have been incredibly life altering for people in treatment, especially when they include outsider witnesses (White, 2007a) in the form of definitional ceremonies (Denborough, 2006; White, 2004, 2007b).

Narrative therapy also addresses issues such as lack of control, lack of connection, lack of meaning, and sense of hopelessness or emptiness that often lie at the root of crises. In general, however, the deconstruction of people's dominant storylines and the creation and performance of preferred realities tend to grow and strengthen over time,

which tends to make narrative therapy more long term, although much of its philosophy and practice can also be useful in constructing various types of crisis models.

Implications for Practice

Based on this analysis above, which compared and contrasted the utility and application of these two approaches to clinical practice with adolescent PCA survivors, the following implications for practice can contribute to defining "best practice" with this population.

1. *Clinicians need to be fully aware of the vast differences between the experiences and frequent treatment needs of people who have grown up in unprotective and/or abusive environments and the effects of single-incident trauma*. The conceptual framework of the family contextual model (Gold, 2000) is especially conducive to this end. It acknowledges the potential impact of discrete traumatic incidents, as are so often focused on in PTSD treatment, while asserting that for many survivors of prolonged childhood abuse, these incidents are simply affirmations of "a much more extensive historical narrative of negation, objectification, and subjugation" (Gold, 2000, p. 86). The model, therefore, articulates the broad, complex origins of the difficulties many PCA survivors experience (which frequently far subsume those of PTSD). It also gives clinicians a clear explanation as to why standard PTSD treatments are not indicated with this population (unless applied as part of a much more comprehensive treatment plan; see Chapter IV) and why they can easily retraumatize clients. Finally, the contextual model articulates what some of the most pervasive difficulties that PCA survivors often experience are and why this is frequently the case (Gold, 2000). The areas of difficulty

outlined in this model overlap significantly with the six problem areas found in the Complex PTSD, or DESNOS, diagnostic construct (van der Kolk et al., 2005) (officially listed as "Associated and Descriptive Features" of PTSD in the *DSM-IV* (American Psychiatric Association, 1994). They also help clinicians to understand the origins and scope of complex trauma presentations in order to maintain a non-pathologizing and supportive stance, to remain conscious of this population's frequent treatment needs, and to assist in the general conceptualization of treatment.

2. *It is of utmost importance that the clinicians be aware of and work to actively disempower dominant "voices" or systems of power that often leave PCA survivors feeling hopeless and powerless*. Although both approaches aim to accomplish this, narrative therapy (and specifically working from this worldview) (Denborough, 2006; Freedman & Combs, 1996; White, 1995, 2004, 2007a, 2007b) is more conducive to promoting a sense of personal agency in the people coming to treatment. It also actively supports people in the re-creation and expansion of their sense of "self" through what is called a "thickening" (enriching) of peoples' preferred narratives (White, 2007a). Thus, narrative therapy helps people to connect to their values and intentions, and strengthens their sense of self as connected to a greater sense of meaning and agency. Further, it aims to keep clients in the position of expert by structuring inquiry in a particular way and by consistently working to dismantle systems of modern power (White, 2007a), including the traditional hierarchy of therapist as expert and client as recipient. In line with this philosophy, narrative therapy refrains from using "traditional forms of acknowledgement" (White, 2007a) (e.g., offering congratulatory responses based on one's own perceptions, pointing out positives, etc.) so that the people in treatment are always

the ones to define and make meaning of their own experiences. This is particularly important for adolescents, so often exposed to varied authority figures, and even more poignant for PCA survivors, who often have their thoughts and feelings negated or belittled. Such consciousness on the part of the therapist to stay out of an authority role and to honor the inner voice of the person in treatment makes it a unique experience. While clinicians should be flexible in terms of practices and interventions, then, a narrative framework for treatment is well suited to work with PCA survivors – and on the whole, better suited than the family contextual approach.

3. *Clinicians should not be rigid in their use of treatment practices and resources. Rather, they should know about a wide variety of intervention strategies for addressing the major areas of difficulty experienced by PCA survivors*. While this research finds that it is most effective for clinicians to filter specific practices through a narrative philosophy and with attention to power dynamics (e.g., through transparency regarding information or ongoing invitations to comment on dynamics), clinicians should connect people in treatment to all useful information and resources. Whether psychoeducation is used to normalize the experiences of PCA survivors, stress-reduction techniques are introduced, or autobiographies of other PCA survivors are recommended, a range of information and resources should be made available. An example of when specific resources might need to be pulled into, e.g., practice from a narrative perspective might be when someone in treatment is unable to control his/her physiological and psychological reactions and is having a strong dissociative experience. In such cases, clinicians should be well versed in grounding techniques and other related practices to assist the person to maintain a sense of safety and control. Within a narrative framework,

the therapist would also help the person, through inquiry, to reconnect to his or her sense of autonomy after feeling more grounded by inviting the person to talk about the dissociation and by helping him/her to process the experience. Through this process the person might come to redefine the act of dissociation as, e.g., an act of resistance against the re-experiencing of prior traumatic events, rather than as an instance in which s/he lost control and failed to pay attention in the moment. Dissociation could then be recognized as a protective action and then further assessed by the person in treatment. If desired, dissociation could eventually be replaced by more adaptive protective actions as the person in treatment deems fit.

4. *The narrative practice of definitional ceremonies* (White, 2007a) *should be integrated into practice with adolescent PCA survivors.* Because of the structure of these ceremonies, people in treatment often experience feeling meaningfully connected with others, feeling seen and deeply acknowledged in a way that defies traditional forms of affirmation (i.e., people feeling moved by a person's story in their own lives instead of judging it as "impressive"), and feeling re-connected with the values and intentions of their lives (Denborough, 2006; White, 2004, 2007a). These experiences are powerfully transformative for many PCA survivors, who have often gone through most of their lives feeling profoundly alone (Gold, 2000) and disconnected from any sense of personal agency. In fact, definitional ceremonies (Denborough, 2006; White, 2004, 2007a) have the potential to greatly alter peoples' experiences and to open up possibilities not previously imagined. Further, because future possibilities come from how people experience themselves in the eyes of others during these ceremonies (rather than as a result of others' suggestions), they are all the more powerful. These ceremonies have

been even described by a number of people as being able to accomplish what might otherwise have been months of work in one or two sessions (White, 2007a, 2007b). One complex trauma survivor, whose story was at the center of a definitional ceremony, described a physical reaction to the conversational experience: she felt like she was "coming out of years of hibernation" (White, 2007b). While they may not encompass the entirety of treatment, therefore, definitional ceremonies have the potential to significantly transform treatment and the lives of PCA survivors.

The next section reviews the methodology used in this exploration.

Methodology Reviewed

This study explored the applicability of both narrative therapy (Denborough, 2006; Freedman & Combs, 1996; White, 1995, 2004, 2007a, 2007b) and contextual therapy (Gold, 2000) in the treatment of adolescent PCA survivors with an aim to contribute to developing a "best-practice" approach to treatment with this population. Chapter III detailed the current approach, or "meta-model," for working with people manifesting complex trauma presentations and described the six areas of difficulty frequently experienced by PCA survivors that transcend the symptomatology of PTSD. These six areas of difficulty, which were identified by the *DSM-IV* Field Trial for PTSD (van der Kolk et al., 2005), were then used to compare how well each treatment approach attends to these various difficulties. In order to compare and contrast the two sets of philosophies and practices in terms of their potential effectiveness with adolescent PCA survivors, content analysis was employed within and across related bodies of literature. Implications for practice were then outlined based on my analysis of the "goodness of fit"

between the therapies and the needs of these adolescents. Finally, this methodology was reviewed, followed by recommendations for future research.

Strengths of this study include its ability to provide an extensive consideration of the phenomenon and the potential effectiveness of the two approaches on working with the adolescent PCA survivor population. In choosing these two approaches, however, I inevitably ended up leaving out many other treatment options. Similarly, while I was able to draw from a wide variety of resources in order to develop the final sample of content, it is not exhaustive and is necessarily limited by both time and scope and my choice of research methods. Another limitation is that this research fails to examine the impact of a multitude of other variables and how those variables might or do intersect. Further, because of the lack of empirical research on these treatment approaches in working with this population, this study remains theoretical. The next obvious step is to carry out empirical research on treatment outcomes related to these two approaches.

Recommendations for Future Research

This investigation suggests the following areas for future research:

1. Does providing support for clients in redeveloping a sense of meaning, personal agency, and connection (i.e., through narrative practices), improve other identified problem areas commonly experienced by PCA survivors (i.e., with distress tolerance, impulse control, experiential presence and continuity, interpersonal relations, somatization, etc.) (Gold, 2000; van der Kolk et al., 2005), or do these other skill sets always need to be explicitly taught? Further, regardless of whether or not these skills need to be explicitly taught, which is a more effective treatment with this population:

narrative therapy's predominately "bottom-up" approach or contextual therapy's largely "top-down" approach?

Gold (2000) argues that skills such as affect regulation, distress tolerance, critical thinking, judgment, interpersonal and daily living skills need to be taught and learned; that these skills are not innate. However, learning can take on many forms and may not need to be explicit. Is it possible, therefore, that changes in these identified areas can grow out of an altered experience of self?

According to Michael White (2007b), it is not uncommon for individuals with histories of complex trauma to experience significant indirect changes as a result of narrative conversations. He shares the following example. Toward the end of the interview, he noticed that (the woman's) posture had changed, her general facial expression was altered, and she seemed to have more color in her face. When he asked her what was going on for her, she said, "There was an experience of warmth in my limbs" (White, 2007b). It almost seems as though some of the trapped energies in her body that contribute to somatization, hyperarousal, or numbing and dissociation had been released through their conversation. This is just one example, but it raises the question of what kinds of changes can be brought about from a strengthened sense of self and meaning that stems from these kinds of conversations.

2. What crisis models would be best suited for the needs of this population?

3. Given that all types of trauma inevitably affect the body in some way and that the incorporation of the body into the treatment of trauma is becoming more widely accepted and suggested in clinical practice (Eckberg, 2000; Levine, 1997; Ogden, Minton, & Pain, 2006; van der Kolk et al., 1996), it would be also interesting to ask how

some of these body-based or body-incorporating practices might be further integrated into treatment with PCA survivors. This would be particularly interesting in relation to adolescent survivors, who are in the midst of intense bodily and hormonal changes.

Conclusion

Survivors of prolonged childhood abuse frequently come into treatment with complex and layered needs and difficulties from a long history of neglect and maltreatment. Practitioners need to be able to see and understand the origins of what are sometimes deemed difficult behaviors or needs at times in order to treat them with patience and empathy rather than negative countertransference reactions. They also need to honor, respect, and draw on the incredible resilience of so many survivors who have traversed their lives while feeling incredibly alone in the world.

In recent years, narrative (Denborough, 2006; Freedman & Combs, 1996; White, 2004, 2007a) and contextual therapy (Gold, 2000) have significantly contributed to improved clinical practice with survivors of prolonged childhood trauma, as have clinicians' and researchers' efforts in the field to study, articulate, and advocate for the recognition a Complex PTSD or DESNOS diagnosis that is separate from PTSD as currently defined. These progressions are cause for hope regarding the ability of practitioners to better support PCA survivors in taking back their lives and re-developing a sense of meaning, competence, connection, self worth, and personal agency.

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