

Editor’s Note: for the interested reader, an outline of the structure of the case study of “Chloe” is shown in Appendix 1.

A Sequenced, Relationship-Based Approach to the Treatment of Complex Posttraumatic Stress Disorder (CPTSD): The Hybrid Case Study of “Chloe”

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ABSTRACT

Chronic and repeated exposure to relational and developmental trauma can result in a presentation that differs from posttraumatic stress disorder (PTSD), with a unique cluster of complicated symptoms, and has thus been labeled as complex PTSD (CPTSD). Many such individuals meet criteria for PTSD while also exhibiting additional symptomology not accounted for in a traditional PTSD diagnosis. This case study provides an overview of the differences between PTSD and CPTSD, using empirical evidence to illustrate the necessity of distinguishing between these two differing diagnoses and subsequently the need for differing treatment approaches. The purpose of this case study is to examine the benefits of using a three-phase, integrative model for an individual with CPTSD. Specifically, it explores the delivery of Courtois and Ford’s (2013) sequenced, relationship-based approach to the treatment of complex trauma. This model was chosen due to the emphasis on attachment and because it allows for clinicians to tailor interventions to the unique individual while also providing an overarching structure to treatment. This treatment analysis is demonstrated via the hybrid case of “Chloe,” who serves as a meaningful representation of a psychotherapy patient with a history of chronic relational and developmental trauma who presents to treatment with symptoms concurrent with a CPTSD diagnosis. Chloe’s composite case example is based on the author’s actual, de-identified psychotherapy cases in addition to clinical examples in the relevant literature. Using the format of a pragmatic case study (Fishman, 1999, 2013), Chloe’s case is analyzed through qualitative processes and quantitative measures. An in-depth illustration of this hybrid patient’s course of treatment provides an avenue for describing key clinical issues related to the treatment of CPTSD and the utility of an integrative treatment approach. Chloe’s case study is intended to be a resource for clinicians seeking more knowledge and understanding of the impact of chronic developmental and relational trauma and the implications this has for effective treatment.

Key words: Complex PTSD (CPTSD); Major Depressive Disorder; a Sequenced, Relationship-Based Approach to Treatment; dissociation; depersonalization; Sensorimotor Psychotherapy (SP); Accelerated Experiential Dynamic Psychotherapy (AEDP); hybrid case study; hybrid clinical case study

1. CASE CONTEXT AND METHOD

The Rationale for Selecting this Particular Client for Study

Prolonged and repeated exposure to relational trauma can result in severe psychological difficulties and can manifest as a challenging and complicated clinical presentation, historically labelled in the literature as complex posttraumatic stress disorder (CPTSD) (Herman, 1992a). Through this study, it is proposed that due to the differing nature of CPTSD, it requires different treatment interventions than those typically used to treat PTSD. Specifically, this study provides support for the need to implement an integrative treatment model that emphasizes relational approaches, and it explores the impact of Courtois and Ford's (2013) sequenced, relationship-based approach to the treatment of complex trauma. Their model consists of three phases: (1) Safety, Stabilization, Engagement; (2) Trauma Memory and Emotion Processing; and (3) Consolidating Therapeutic Gains. Their model is flexible and integrative, as the clinician can use many different interventions to achieve safety and aid the client in trauma processing. In this study, I employ elements from a variety of approaches including Ogden's (e.g., Ogden & Fisher, 2015) Sensorimotor Psychotherapy (SP); Fosha's (e.g., 2000) Accelerated Experiential Dynamic Psychotherapy (AEDP); cognitive-behavioral therapy (e.g., Persons, 2008; Beck, 1976; Lewinsohn, 1974); and techniques that span multiple treatment approaches such as mindfulness, grounding, psychoeducation, and guided imagery.

In order to demonstrate the application and effectiveness of a three-phase, integrative, relational model for treating CPTSD as applied to a pragmatic case study, I will use the hybrid case example of "Chloe." Chloe's composite case example is comprised of actual, de-identified psychotherapy clients I have treated using this integrative model in combination with findings and examples detailed in the relevant literature. By using this fictionalized, composite case, I can protect my clients' confidentiality, which is especially important due to the nature of CPTSD and this particular treatment model. Because the relationship with the clinician is the most important component of this model, it is important to protect my clients from any outside factors that may interfere with our relationship and their feelings of safety with me.

This hybrid case will detail common presenting problems among those with chronic relational and developmental trauma, barriers to treatment, clinical issues that arise when working with a client with CPTSD, and interventions proven effective in the literature and in my personal clinical experiences. This composite case is intended to be very comprehensive in the description of these themes and experiences; however, it is important to note that the case study will not represent the experiences of all people with CPTSD, as it cannot address every factor that may influence an individual's unique experience. Overall, the hybrid case example will highlight the need for more research, exploration, and understanding of CPTSD and will lend

support for the use of a three-phase, integrative model that emphasizes the client-therapist relationship for the treatment of this specific type of trauma.

This case study's structure will follow the format of a pragmatic case study as outlined by Fishman (1999; 2013). Thus, it begins with a description of the hybrid client, and next presents the guiding conception including relevant research and my own experiences with this treatment model, and an assessment of the client's problems, goals, strengths, and history. Then, it will describe the resulting case formulation and treatment plan; course of therapy; therapy monitoring and use of feedback information; a final quantitative and qualitative analysis of the therapy's process and outcome; and a discussion of the limitations of the study and potential areas for future research.

Through taking a qualitative, disciplined inquiry approach, I will describe a three-phase course of treatment that addresses the hybrid client's difficulties as related to her chronic relational and developmental trauma and the resulting CPTSD symptoms she presents with. This approach will also allow me to take into consideration a variety of individual and systemic factors that contribute to her presenting problems in order to provide a holistic and comprehensive depiction of an individual struggling with CPTSD and to illustrate the implementation of an integrative model. The nature of CPTSD is very complicated and multifaceted; thus, the ability to analyze data from a more objective, normative standpoint (quantitatively) and from a more descriptive, narrative, storytelling approach (qualitatively) that addresses the subtleties not captured through experimental procedures is very beneficial. Also, because CPTSD is a more recently recognized diagnosis, there are limited quantitative measures designed to address it. Most of the established psychometric procedures used for CPTSD were created and normed for populations with a PTSD diagnosis.

Over the course of my clinical training and experiences, I have worked with an estimated 5-10 adult clients and 5-10 children and adolescents that presented with severe and often debilitating symptoms that met criteria for CPTSD. I have tried implementing many different interventions designed to address trauma, and while each of these interventions led to some success, I have often felt that I needed to combine multiple treatment modalities at different points in treatment to address the complexity of the client's trauma and trauma-related symptoms. I also have made the mistake of attempting to process my client's trauma too early on in treatment and have since learned that with this population it can take a very long time for them to feel safe in therapy. Utilizing Courtois and Ford's (2013) sequenced, relationship-based approach for the treatment of complex trauma allows me to tailor the treatment specifically to the individual's presentation.

With this hybrid case study, I hope to illuminate the similarities and differences between those suffering from CPTSD and PTSD, and the resulting implications for the assessment, conceptualization, and treatment of CPTSD clients. While there is a growing body of literature on this topic, it is still a more recent development and focus in the field of clinical psychology. As such, I hope to contribute to this discussion so that we can continue to better understand this clinical population and develop and disseminate more intervention techniques to best help them and lead to beneficial treatment outcomes. Ideally, this study will also add to the growing amount of support for the need to include CPTSD as its own, separate diagnosis in future diagnostic manuals.

The Clinical Setting in Which the Case Took Place

Chloe's treatment took place at a psychological services training clinic in the Northeastern United States. The clinic provides treatment to university students as well as members of the community, and the primary providers at the clinic are clinical and school psychology graduate students. Chloe was referred to the clinic by the university counseling center because she was interested in a more long-term therapy than the counseling center was able to provide. The fee for treatment was based on a sliding scale and Chloe qualified for the lowest tier of payment, which was standard for all students without university insurance.

At the time of therapy, I was an advanced clinical psychology doctoral student, and Chloe's case was assigned to me by the clinic coordinators due to their knowledge of my interest in, and experience with, the treatment of survivors of complex trauma. Throughout Chloe's treatment, I was supervised by a licensed clinical psychologist with in-depth expertise in complex trauma, and I consulted about Chloe's case in a weekly supervision group run by the prominent clinical psychodynamic scholar and master therapist, Nancy McWilliams (e.g., 2004, 2021). Chloe's treatment consisted of 80 sessions that occurred over the span of approximately two years (100 weeks).

Sources of Data Available Concerning the Client

No information was available to me prior to beginning treatment with Chloe other than her responses to an initial phone intake at the clinic. This was Chloe's first experience with psychotherapy, and collateral information (e.g., from family members or medical providers) was not accessible nor acquired.

Confidentiality

Given that Chloe is a composite of multiple individuals, the confidentiality of my clients will be protected. Additionally, some details of Chloe's case have been fictionalized in order to

further protect my clients' identities. The conversations quoted herein are reproduced from actual conversations across several settings, and session content may be condensed to focus on the most relevant material.

2. THE CLIENT

At the onset of treatment, Chloe was a 20-year-old, White, cisgender, heterosexual, single woman. She lived in a house with two roommates and was a full-time undergraduate college student in her junior year. This was Chloe's first time in therapy, and she sought treatment to address her symptoms of depression and history of trauma. Chloe stated that she witnessed her mother's suicide attempt one year prior and that her father recently contacted her for the first time since he left following her parents' divorce when she was 10 years old, all of which was triggering disturbing childhood memories.

She presented to the clinic with symptoms of major depressive disorder (MDD), as defined by the American Psychiatric Association's (2013) *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5), including feelings of sadness and hopelessness, decreased appetite, anhedonia, difficulties concentrating, and insomnia. In addition, Chloe met DSM-5 criteria for posttraumatic stress disorder (PTSD), as she endorsed experiencing intrusive memories, nightmares, flashbacks, persistent guilt, shame, and negative beliefs about herself, others, and the world, avoidance of traumatic reminders, hypervigilance, and periods of dissociation (particularly depersonalization) where she felt like she was detached from her body and "watching a movie" of her life.

Chloe also endorsed symptoms related to complex posttraumatic stress disorder (CPTSD), as defined by the World Health Organization's (2019) *International Classification of Diseases, 11th Revision* (ICD-11), including emotion regulation difficulties, disturbances in relationships, and severe negative self-concept. While Chloe was a survivor of repeated childhood familial abuse and neglect, she was very hesitant to revisit her traumatic childhood, stating that she did not think her past related to her current difficulties. As she began to feel safer and became more open, the trauma became the primary focus of treatment.

3. GUIDING CONCEPTION WITH RESEARCH AND CLINICAL EXPERIENCE SUPPORT

The guiding conception underlying Chloe's case formulation and treatment plan is rooted in Courtois and Ford's (2013) sequenced, relationship-based approach to the treatment of complex trauma. Within this approach, I chose to integrate three additional treatment modalities based on my clinical experiences with this population, relevant research, and cases in the

literature. I will start by giving an overview of the diagnosis of complex posttraumatic stress disorder and how it differs from posttraumatic stress disorder. I will then provide empirical research and theory that support the use of a relationship-based, phase-oriented model for treating the effects of complex trauma, and I will conclude by elaborating on the rationale for incorporating three therapy modalities into Courtois and Ford's (2013) three-phased approach.

The Nature of Complex Posttraumatic Stress Disorder

The effects of chronic and repeated relational trauma can be profound, pervasive, and long-lasting, resulting in a complicated clinical presentation, labelled as complex PTSD (CPTSD). Herman (1992a) proposed that this chronic form of trauma differs from a single traumatic event in that it occurs where the victim is in a state of captivity, unable to escape, and under the control of the perpetrator for a prolonged amount of time. This kind of captivity can result in a unique type of relationship that Herman (1992a) labels as "one of coercive control" (p. 378). Examples of these conditions include prisons, concentration camps, and families where caregivers exhibit signs of physical and/or sexual abuse or neglect. These individuals typically meet criteria for PTSD while also exhibiting additional symptomology not accounted for in a traditional PTSD diagnosis.

These additional symptoms were first referenced by Courtois (2004) as falling under the following seven areas of impairments: (a) alterations in the capacity to regulate emotions, (b) alterations in consciousness and identity (e.g., dissociation and depersonalization), (c) alterations in self-perception (e.g., chronic guilt and intense shame), (d) alterations in perception of the perpetrator (including incorporation of their belief system), (e) alterations in perception of others, (f) somatization and/or medical problems, and (g) alterations in systems of meaning (Courtois, 2004). Others have identified the additional symptomology as falling under five broad domains: (a) emotion regulation difficulties, (b) disturbances in relational capacities, (c) alterations in attention and consciousness (e.g., memory problems and dissociation), (d) adversely affected belief systems, and (e) somatic distress or disorganization (Cloitre et al., 2011).

While this diagnosis has been present in the literature for decades and has support among clinicians, it is not a recognized diagnosis in the DSM-5 and thus has historically not been an area of focus when designing and implementing treatment interventions (American Psychiatric Association, 2013). However, during the last decade, a substantial body of literature exploring CPTSD has developed. Due to this upsurge in literature and an increased understanding of the need for more effective treatment modalities, CPTSD is now included in the ICD-11 (World Health Organization, 2019). In the ICD-11, CPTSD is defined as a result of chronic, prolonged, and repeated trauma and includes the three symptom clusters of PTSD (re-experiencing of

trauma in the present, avoidance of traumatic reminders, and a persistent sense of current threat that is manifested by exaggerated startle and hypervigilance), but has three additional symptom clusters to reflect disruptions in self-organization: (1) affect dysregulation, (2) negative self-concept and (3) disturbances in relationships.

For the purposes of this study, I will focus on a particular type of complex trauma, namely, childhood relational trauma, using Courtois and Ford's (2013) definition of complex trauma as:

traumatic attachment that is life- or self-threatening, sexually violating, or otherwise emotionally overwhelming, abandoning, or personally castigating or negating, and involves events and experiences that alter the development of the self by requiring survival to take precedence over normal psychobiological development (p. 25).

In this definition, they emphasize the developmental disturbances typically resulting when the traumatic experiences begin in childhood, as these are the most formative years in one's development.

Early Childhood Relational Trauma

While CPTSD can manifest at any age as long as there is a relationship of coercive control, ample empirical and clinical findings show that early childhood relational trauma gives rise to more complex PTSD symptomology than prolonged relational trauma occurring in adulthood, as it can result in additional developmental disturbances (Van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005).

One of the most important and notable developments in the literature regarding the long-term effects of early childhood relational trauma on mental and physical health was the Adverse Childhood Experiences (ACE) Study, conducted by the Centers for Disease Control and Prevention (CDC) and Kaiser Permanente, with Robert Anda, MD, and Vincent Felitti, MD, as co-principal investigators. The ACE Study examined the relationship of adult health risk behaviors, health status, and disease states to childhood abuse and household dysfunction. The researchers developed an 18-question questionnaire covering seven specific categories of adverse childhood experiences (ACEs) that fell under two broad domains, childhood abuse and household dysfunction. Childhood abuse consisted of three categories: psychological abuse, physical abuse, and sexual abuse; while household dysfunction consisted of five categories: exposure to substance abuse, exposure to mental illness, violent treatment of mother or stepmother, incarcerated household member, and parental separation or divorce (Felitti et al., 1998; Anda et al., 2006). Respondents were defined as exposed to a category if they responded "yes" to one or more of the questions in that category.

The ACE score was obtained by summing the categories with an exposure, leading to a possible ACE score ranging from zero to eight. 17,421 adult participants, aged 18 to 72, filled out the questionnaire, and the ACE scores were then compared to ten risk factors that contribute to the leading causes of morbidity and mortality in the United States. These risk factors were smoking, severe obesity, physical inactivity, depressed mood, suicide attempts, alcoholism, any drug abuse, parenteral drug abuse, a high lifetime number of sexual partners (>50), and a history of having a sexually transmitted disease. The CDC-Kaiser ACE study also included a Wave 2 collection of data where two more categories of ACEs were added: physical neglect and emotional neglect.

Results from the ACE study indicated that traumatic experiences during childhood and adolescence are much more common than expected, as almost one third of the respondents experienced one or more ACEs (Anda et al., 2006). Further, given exposure to one ACE, there was an 80% greater likelihood of exposure to a second, indicating that ACEs do not occur in isolation (Felitti et al., 1998). Overall, the ACE study demonstrated a powerful relationship between people's emotional experiences as children and their physical and mental health as adults, and findings had important medical, social, and public health ramifications. In regard to physical health, the researchers found a strong relationship between the number of ACEs and the number of health risk factors for leading causes of death in adults. For example, 56% of people with an ACE score of 0 had none of the ten risk factors whereas only 14% of people with an ACE score of 4 had no risk factors (Felitti et al., 1998).

In regard to mental health, people who had an ACE score of 4 or higher were 460% more likely to suffer with depression, 1,220% more likely to have ever attempted suicide, 740% more likely to struggle with alcoholism, and 1,300% more likely to have ever injected drugs (Felitti et al., 1998). At highest ACE scores (8), the increased likelihood of childhood/adolescent suicide attempts increased by 5,100%, and adult attempts by 3,000% (Dube et al., 2001). Articulated in a powerful statement by Felitti (2009), the ACE study demonstrated that "what happens in childhood—like a child's footprints in wet cement—commonly lasts throughout life. Time does not heal; time conceals" (p. 131).

The original ACE study was groundbreaking and critically important in the field of public health, showing an integrative understanding of complex trauma and the connection between mental and physical health. Since the original study, ACE studies have evolved and are ongoing. Many states have been collecting information about ACEs through the Behavioral Risk Factor Surveillance System (BRFSS), which is an annual telephone survey that collects data from U.S. adults regarding health conditions and risk factors. The BRFSS Adverse Childhood Experiences (ACE) module was adapted from the original CDC-Kaiser ACE Study in 2008 and

is used to collect information on child abuse and neglect and household challenges. The questionnaire consists of 11 questions that cover the same categories as the original ACE study with one change—the category of violent treatment of mother or stepmother has changed to “intimate partner violence” (Centers for Disease Control and Prevention [CDC], 2020).

Because of the developments in the literature related to ACEs and the extensive ongoing ACE-related research and surveillance, early childhood relational trauma is no longer viewed as solely a mental health problem but also a public health problem. Thus, effective mental health treatments that target this particular type of pervasive trauma have become even more important.

Effects of Complex Trauma and Clinical Implications

Emerging literature focusing on the neurobiological effects of complex trauma has important clinical implications for treating individuals with CPTSD. There is research indicating that chronic, repeated exposure to relational trauma, particularly in childhood, such as sexual and/or physical abuse and neglect, causes enduring brain dysfunctions that affect physical and mental health throughout one’s lifespan (Herzog & Schmahl, 2018; Anda et al., 2006; Bremner, 2003). Important developments include evidence showing the vast memory disruptions caused by chronic childhood trauma, such as reduced hippocampus volume that can impair one’s short-term memory abilities, ability to process elements into explicit memory, and one’s overall acquisition of a sense of self in the world (Calem, Bromis, McGuire, Morgan, & Kempton, 2017; Bremner et al., 1995; Ford, Courtois, Steele, Hart, & Nijenhuis, 2005).

Another notable finding relates to what Van der Kolk (2014) labels as “speechless horror” resulting from a significant decrease in Broca’s area when an individual is experiencing a traumatic flashback (p. 43). Broca’s area is a region in the brain’s left frontal lobe that is responsible for putting thoughts and feelings into words. Thus, without this activation, it is extremely difficult for individuals to verbalize their traumatic experiences.

Overall, there is research indicating that when experiencing or re-experiencing trauma, most brain activation occurs in the right part of the brain, with little activity in the left part of the brain (Van der Kolk, 2014). In general, the right brain processes memories in a non-linear, visual, spatial, and tactual way, and the left brain is linguistic, sequential, and analytical (Van der Kolk, 2014). This is particularly relevant for survivors of early childhood complex trauma because children are right brain dominant for most of their childhood, and the corpus callosum, which is the part of the brain that allows for right brain-left brain communication, develops slowly and is only fully elaborated around age 12 (Fisher, 2017). There has been some research suggesting that a history of abuse and/or neglect correlates with an under-developed corpus callosum, further supporting the notion that complex trauma significantly impacts the right and

left brain's ability to communicate with each other (Fisher, 2017). These findings suggest that treatment of complex trauma should include approaches to trauma processing that integrate images, sensations, metaphors, and other modes of engaging the right brain because in early stages, individuals may not be able to logically access or describe their trauma verbally.

Lanius, Bluhm, and Frewen (2011) expand upon these concepts as they emphasize that individuals with PTSD related to chronic trauma as opposed to a single traumatic event have impairments in a core set of brain regions that mediate emotional/self-awareness, emotion regulation, social emotional processing, and self-referential processing. They posit that treatment of individuals with complex trauma will not be effective if it only addresses traumatic memory but that it needs to also utilize interventions that address these additional deficits.

Overall, emerging literature in the field regarding the neurobiology of CPTSD and resulting clinical implications suggests that due to the complexity of the disorder, a conventional PTSD treatment may not be enough to achieve lasting change, leading to the recent focus on models that allow for integration.

Courtois and Ford's (2013) Sequenced, Relationship-Based Approach

As CPTSD becomes more of a focus in the field in recent years, the number of studies looking at the potential differences in treatment between CPTSD and PTSD is increasing. Some preliminary studies have indicated that individuals with complex trauma histories may respond less optimally to conventional PTSD treatments than those without complex histories (Ford et al., 2005; Hembree, Street, Riggs, & Foa, 2004; Van der Kolk et al., 2007). Additionally, emerging research suggests that models with an overarching emphasis on the relationship between client and therapist are more effective when treating CPTSD, due to the nature of the disorder as one of attachment trauma (Mucci, Scalabrini, & Northoff, 2018). As Ford and Kidd (1998) point out, individuals suffering from this type of trauma must have a treatment that addresses their developmental and relational difficulties in addition to the PTSD symptoms. The therapeutic relationship can be both a "testing ground" for the ability to form and sustain satisfying relationships and healthy attachments, and the context in which their attachment difficulties are experienced, explored, understood, and ultimately resolved (Pearlman & Courtois, 2005, p. 450).

I chose to utilize Courtois and Ford's (2013) sequenced, relationship-based approach to treating complex trauma during Chloe's treatment, given the research and developments in the literature that point to the importance of the therapeutic relationship and the benefits of phase-oriented models that expand upon traditionally used PTSD treatments.

Phase-Oriented Model

More than a century ago, the French psychiatrist Pierre Janet (1889/1973) recognized that the treatment of posttraumatic psychopathology needed to be adapted for severely traumatized and complex clients (often those with dissociative symptoms). This resulted in his formulation of a sequenced, three-stage model for the treatment of posttraumatic stress. Janet's model was reintroduced more than three decades ago by Van der Hart, Brown, and Van der Kolk (1989) and later Herman (1992b). The first stage of this model included stabilizing the client, establishing a therapeutic relationship, regulating debilitating trauma-related symptoms, and preparing for trauma memory processing. The second stage consisted of identification, exploration, and modification of traumatic memories, and the third stage was focused on relapse prevention and personality reintegration. Since then, there has been research conducted to support the need for, and effectiveness of, a phase-based treatment model that is more long-term and integrative when treating clients with complex trauma symptomology.

Results from an expert opinion survey initiated by the International Society for Traumatic Stress Studies Complex Trauma Task Force regarding best practices for the treatment of CPTSD showed that 84% of experts endorsed a phase-based treatment approach with interventions selected based on the prominence of a particular symptom (Cloitre et al. 2011). Multiple studies investigating the use of a treatment model consisting of a trauma-focused component integrated with a phase-based component that addressed stabilization, skills training, and issues specific to repeated, prolonged, childhood trauma reported improvements in CPTSD symptoms (Cloitre, Koenen, Cohen, & Han, 2002; Steil, Dyer, Priebe, Kleindiest, & Bohus, 2011).

Cloitre et al. (2010) conducted a randomized controlled trial (RCT) comparing a phase-based treatment that began with a skills training followed by exposure to two separate single phase conditions (only exposure and only skills training) in the treatment of PTSD related to childhood abuse. In their study, the phase-based approach was associated with greater treatment outcomes and fewer adverse effects than single phase treatments. These results suggest that a phase-based, integrative approach is not only effective in treating CPTSD but may also be more effective than traditional, single phase trauma-focused approaches.

Courtois and Ford's (2013) work builds on the earlier work of Pierre Janet to further develop a phase-based treatment model. The approach is grounded in a relational view of the process of treatment for survivors of complex trauma. Accordingly, successful treatment is based on a trustworthy and secure relationship between the clinician and client that "simultaneously serves to facilitate the emergence of unresolved relational issues" (Courtois & Ford, 2013, p. xv). While Courtois and Ford's (2013) approach emphasizes the relationship, it also allows for

flexibility to use a variety of trauma processing techniques from a wide range of theoretical backgrounds.

The three phases are not typically linear in practice, as the tasks and techniques of each phase are implemented on the basis of the client's emotion-regulation capacity, motivation, response to treatment, and current clinical presentation. Thus, while Chloe's treatment was guided by these phases, it did not progress in a linear fashion, as we frequently moved back and forth between the phases based on her presenting needs.

Phase 1: Safety, Stabilization, and Engagement

Phase 1 focuses on safety, stabilization, client engagement and psychoeducation, and skills training, and it is generally the longest of the treatment phases. It is "measured in skills, not time" (Courtois & Ford, 2013, p. 120). The initial focus of treatment is ensuring that the client is physically safe and not at risk of harming themselves. There is also a focus on the establishment of a strong therapeutic alliance and the development of relationship safety, as well as the acquisition of skills (e.g., grounding, mindfulness, and breathing techniques and exercises) that clients can use to manage extreme arousal or emotion dysregulation. Attachment security and emotion regulation are the therapeutic foundations that allow clients to identify other ways to modulate distress and develop more effective coping strategies (Courtois & Ford, 2013). This phase also involves preparing the client for Phase 2, both through psychoeducation and "resourcing," all of which enhances the client's readiness for change. "Resourcing" is described by Courtois and Ford (2013) as the development of specific skills, especially emotion identification and methods to achieve emotional regulation (p. 122).

Phase 2: Trauma Memory and Emotion Processing.

Phase 2 focuses on trauma memory and emotional processing. The key component of Phase 2 is processing trauma-related memories and resolving their emotional and cognitive aftermath in the presence of a safe, accepting, nonjudgmental therapist, so the previous emotional response is counterconditioned. An important piece of this process is "creating a condition of emotional disparity," where the client recognizes that there is a difference between what she is experiencing (i.e., extreme fear) and the current state of reality (i.e., in the presence of an accepting therapist and safe environment) (Courtois & Ford, 2013, p. 150). Thus, it is the therapist's job once the client is fully activated in the painful memory to bring themselves into the space and tell the client that they are not alone and that they are in a safe space.

Throughout emotional processing, it is important to make sure the client stays within a window of affective intensity and bodily arousal, also known as the window of tolerance

(Courtois & Ford, 2013). The window of tolerance is the range of activation within which the individual can experience arousal as tolerable and can integrate information on a cognitive and emotional level (Siegel, 1999). It is the zone between the two extreme physiological states of hyper- and hypoarousal, and in order to effectively process trauma, one must be in this state of "optimal arousal" (Ogden, Pain, & Fisher, 2006, p. 270).

Trauma processing methods. While there are multiple interventions that can be employed in Phase 2 to achieve the goal of trauma processing, I chose not to use trauma-focused cognitive-behavioral (CBT) models, such as Cognitive Processing Therapy (CPT) (Resick, Monson, & Chard, 2016) and Prolonged Exposure (PE) (Foa, Hembree, & Rothbaum, 2007), for multiple reasons. First, while there are data indicating that some of these models can be effective in treating PTSD and CPTSD, many of these studies have shown high non-response rates and dropout rates (Bomyea & Lang, 2012; Bradley, Greene, Russ, Dutra, & Westen, 2005; Cahill, Rothbaum, Resick, & Follette, 2009; McDonagh et al., 2005; Schottenbauer, Glass, Arnkoff, Tendick & Gray, 2008). Dropout rates for PE for PTSD were as high as 33% to 43% in three of the largest studies (Hembree et al., 2003). PE and CPT also presuppose that traumatic memories are available to conscious thought and can be organized with enough coherence to form a complete narrative, but often those with CPTSD have high levels of dissociation which compromises one's ability to do this (Gleiser, Ford, & Fosha, 2008).

Further, the aforementioned research indicating that survivors of chronic, prolonged trauma often have more deficits in memory and information processing than survivors of a single traumatic event suggests that interventions that solely address traumatic memory, such as CPT and PE, may not be sufficient in treating individuals with CPTSD. Ford et al. (2005) posit that exposure-based CBT used to treat chronic relational and developmental trauma may inadvertently lead to severe problems with affect regulation and information processing due to the greater deficits in these capacities associated with this type of trauma.

Because of these findings and developments in the literature regarding CPTSD, I instead chose to integrate elements from Accelerated Experiential Dynamic Psychotherapy (e.g., Fosha, 2000) and Sensorimotor Psychotherapy (e.g., Ogden & Fisher, 2015) in order to achieve trauma processing. These therapy models do not focus solely on the cognitive realm and involve many techniques that take into account the unique effects of early childhood relational trauma, as they involve approaches to trauma processing that engage the right brain when Chloe may not be able to logically access or describe her trauma verbally. I will explain these two modalities in depth later on.

Phase 3: Consolidating Therapeutic Gains

Lastly, Phase 3 focuses on consolidating therapeutic gains and applying that knowledge and skills to daily life and the future. As a result, the client will become better equipped to respond to life events and make choices from a position of increased self-knowledge, healthy self-regard, and mindful awareness (Courtois & Ford, 2013). This phase also can involve deepening relational intimacy, discussing possible career development, and overall, consolidating identity development and one's sense of self. There is a move towards ending treatment, which includes the building Phase 1 into Phase 3 to create a relapse prevention plan. It is also important to review the work and the therapeutic relationship, allowing for a deeper connection and secure attachment.

Incorporated Therapy Modalities

Courtois and Ford's (2013) sequenced, relationship-based approach acts as an overarching three-phase structure, providing general guidelines for effective complex trauma treatment that allow for the clinician to integrate different interventions and techniques throughout the course of therapy. For Chloe's treatment, I chose to integrate aspects of cognitive-behavioral therapy (CBT), Accelerated Dynamic Experiential Psychotherapy (AEDP), and Sensorimotor Psychotherapy (SP). In the following sections I will provide a general overview of each of these treatment modalities, with an emphasis on how and why I integrated them into the three phases as outlined by Courtois and Ford (2013).

Cognitive-Behavioral Therapy

Various aspects of cognitive-behavioral therapy (CBT) have been shown to stabilize depressive symptoms and can provide useful tools when treating individuals with a history of complex trauma, particularly those exhibiting depressive symptoms (Courtois & Ford, 2013). For the purposes of my work with Chloe, I utilized an element of CBT, known as behavioral activation, in Phase 1 in order to reduce her depressive symptoms so she could engage productively in therapy and feel stable enough to move toward trauma processing.

Behavioral activation originated as a component of cognitive therapy for depression (Beck, 1976; Lewinsohn, 1974). Empirical findings have since shown that behavioral activation is an independently effective intervention for depression (Gortner, Gollan, Dobson, & Jacobson, 1998; Jacobson et al., 1996). Behavioral activation has also been shown to be effective at reducing both trauma-related and depressive symptoms among individuals with PTSD (Flint, Ferrell, & Engelman, 2020). Behavioral activation targets depression by helping people re-engage in their lives through strategies that counter patterns of avoidance, withdrawal, and

isolation that may exacerbate depressive symptoms. (Jacobson, Martell, & Dimidjian, 2001). It can help people to gain awareness of how different activities impact their mood and then provides tools for increasing positive activities and interactions while minimizing harmful behaviors that perpetuate depressive symptoms (Persons, 2008).

Accelerated Experiential Dynamic Psychotherapy

As previously mentioned, Courtois and Ford's (2013) approach emphasizes the relationship and the importance of attachment security, but it is more of an overarching treatment structure rather than a specific treatment modality. Diana Fosha's (2000) Accelerated Experiential Dynamic Psychotherapy (AEDP) fits well into Courtois and Ford's (2013) approach as it provides specific techniques and strategies to achieve attachment security and maintains an emphasis on the relationship throughout treatment. I drew from AEDP particularly in Phase 2 to facilitate the processing of Chloe's relational trauma.

A recent study conducted by Iwakabe et al. (2020) provides initial empirical evidence for the effectiveness of AEDP as a therapy model that can lead to meaningful and significant change across a range of psychological symptoms. Their study examined outcomes for 62 adults treated using a 16-session format of AEDP in independent practice outpatient settings in the US, Canada, Israel, Japan, and Sweden. Results showed that 67.7% of the patients who received AEDP showed significant improvements in depressive symptoms and 74.2% in general symptom severity, with many patients also showing significant improvements in interpersonal functioning, experiential avoidance, and emotion regulation (Iwakabe et al., 2020). While these results are promising, this study mainly focused on depression, anxiety, and interpersonal problems and did not examine the use of AEDP for treating PTSD or CPTSD.

AEDP has been presented in the literature as a "multimodal, integrative' model well-equipped to address the clinical complexities of complex PTSD," and it addresses the previously mentioned neurobiological effects of complex trauma by recognizing "that the right-brain speaks a language of experience, not words" (Gleiser et al., 2008, p. 341; Lipton & Fosha, 2011, p. 262). Gleiser et al. (2008) provide support for the use of AEDP for the treatment of CPTSD by comparing it to a behavioral exposure therapy (prolonged exposure [PE]). They argue that AEDP's model of attachment-based relational interventions, dyadic regulation of emotion, and a somatically grounded approach to full emotional processing provides specific mechanisms lacking in the PE protocol to address complex PTSD symptoms such as attachment disturbance, emotional dysregulation, dissociation, and identity diffusion.

The two main goals in AEDP are "undoing the individual's aloneness in the face of overwhelming emotions" and helping the patient have a transformational experience in order to

allow them to access their core state, or true self (Fosha, 2003, p. 245). Fosha (2000) explains that the core state is "an altered state of openness and contact, where the individual is deeply in touch with essential aspects of [their] own experience" (p. 20). It is "the internal affective holding environment generated by the self," and an indicator that this state has been achieved is when both the therapist and patient "have the subjective experience of purity, depth, and 'truth'" (Fosha, 2000, pp. 20-21). In order to achieve these goals, AEDP uses emotion-processing strategies to facilitate new emotional experiences and attachment-based strategies to facilitate new relational experiences all within the therapeutic dyad.

The major agents of change in AEDP are (1) experientially processing intense negative emotions to completion within an emotionally engaged patient-therapist dyad and (2) meta-processing the emotional experiences associated with the therapeutic transformational experience until core state is reached (Gleiser et al., 2008). In AEDP, it is understood that the experiential processing of painful and difficult emotions to completion is healing in and of itself and also enables the patient to feel a sense of mastery by overcoming what was previously overwhelming. Moreover, central to AEDP is the above-mentioned emphasis on meta-processing (also referred to as "meta-therapeutic processing") which involves "exploring what is therapeutic about therapeutic experiences" and "focusing on the patient's *experience* of transformation" (Fosha, 2006, p. 572).

While AEDP has been put forth as an all-encompassing trauma treatment, I chose to integrate it into Courtois and Ford's (2013) approach because AEDP does not include phases or an overall concrete treatment structure. Based on empirical research documenting the effectiveness of phase-based models for treating CPTSD and my clinical experiences with the complicated and recursive nature of treatment, I believe that Chloe's treatment would have been far less successful without the three phases as a guide. Also, while AEDP does include an emphasis on "accessing somatically rooted experience," based on Chloe's severe dissociative symptoms and somatic symptoms, I did not expect AEDP alone would sufficiently address all of Chloe's presenting concerns (Lipton & Fosha, 2011, p. 262). Thus, in order to more thoroughly address all of Chloe's symptomology, I decided to integrate an additional modality, described in the following section, that is more specifically focused on the effects of trauma on the body.

Sensorimotor Psychotherapy

Emerging research on the neurobiological effects of complex trauma as described previously suggests that it is necessary to also integrate techniques into treatment that specifically address the problematic mind-body split often experienced in individuals with CPTSD. Courtois and Ford (2013) support the use of somatic techniques in their approach, particularly for enhancing client engaging, as they note that these tactics can help the client

become aware of and reflect on possible meanings of physical reactions and sensations and body states.

As such, I decided to integrate Sensorimotor Psychotherapy (SP). SP is a method for facilitating the processing of unassimilated sensorimotor reactions to trauma and for resolving the debilitating effects of these bodily reactions and somatic symptoms on cognitive and emotional experience (Ogden & Fisher, 2015; Ogden, Minton, & Pain, 2006; Ogden, Pain, et al., 2006; Ogden & Minton, 2000). Ogden and Minton (2000) emphasize that it can be particularly beneficial for clinicians working with dissociation, flat affect, frozen states or hyperarousal and other PTSD symptoms.

In SP, the body is used both as a source of information about "procedurally learnt tendencies" and as a vehicle for intervention (Fisher, 2011, p. 104). First, the therapist mindfully observes and tracks the sensorimotor experience of the patient, focusing on both subtle changes (e.g., skin color change, slight tension) and more obvious changes (such as a dramatic change in posture), and then points out these changes to the patient by making "contact" statements, such as, "Your hand is changing into a fist" (Ogden & Minton, 2000, p. 163). This prompts the patient to notice rather than interpret their physiological and emotional reactions and facilitates patients' increased capacity for mindfulness and self-regulation.

Then, after the patient is more attuned to and mindful of their bodily experience, the body can be used as a way for them to access components of their trauma that they were unaware of or that have been encoded only as sensory fragments or physical patterns. For example, the therapist asks questions such as, "If your hand could do something, what would it do?" As patients become more aware of their habitual reactions, they can practice alternative somatic responses or engage defensive responses or movements that were inhibited at the time of the traumatic experience, thereby disrupting the procedurally learnt tendencies and providing them with a sense of greater control over their body and emotions (Fisher, 2019). This process is one of the defining features of SP, distinct from other treatment models such as AEDP. As Janina Fisher (2017) eloquently remarks, "Sensorimotor Psychotherapy speaks the language of the body" (p. 8).

While there is currently no formal control group effectiveness research to attest to the efficacy of SP in individual psychotherapy, the development of SP was guided by research findings in the areas of sensory integration, trauma, and neuroscience. Also, two studies of SP-informed group psychotherapy designed for Phase 1 symptom stabilization treatment of CPTSD provide preliminary evidence for SP in a group setting, as results include subjects reporting a decrease in dissociative symptoms and improvements in body awareness and receptivity to soothing (Gene-Cos, Fisher, Ogden, & Cantrell, 2016; Langmuir, Kirsch, & Classen, 2012).

Classen et al. (2020) conducted a RCT examining the efficacy of a SP-informed group therapy for complex trauma survivors. Results from their study showed significant improvements in body awareness, anxiety, and soothing receptivity when comparing treatment to no treatment.

Given Chloe's severe dissociative reactions and somatic symptoms (e.g., asthma and migraines) at the beginning of treatment, I believed that techniques from SP would be helpful in Phase 1 to increase her capacity to stay in the present moment as well as identify and label her emotions and bodily sensations. It also gave me tools to increase my ability to be present and mindful in sessions and track subtle changes. Further, the use of SP in Phase 2 allowed for Chloe's treatment to emphasize the sensorimotor component of trauma processing, particularly through the use of movement interventions.

4. ASSESSMENT OF THE CLIENT'S PRESENTING PROBLEMS, GOALS, STRENGTHS, AND HISTORY

Presenting Problems

Chloe reported coming to treatment to address her feelings of "loneliness and sadness" and because of recent events involving her parents that were triggering trauma-related symptoms and distressing childhood memories. She endorsed the following depressive symptoms: increased isolation and feeling "disconnected" from people, lack of appetite, anhedonia, feelings of sadness and hopelessness, fatigue, difficulties concentrating, and insomnia. She reported that she had lost twenty pounds over the past year. Additionally, Chloe witnessed her mother's suicide attempt one year prior. Chloe reported that during this incident her mother held a gun to her head, and Chloe reacted by grabbing the gun and calling 911. Since that traumatic experience, Chloe stated that she had been experiencing flashbacks, avoidance of traumatic reminders, hypervigilance, and periods of dissociation (particularly depersonalization) where she felt like she was detached from her body and "watching a movie" of her life. She stated very early on in our treatment that the night of her mother's suicide attempt "haunts" her. She also commented that she often feels "unlike her normal self" and like she has multiple different "versions" of herself. While she noted that she experienced some depressive symptoms in high school, she stated that these symptoms have significantly worsened since her mother attempted suicide and her father contacted her a few months prior to the start of treatment for the first time in ten years.

Chloe reported that a major difficulty throughout her life had been her relationship with her mother. In our first session, Chloe called her family "crazy" and described her relationship with her mother as "like dealing with a child." After a few sessions, it became apparent that there were more difficulties beyond her initial presenting problems; specifically, it appeared that Chloe

has been experiencing chronic relational trauma as a result of an upbringing in which her parents were unable to provide her with a safe and emotionally supportive environment. While Chloe reported substantial memory gaps, as well as fragmented memories from her childhood, she did report instances where her mother was emotionally abusive. She also reported recent memories of her father leaving when she was young that were causing her distress. Chloe appeared very conflicted about whether she wanted her father back in her life and presented with guilt and shame about these conflicting feelings.

Relevant Personal History

Chloe grew up with her mother, father, and younger sister in a small town in the Northeastern United States until her parents divorced when Chloe was 10 years old. After the divorce, Chloe and her sister lived with their mother and did not have any contact with their father. Her mother never remarried following the divorce. Chloe described her childhood as one in which she felt "constantly worried" about her parents. She reported feeling the need to "take care of" her mother and father from a very young age and described a memory of checking out a library book when she was 8 years old about how to help alcoholics (in an attempt to stop her father from drinking so much). Chloe remembered her father as often being intoxicated while driving her, and she stated that her parents often fought about his drinking. Reportedly, her father had "anger issues" and was verbally, and at times, physically abusive towards her mother. Her mother struggled with anxiety and depression, and Chloe reported that her mother would often express suicidal ideation during Chloe's childhood. Chloe stated that she did not remember her mother ever having attempted suicide other than the event one year prior to the onset of treatment. She also said that any expression of sadness towards or about her mother was invalidated, as her mother would tell her that she had no reason to be upset.

Chloe's maternal grandparents often took care of her when she was young, as her mother worked full-time as a parole officer. Chloe reportedly had a bad relationship with her grandmother and grandfather, and she stated that they consistently told her that she could not be upset about her mother's mental health struggles because it must be so hard for her mother. Chloe described her relationship with her sister as "very close" and stated that she was the only person in her life that made her feel truly loved. She reported that her sister had always been her "best friend" as they were only two years apart in age. Other than her sister, Chloe reported having few close friends. She stated that she made friends easily but that these friendships typically would not last for more than a few months. She explained that she had many "acquaintances" and "people to hang out with" but that she did not feel that these friendships were meaningful or supportive. Similarly, Chloe had difficulty with long-term romantic relationships and intimacy. She reported that she had cheated on multiple partners in the past.

At school, Chloe described feeling the need to be the “perfect student” and that she earned validation and praise by earning straight As. She always performed well academically and stated that she recalled applying to college and obtaining financial aid on her own, without the help of her mother or grandparents. Chloe reported that she saved her own money to pay for the applications and that she had a part-time job since she was 16 years old.

Medical History

Chloe reported a history of recurrent migraines and recently had seen a neurologist who prescribed her medication. She stated that the medication was minimally effective at treating her migraines, though she noted that her migraines only occurred when she was very stressed or anxious. She also stated that she broke her collarbone at age 7. Reportedly, she was under the care of her grandparents at the time, and they did not get her medical help following the incident. She had to wait hours in pain until her mother came home and took her to the hospital. Lastly, Chloe endorsed a history of asthma. She had an inhaler that she would typically only have to use when experiencing “extreme anxiety” that led to trouble breathing.

Presentation at the Beginning of Therapy

This was Chloe’s first experience in therapy. At the beginning of therapy, she presented with depressed affect and a sense of hopelessness. During the first few sessions, Chloe was friendly and engaged but also appeared anxious and uncomfortable. She also often appeared to dissociate, as she would abruptly stop talking and present with a blank stare. After long moments of silence, when I realized that she was no longer present in the room (as opposed to just taking time to gather her thoughts), I would prompt her by saying “are you here in the room with me?” She initially was still nonresponsive, which led me to introduce grounding and breathing exercises very early in treatment in order to help her manage these dissociative symptoms. When her dissociative symptoms would subside, Chloe was able to articulate that her mind frequently “went blank” and that her thoughts were “fuzzy” in these moments in session. Overall, Chloe was very motivated to learn and use the breathing and grounding techniques and was able to grasp the concepts quickly and integrate them into her life. However, this skills training would be a large component of the treatment, and we frequently returned to basic use of grounding exercises in future sessions.

Chloe was very invested in obtaining my approval and presented as overly apologetic, as she was very embarrassed and apologetic following her dissociative episodes. When she showed any negative emotion, she would also apologize and state that she did not want to be a “burden” to me. Chloe expressed many negative thoughts about herself and others, such as “I’m always wrong and it’s always my fault” (typically in relation to arguments with her mother), “people

can't be trusted," and "people are mean." From the beginning, Chloe expressed a deep desire to "feel happier" though she did not have much hope that she could ever feel differently. She reported that she had a high level of anxiety and migraines for the entire day before each therapy session and often felt "out of it" when walking to the clinic. While she was very nervous coming to therapy, she reported that she felt noticeably better after the sessions.

Quantitative Assessment

During the initial assessment session, I conducted an unstructured clinical interview with Chloe and also administered three standardized, self-report measures: the Life Events Checklist for DSM-5 (LEC-5), the PTSD Checklist for DSM-5 (PCL-5), and the Beck Depression Inventory—Second Edition (BDI-II). Because Chloe was experiencing symptoms of PTSD and depression, the PCL-5 and BDI-II were subsequently administered every four sessions throughout Chloe's treatment. Chloe's scores on these measures were not overtly discussed in our sessions; rather, the scores enabled me to monitor her distress level, symptom intensity, and overall treatment progress as well as make any changes in the treatment plan if needed. To balance the need for quantitative feedback with the somewhat tedious nature of completing forms before every session which could interfere with Chloe's feelings of safety and engagement with the therapeutic process, I had Chloe complete these measures every four sessions, and additionally at our final session. As treatment progressed, Chloe would often underreport her symptoms when filling out these measures but was able to honestly disclose her symptoms while in session with me. As such, I realized that her statements in session more accurately reflected her symptoms and functioning than her scores on these measures.

The Life Events Checklist for DSM-5 is a self-report measure that screens for potential exposure to traumatic events over one's lifetime (Weathers, Blake, et al., 2013). The LEC-5 assesses exposure to 16 events known to potentially result in PTSD and includes one additional item assessing any other extraordinarily stressful event not captured in the first 16 items. Chloe completed the LEC-5 self-report at the first session in order for me to obtain information regarding her possible exposure to traumatic events. When filling out the measure, Chloe identified one stressful event that happened to her, falling under the category of "any other very stressful event or experience" (item 17) on the LEC-5. During our first session, Chloe confirmed that the stressful event she was referring to on this measure was the same traumatic experience that led her to seek therapy (witnessing her mother's recent suicide attempt). However, as treatment progressed, it was evident that Chloe had experienced many more traumatic events than she had reported on the LEC-5.

The PCL-5 is a 20 item self-report measure with each item scored from 0-4 points, leading to a total possible score range of 0-80, where higher scores reflect increasing PTSD

symptom severity. Current psychometric work suggests that a PCL-5 score between 31 and 33 is indicative of probable PTSD, though the authors note that choosing a cut-point score requires consideration of the prevalence of PTSD in the therapeutic setting (Weathers, Litz, et al., 2013). Generally, the lower the prevalence of PTSD in a given setting, the lower the optimal cut-point; thus, given that Chloe's treatment occurred at a clinic that served the general population, the cut-point score of 31 was chosen as clinically significant. Chloe's PCL-5 score was 40 at the start of treatment, indicating that she was experiencing significant PTSD symptoms. All of her PCL-5 scores can be found in Table 1. It is important to note that while the PCL-5 was useful in the initial assessment and diagnosis phase of treatment, this measure was created and normed for populations with a PTSD diagnosis, not a complex PTSD diagnosis. As such, while the PCL-5 data provided a guide throughout treatment to monitor any trauma-related symptomology, it was not as useful as qualitative measures when evaluating treatment outcomes.

The Beck Depression Inventory—Second Edition (BDI-II) consists of 21 items (scored from 0 to 3 points each), with higher scores reflecting increased depressive symptom severity (Beck, Steer, & Brown, 1996). Scores range from 0-63, with scores of 0-13 indicating minimal depression, 14-19 indicating mild depression, 20-28 indicating moderate depression, and 29-63 indicating severe depression (Beck et al., 1996). At the beginning of treatment, Chloe's score on the BDI-II was 28, indicating that she was experiencing moderate symptoms of depression on the cusp of severe depression. Chloe's BDI-II scores are provided in Table 3.

Diagnosis

As shown in Table 4, at the onset of treatment, Chloe met DSM-5 criteria for major depressive disorder, single episode, moderate. For the month prior to her initial assessment, she had been experiencing a depressed mood, most of the day, nearly every day. Additionally, she reported feelings of worthlessness and guilt, decreased appetite, weight loss, fatigue, anhedonia, concentration difficulties, and insomnia. Chloe also endorsed passive suicidal ideation (thoughts such as "what is the point of living?") but denied a plan or intent to harm herself. She reported feeling increasingly isolated and stated that it had been very hard to get out of bed in the morning or complete her school assignments.

Chloe also met the DSM-5 criteria for PTSD at the onset of treatment. Chloe had experienced a traumatic event one year prior to treatment (witnessing her mother's suicide attempt) (criterion A). In recent months, Chloe had been experiencing intrusive memories, nightmares, flashbacks to the traumatic event, and periods of dissociation where she felt like she was detached from her body and "watching a movie" of her life (criterion B). She also frequently tried to "suppress" her thoughts and feelings about the event and tried to avoid anything that reminded her of the traumatic event, such as pictures of guns (criterion C). She endorsed

experiencing persistent guilt, shame, and negative beliefs about herself, others, and the world, feelings of detachment from others, and extreme difficulty experiencing any positive emotion (criterion D). Further, she endorsed experiencing hypervigilance, sleep disturbances, and concentration difficulties (criterion E). The breakdown of Chloe's initial response profile on the PCL-5 also supported a diagnosis of PTSD (see Table 2).

Goals and Strengths

Chloe had difficulty articulating specific treatment goals early on, consistently stating that she just wanted to "feel better" and find the "one thing" that would fix her. Nevertheless, Chloe presented with many strengths. She was extremely bright and capable of self-reflection and analysis. She also achieved academic success, financial stability, and independence, despite her history of trauma and lack of support from her parents. Chloe was self-referred to treatment, which exemplified her ability and desire to seek out help and emotional support when needed. She also demonstrated motivation and engagement from the start of therapy, as she was always on time and did not often miss scheduled sessions. Chloe was very willing from the start to take what she learned in therapy and use it outside of sessions. For example, she quickly learned and internalized deep breathing techniques taught in session and utilized these techniques in her daily life as well as in future sessions in order to self-regulate. As such, she was often able to tolerate my attempts to gently challenge her defenses without becoming overwhelmed by anxiety. Her intelligence, motivation, and high level of insight were consistent assets throughout the therapy process.

5. CASE FORMULATION AND TREATMENT PLAN

Formulation

Chloe's symptoms seem to have developed as a result of growing up in an unstable, abusive environment with parents who failed to provide her with a sense of safety – which I conceptualized as relational trauma. As a result, she experienced persistent feelings of aloneness in the face of overwhelming emotions which, in turn, compromised her ability to process affect (Fosha, 2000). She fit much of the typical complex trauma profile described by Courtois and Ford (2013), as she had significant alterations in the regulation of affective impulses, alterations in self-perception, alterations in relationship to others, and alterations in systems of meaning. In Chloe's case, alterations in affective impulses resulted in her consistent suppression of emotions, as she typically relied on defenses of avoidance and denial. Her successful use of these defenses for much of her life resulted in a significant phobia of emotions, a phobia further compounded by the fact that any expression of emotion throughout her life had been deemed invalid and selfish by her mother and her grandparents.

The alterations in relationships to others and in self-perception seemed to be the primary contributors to her depressive symptoms. Her severe mistrust of others typically resulted in social detachment; and, when she was able to make friends, her alterations in systems of meaning led her to believe that any friends she made could never understand her or what she has been through. She seemed to have developed a "dismissive" or avoidant attachment style that also contributed to her tendency towards social withdrawal and isolation. Moreover, Chloe took on the "parentified/caretaking" role, as she had to learn to take care of her mother in order to survive (Courtois & Ford, 2013, p. 39). Additionally, she became "compulsively self-reliant," which led to her beliefs that other people are unreliable, all of which perpetuated her depressive symptoms of hopelessness (Courtois & Ford, 2013, p. 290). She tended to take on this caretaking role in other relationships as well, and then would end up withdrawing or isolating because of her inability to assert herself.

Finally, alterations in self-perception as a result of childhood relational trauma led Chloe to develop a fragmented sense of self that was negative, as she believed herself to be unworthy of love and unable to give love to others. Guilt seemed to be the predominant affect that guided most of her decisions and beliefs about herself, especially regarding her mother. Because of her caretaking role, she was constantly conflicted between the desire to be autonomous from her mother, and the guilt and fear that pulled her back to the need to take care of, and protect, her mother.

Treatment Plan and List of Treatment Goals

Chloe's treatment plan was structured to follow the three-phase format of Courtois and Ford's (2013) sequenced, relationship-based approach to complex trauma. Using this overarching treatment structure enabled me to tailor Chloe's treatment to address her most prominent CPTSD symptoms and her presenting problems, as the approach allows for flexibility and integration of a variety of trauma-focused interventions and techniques. As aforementioned, in practice, this model is not applied in a rigid fashion, as the progression through the phases is not typically linear. As such, I used quantitative and qualitative measures, clinical observations, and Chloe's self-reported symptoms and functioning as a guide in deciding what phase of treatment to proceed to and what treatment goals to address. Overall, it was expected that there would be instances of both progression and regression through the phases of treatment, and goals for different phases may be worked on simultaneously. The goals for Chloe's treatment follow the general structure and suggestions for each phase outlined by Courtois and Ford (2013) but have been tailored to match her specific presentation, struggles, and trauma-related symptomology.

Phase 1: Safety, Stabilization, and Engagement

Treatment goal 1: Ensure safety and build a therapeutic working alliance. At the beginning of treatment, it would be important for me to focus on creating safety in therapy, a holding environment, and a secure therapeutic relationship. Because Chloe endorsed passive suicidal ideation, I needed to ensure that she felt physically safe and not at risk of harming herself inside or outside of sessions. Also, the focus on building a working alliance would be imperative in the development of this personal safety and is a necessary precursor to further therapeutic work, as this would set the foundation for Chloe to build a secure attachment with me. One way in which I intended to build this strong therapeutic alliance was through consistent validation and identification of Chloe's strength and resilience, including her use of survival skills and adaptations. I also would utilize a strategy suggested by Courtois and Ford (2013) where I explicitly acknowledge and reframe the possible threatening aspects of the therapeutic relationship and emphasize that trust is not expected to automatically be given but that it needs to be earned over time through consistency, reliability, and honesty in my words and actions. Because Chloe has had so few reliable and trustworthy relationships in her life, I wanted her to feel understood in regard to how difficult it may be for her to trust me.

Treatment goal 2: Stabilize disabling symptoms. In order for Chloe to fully engage productively in treatment, as well function in her daily life, it would be necessary to first focus on stabilizing her debilitating symptoms and overall symptom management. Early on, Chloe was experiencing significant depressive symptoms as well as endorsing many trauma-related symptoms, the most prominent of which was dissociation. Thus, it was important to address both her depression and her dissociative symptoms immediately so that she felt stable enough to continue the work with me. While many cognitive-behavioral interventions can be effective in stabilizing a client with complex trauma and reducing symptoms, I intended to start with behavioral activation for depression through the use of activity scheduling and monitoring. Chloe would use an activity monitoring sheet to record all of her social activities (including any phone calls, texts, meals with people etc.), and we would come up with a plan for her to slowly introduce more positive activities into her daily schedule.

Aligned with the Phase 1 goals of Courtois and Ford's (2013) approach, I also intended to focus on preparing Chloe for Phase 2 through resourcing. I chose to use mindfulness and sensorimotor techniques to help ground Chloe in session, and I intended to teach Chloe various grounding exercises and breathing strategies to address her dissociative symptoms. I also planned to introduce additional emotion regulation skills in order help her learn to identify and label her emotions and regulate herself more effectively.

Treatment goal 3: Enhancing readiness for change through psychoeducation. Courtois and Ford (2013) emphasize that an integral component of Phase 1 is enhancing readiness to change through providing psychoeducation about trauma, posttraumatic reactions, and how treatment can be beneficial. I intended to first explain that the dissociative symptoms she was experiencing are a very common posttraumatic reaction, with the hope that this would decrease Chloe's self-blame and increase self-compassion and understanding. Providing rationale for trauma-focused treatment is also extremely important because a primary goal of therapy is to keep the client engaged and coming to sessions, as none of the other goals can be accomplished if the client is not physically present. I intended to ask Chloe about her goals for treatment and what she hopes to change in her life, as well as provide her with an overview of what future treatment may look like in Phase 2, so that she could feel like it was a collaborative environment where she had some control and knew what to expect. I would also explain the Subjective Units of Distress Scale (SUDS), a scale developed by Joseph Wolpe (1969) that is used to measure one's subjective experience of distress in a given moment. This scale would be an important component of Phase 2 in order to monitor Chloe's distress levels during trauma processing and adjust treatment accordingly. As trauma processing can be very difficult, this goal would be important in ensuring Chloe's participation and engagement when progressing to Phase 2.

Phase 2: Trauma Memory and Emotion Processing

Treatment goal 4: Process trauma-related memories and resolve their emotional and cognitive aftermath. This goal would involve processing emotions and cognitions connected to Chloe's traumatic experiences, beginning with her mother's recent suicide attempt. While Chloe was able to talk about the traumatic memory, she initially presented as detached emotionally from the trauma. Thus, with Chloe, I would take an emotional processing approach that combines elements of AEDP, such as statements aimed at ensuring Chloe feels not alone during trauma processing and is able to process traumatic memory and emotion in presence of a secure attachment figure, with elements of SP, such as contact statements and movement interventions. I also hoped that AEDP would be particularly helpful with Chloe because of her constant feeling of aloneness as a result of her detached/avoidant attachment style. Overall, with this goal, I intended to help Chloe face and process her trauma and its associated emotions, beliefs, and cognitions in enough detail to achieve mastery over the memories and the emotional states associated with her traumatic stress symptoms and her depression.

Throughout trauma processing, it would be important to make sure that Chloe remained in the window of tolerance. This is why it is necessary for me to go over SUDs with her in Phase 1, so I could ask her throughout this process where she is on the scale and help to deactivate her if she is in too much distress. In order to keep Chloe actively engaged in trauma processing as

both a participant and an observer I would use sensorimotor techniques of carefully monitoring subtle nonverbal signs of somatic changes that would indicate hypo- or hyperarousal, commenting on those changes in order to prompt Chloe to notice her reactions, thereby increasing her capacity for mindfulness and regulation of her autonomic arousal.

I intended to integrate concepts from AEDP, such as meta-therapeutic processing (or meta-processing for short), during each session involving trauma processing in order for the sessions to end with Chloe not only *having* a transformational experience in the presence of a secure attachment figure, but also *knowing* that she had that experience. By using this technique often, I intended to affirm Chloe's courage and reestablish her feeling of safety within the therapeutic relationship and environment.

Treatment goal 5: Integrate and improve Chloe's sense of self. Once Chloe's trauma-related symptoms related specifically to her mother's recent suicide attempt have lessened, I intended to focus on helping her to integrate and improve her sense of self. This goal reflects one of the primary goals of AEDP, namely, the transformation and integration of self. I would use various methods to enable Chloe to have a transformational experience in order to access her core state, or true self (Fosha, 2000). We would begin by exploring and identifying the various parts of herself that have been fragmented as a result of her early childhood trauma. In order to achieve this goal, I intended to use portrayals (AEDP guided imagery technique) to help Chloe access her younger wounded self that was still suffering from relational trauma.

We would also explore and identify the parts of herself that have been fighting to protect her through the use of old survival mechanisms that have now become maladaptive. In AEDP, this "survival-based self-organization" is understood as the *compromised self* or *self-at-worst* (Fosha, 2013, p.498; Fosha, 2000). Using AEDP as a theoretical basis, I intended to guide Chloe in recruiting resources from her *resilient self* or *self-at-best* (the self-organization that emerges in conditions of relative safety) in order to work with, and transform, her compromised self (Fosha, 2013). Because Chloe did not have many memories of her childhood, I thought that the use of guided imagery and metaphors would be more successful in accessing and processing that trauma and the resulting fragmented parts of self.

Phase 3: Consolidating Therapeutic Gains

Treatment goal 6: Consolidate treatment gains and apply that knowledge and the skills to daily life and the future. In this final phase of treatment, it would be crucial to aid Chloe in articulating and consolidating treatment gains so she could then apply those gains to her present and future life decisions and domains. I planned to first allow space for Chloe to articulate the progress she has made, and to reflect on how her life was better after going through this

treatment. I also intended to encourage her to use knowledge she has gained about herself in order to evaluate and understand her life options based on who she is and what she really wants in her life. Through reflectively examining and placing her traumatic memories into context from a place of stability, my hope was that Chloe would develop the capacity for self-compassion, empathy, and forgiveness, resulting in the development of a more positive sense of self.

I also hoped that as Chloe continued to integrate her identity and understand herself, she may begin discussing possible career development or future life goals. Moreover, through reviewing and reflecting upon our therapeutic relationship, I aimed to help Chloe begin to deepen her ability to connect with others outside of therapy sessions. This could involve discussing the possibility of pursuing a romantic partner or more intimate friendships, as the therapy relationship will hopefully have allowed Chloe to move from an insecure attachment style to "earned security" that promotes increased interpersonal health and applies to relationships outside of therapy (Courtois & Ford, 2013, p. 64).

Treatment goal 7: Review coping skills and develop relapse prevention plan. To further aid in the application of treatment gains to Chloe's daily life, I planned to review coping skills in order to help Chloe integrate emotional regulation skills, safety planning, and self-care strategies learned in Phase 1 into her daily living. This would include establishing healthy lifestyle routines through revisiting Phase 1 in a more comprehensive approach. As we moved toward termination, it would also be important to not only review the skills from Phase 1, but to develop a concrete relapse prevention plan so that Chloe could feel more in control of her life and feel prepared for any distress that could arise following termination.

Treatment goal 8: Provide Chloe with the space to process treatment termination. I wanted to ensure that Chloe and I had time to discuss and prepare for the end of treatment. Because Chloe had experienced unexpected and traumatic loss in her childhood, I expected that the end of treatment would bring up difficult feelings for her. Thus, it would be important to provide her space to process any feelings of grief and loss as well as to share my own feelings about our connection and the therapeutic relationship. I hoped that this could be an opportunity for Chloe to have a new experience with loss, as she would experience an ending that was expected, processed, and planned ahead of time; an ending where she felt secure and in control. Lastly, it would be important to review future treatment options in the event that Chloe believed she needed more support.

6. COURSE OF TREATMENT

This treatment model consists of three clinical phases: Phase 1: Safety, Stabilization, and Engagement; Phase 2: Trauma Memory and Emotional Processing; and Phase 3: Consolidating

Therapeutic Gains. However, it is expected that treatment in this model will not progress linearly. Often, a client will progress from a particular phase to the next, and later regress back to a previous phase. As such, I chose to organize the description of Chloe's course of treatment into chronological stages, describing her progression or regression between the clinical phases over time, in order to differentiate between the chronological progression of therapy and the clinical course of Chloe's treatment through the three phases. This allowed for an in-depth exploration of what caused Chloe's progression or regression through phases, and how I made the clinical judgment regarding what phase to be in at what stage of treatment.

In line with the above, the course of treatment will be described in eight chronological stages, with each stage indicating a time where the treatment switched to a different phase (either a phase progression or regression). Each stage consists of a number of weeks rather than a number of sessions. I chose to indicate the passage of time in weeks rather than sessions in order to allow for an analysis of sessions missed versus sessions attended by Chloe. In the course of treatment, the scheduled sessions Chloe did not attend were, at times, just as important to reflect on and understand as the sessions she attended, particularly in regard to treatment monitoring and planning. Overall, the treatment occurred over 100 weeks (about two years), with sessions scheduled weekly. In 100 weeks, Chloe attended 80 sessions and missed 13 sessions, and there were seven weeks where a session was either not scheduled or cancelled due to external circumstances (see Table 5 for the treatment timeline).

Stage 1: Phase 1, Weeks 1–15

Weeks 1–3: Ensuring Safety and Building a Therapeutic Working Alliance

Chloe attended all three scheduled sessions during the first three weeks of the treatment. Consistent with my sequenced, relationship-based approach to treating complex PTSD, initial sessions focused on the treatment goals of ensuring safety and building a therapeutic working alliance.

Chloe presented to the first session with depressed affect and expressed feelings of hopelessness. She did not speak much unless I prompted her with questions, and she spoke in a very soft, quiet tone. She sat in a slumped position in the chair and did not make eye contact often, almost as if she were trying to hide or attempting to make herself smaller. At the beginning of the session, Chloe stated that she was very nervous about coming to therapy for the first time and had "no idea what to expect." I immediately validated how hard it must have been to come to therapy and told her that it made total sense that she would have reservations because this is her first time in treatment. Through the use of consistent validation, empathy, and attunement to her current emotions and physiological state, I aimed to begin to establish rapport

and develop a therapeutic alliance with Chloe. I then sought to provide her with as much information as possible about what to expect in treatment, such as the length of sessions and limits of confidentiality.

After I obtained her informed consent, I fully introduced myself to Chloe, as I intended to start the process of gaining her trust and increasing her feelings of safety in the room and with me. I told Chloe that I was a graduate student clinician and would be supervised by a licensed psychologist. Further, I emphasized the mutual nature of the treatment, telling her:

The kind of therapy that I believe in involves a two-way, joint effort between us. I am not here to tell you that I have all the answers or to make you do anything with which you're not comfortable. We are in this together. I also encourage any and all feedback about your reactions or feelings toward me, both negative and positive.

I smiled and took an active, yet relaxed stance, making sure to bring my personality and humanity into the room in as genuine a manner as possible. I did not want to present as the "authority on high" who had all the answers and also did not want her to feel as if I was a detached, neutral observer, all of which is particularly important when working with complex trauma survivors (Courtois & Ford, 2013, p. 136). I also acknowledged that Chloe might find it difficult to trust me and stated that I did not expect trust to be automatically given. When I asked Chloe what it was like to hear me say that, she replied, "I appreciate you saying that. It's really hard for me to trust people, and it feels good to have someone understand that."

I then conducted a brief risk assessment with Chloe, based on her responses on the self-reports she completed prior to the session that indicated she was experiencing passive suicidal ideation. Chloe did not endorse any active suicidal ideation or intent or plan, so I felt comfortable proceeding. I also left time at the end of the first session (and many future sessions) for meta-processing, asking Chloe questions such as "How was this session for you? What's it like to meet me, to be here with me?" Through this AEDP technique of meta-processing, that is, "the reflective and experiential processing of *what the patient feels is therapeutic* about the therapeutic experience he or she has just had," I was aiming to increase Chloe's reflective capacities as well as continue to build a trusting therapeutic alliance by showing her, through my actions, that this was a collaborative process (Gleiser et al., 2008, p. 349; Fosha, 2000). Chloe replied, "It was hard, but I also feel a little relieved, just telling someone about all of this stuff." Then, in an empathic tone, I said, "You've been carrying so much, so much, and I'm so glad you came to meet with me today, that we could be here together. It isn't easy." Consistent with AEDP, I used language such as "we" and "us" to facilitate the creation of a safe and secure base early on.

During the next two sessions, I continued to focus on strengthening our therapeutic alliance through the use of validating and empathic statements of Chloe's experiences. I consistently emphasized that "we are here together" and asked questions such as, "Can we be with this together?" I also continued to gather background information in order to develop a treatment plan that would best meet her needs.

At the beginning of session three, I asked Chloe how she was feeling in the room with me, and she immediately began explaining how depressed she felt in the last week and started telling me she was stressed about an upcoming test in one of her classes. She then switched to describing a recent interaction with one of her roommates. Her rate of speech was very fast, and she exhibited blunted affect. I tried to slow her down in order to truly understand what was happening for her in that moment; yet I also wanted to maintain a holding environment and wanted her to feel validated and understood. Thus, I gently interrupted her and said, "This sounds really important, and I'm wondering if it would be okay if we stopped and slowed down for a moment? Can we stay here together?"

With AEDP in mind, I intended to slow Chloe down so she could connect more to her affective experience and access her core emotions. However, Chloe still was unable to truly connect to any feelings in that moment. She did stop talking, but then we just sat in silence staring at each other. Because I sensed that Chloe was beginning to dissociate, I asked her if it would be okay if we took a deep breath together, since I did not want to overwhelm her. During this time, Chloe showed a pattern of changing the topic and shifting into an intellectualized discussion lacking any emotion, and this pattern continued in future sessions.

Also during this time period, I often found myself feeling confused and having trouble remembering what occurred in a prior session or having difficulty understanding a coherent narrative of Chloe's experiences. During one session, I even completely lost my train of thought. While I initially felt as though I was doing something "wrong" or I was an "unskilled therapist," I soon realized that my reactions were indicators that Chloe was in a dissociative state, as I was feeling as if I were being "drawn into the world of the dissociative client" which can be "an experience of extreme personal disorientation" (Courtois & Ford, 2013, p. 267). Once I recognized this, I realized that I needed to pay more attention to physically grounding and regulating myself during our sessions. From then on, I learned the importance of taking deep breaths in sessions and being mindful of my own thought processes, body reactions, and emotions while interacting with Chloe. By remaining physically and emotionally grounded and regulated while simultaneously attuning to and responding to Chloe, I aimed to present her with a different and corrective relational experience "that encourages integration rather than disintegration and dissociation" (Courtois & Ford, 2013, p.267). This realization also informed

my treatment planning, as I decided to focus the next few sessions on utilizing treatment interventions that have been found to be particularly helpful with dissociative clients.

Weeks 4–15: Stabilizing Depressive and Dissociative Symptoms

During the next 12 weeks, Chloe attended 10 out of the 11 sessions scheduled, as she cancelled one session due to illness. During this initial treatment stage, Chloe continued to present to sessions with depressed or blunted affect and expressed feeling “sad” and “hopeless.” She continued to often dissociate during these sessions as well. Also, she would report to me that she experienced both depressive symptoms and dissociative episodes outside of therapy. As such, I decided to utilize different interventions and techniques that specifically target depressive and dissociative symptoms. In order to address her depressive symptoms, it would first be necessary to stabilize Chloe’s most severe dissociative symptoms that were, at times, inhibiting her ability to remain present and oriented in sessions. The following example illustrates Chloe’s dissociative reaction during a session and describes my use of grounding and breathing techniques in an attempt to stabilize her.

In session four, Chloe was talking about how she had been having difficulty concentrating during class because she would often “zone out” or have memories of her mother’s suicide attempt. As was often the case, she appeared to have little affect while describing her difficulties. To try and help her access and connect to her feelings, I said, “This all sounds like so much. I’m wondering how you’re feeling right now telling me this?” Chloe stared at me. We sat in silence for what felt like forever, but I imagine it was only about a minute. In line with AEDP’s emphasis on moment-to-moment tracking, I was paying careful attention to Chloe’s presentation in order to figure out whether she was using the silence to gather her thoughts, or if the silence was indicative of Chloe dissociating, in which case it would not be helpful for me to continue to stay silent.

I asked, “Are you here with me in the room right now? Can you hear my voice? I’m here with you right now. You are safe” (reflecting an AEDP focus on *undoing aloneness*). Chloe did not respond. I realized I needed to physically “ground” Chloe. I asked, “Chloe, could you look at me?” She slowly looked up, her facial expression was flat, with a nonblinking stare. “Chloe, can you hear me? Can you look at me?” She looked around the room, and then back at me. I said, “Ok, looking at me, focus on some item, my clothes, the picture behind me, the chair, you choose. Can you name it for me?” After a pause, Chloe said “the chair.” I said, “What color is the chair? Can you describe it?” Chloe responded, “It’s brown, with a cushion. It has four legs, it’s big.” I said, “Ok, good. Now name and describe two more items in the room, the color, size, whatever you want.” Chloe proceeded to name and describe a lamp, a picture, and the rug. She then said, “My mind is fuzzy.” I continued, “Ok, you’re safe, I’m here, can you focus on what

you hear? What are two sounds that you notice?" She said she heard the white noise machine and the ticking of the clock. She looked up at me. I asked, "How are you feeling now?" She replied, "I didn't hear you at first. I felt like I was floating. The room looked warped to me, like distorted. It was really weird. I'm still feeling a little floaty. My heart is beating really fast, but I'm starting to feel better."

I then introduced focused, diaphragmatic breathing. "Okay, good. I'm glad you're starting to feel better. How about we take a few deep breaths together?" Chloe nodded her head "yes" and her breathing began to noticeably slow down and become less shallow. I mirrored her as I began to slow down my breathing. I said,

In through your nose and out through your mouth. Breathing from your stomach. As you breathe in, pay attention to your stomach expanding, and as you exhale, your stomach deflates. As your chest remains still, you feel this deep breath coming from your stomach. Now, inhale for a count of four—1, 2, 3, 4, and exhaling slowly for a count of eight—1, 2, 3, 4, 5, 6, 7, 8.

We took three more deep, slow breaths together. Chloe said, "I feel more relaxed. The room looks normal again. My heart is not beating so fast anymore."

Then Chloe apologized to me and said she was embarrassed that she could not gather her thoughts and was worried I thought she was "crazy." She also thought I must be frustrated with her for not being able to engage in the session or answer my questions. I first validated her feelings, and then told her that I did not think she was crazy at all; in actuality, her reactions seemed perfectly understandable to me given the trauma she had experienced. I provided psychoeducation about trauma and dissociative symptoms, and explained that often, during traumatic experiences, the body learns to "dissociate" from those moments in order to survive. Thus, her dissociative reactions initially developed as survival mechanisms and demonstrate her resilience. However, because these survival mechanisms had to be used so often, her body most likely got accustomed to reacting this way whenever she feels very uncomfortable or afraid. I told Chloe that her reaction in session was most likely an example of this dissociative defense, and it was her body's way of saying that it is becoming overwhelmed and needs a break. I emphasized that this is a very common phenomenon for survivors of trauma.

Chloe expressed gratitude following this conversation. Even just giving her the word "dissociation" to describe her experience appeared to provide Chloe with relief, as she did not know about what was happening and found comfort in the fact that many people who have experienced trauma have dissociative reactions. I hoped that by providing her psychoeducation

about dissociation and its relation to trauma, she would begin to feel less need to apologize to me and would start to have more compassion for herself.

This example highlights the need to focus on ensuring that Chloe was present in the room with me before I could proceed to target any other treatment goal. It was an effective intervention, and I would use these grounding and breathing exercises many times throughout treatment when it was clear that Chloe was beginning to dissociate. My aim was to have her eventually be able to recognize that she was about to dissociate and utilize grounding and breathing techniques without my prompting.

Further, the above example illustrates my attempts to help Chloe regain the presence of mind necessary to observe her symptoms and be able to discuss them without uncontrollably being flooded by, or repeating, them. Courtois and Ford (2013) describe this process as "focusing" and emphasize that it is a necessary first step in symptom stabilization (p. 128). Through employing focusing interventions, and by providing psychoeducation about her dissociative reactions, the goal was to help Chloe understand that her thoughts and feelings do not need to control her; rather, they can be observed and selectively focused on in order to gain personal control. I also hoped that as she began to gain some control over her emotions and better understand her dissociative reactions, she would begin to feel safer with me and secure in the therapeutic environment.

After Chloe appeared better able to remain present in sessions and seemed to have increased her capacity for self-reflection, I began, in session seven, to target her depressive symptoms with behavioral activation. However, I would continue to integrate grounding and mindfulness techniques throughout sessions in order to help decrease Chloe's dissociative reactions, as well as to model these skills so that she could begin to practice them on her own outside of therapy. As the weeks progressed, Chloe did start slowly integrating these skills into her daily life. For example, while she began reporting that she would often dissociate on the way to our therapy sessions and was still reporting experiencing significant dissociative episodes outside of sessions, she said she would do deep breathing exercises and told me that these exercises were very effective in calming her down and reorienting her to the present moment.

In session seven, I provided Chloe with a brief overview of behavioral activation, and I introduced the concept of activity monitoring and scheduling. As per the suggestions for presenting the BA treatment model outlined by Jacobson et al. (2001), I began by clearly and thoroughly discussing the relationships among mood, activity, and environment. I highlighted the "vicious cycle" between depressed mood, withdrawal/avoidance, and worsened depression. I then explained the concept of "focused activation," emphasizing the importance of finding pleasurable behaviors and activities that will be positively reinforcing and disrupt the cycle of

depression (Jacobson et al., 2001, p. 260). I believed that this psychoeducation component would be helpful for multiple reasons. It would enhance Chloe's engagement and motivation to participate in this intervention, and I thought it would be helpful throughout treatment to increase Chloe's awareness of how her activities play a role in her depressive and trauma-related symptoms.

After this discussion, I ensured that the decision whether to use this intervention was collaborative by saying, "I think this could be helpful with lessening your depression. I'm wondering what you think? Is this something you'd be okay with trying?" After she agreed to try this method, we discussed what activities she could add to her schedule that would provide her with pleasure and connection. She stated that she used to play guitar years ago and wanted to start playing again, and also that she could try and go to dinner with someone from one of her college classes. Additionally, I provided her with psychoeducation about the benefits of exercise, and she agreed to try going to the gym. I gave her a weekly activity monitoring sheet, and on this sheet, we wrote in the activities that she committed to engaging in before the next session. Chloe was assigned homework to record all of her social activities in between sessions and to engage specifically in the activities that we had written into the schedule.

We reviewed her activity monitoring sheet at the beginning of each of the next few sessions, and we discussed whether she engaged in the activities that we had added to the schedule (such as going to the gym twice a week, playing guitar once a week, and calling a friend twice a week). Chloe was very compliant and diligent with the homework assignments, often filling out the activity monitoring sheet in a very detailed manner (see Figure 1 for sample activity monitoring sheet). This intervention was effective right away, as she began to engage in her chosen activities. Chloe reported that she began to feel less alone and reported fewer days of feeling hopeless or depressed.

After a few weeks of assigning Chloe homework to observe and record her activities, I decided to no longer explicitly use behavioral activation techniques in sessions, as Chloe appeared to be integrating the activities into her daily life and her depressive symptoms had begun to lessen. Further, from the beginning of treatment, I noticed that Chloe was very invested in pleasing me and obtaining my approval, which I hypothesized was due to her need to take on a "parentified/caretaking" role throughout her life in order to survive her traumatic experiences. Because her mother was so emotionally dysregulated, Chloe had to be the mature, put together one in the family. I did not want this role to be reenacted between us, or for Chloe to feel like she had to be that "perfect" in therapy with me, so I chose not to assign homework for the rest of our treatment. Even though behavioral activation was initially effective in decreasing her depression,

I believed that avoiding the encouragement of behaviors that reinforced her desire to be the "perfect" compliant child with me was more clinically important.

As treatment progressed, Chloe still had difficulty with identifying, labeling, and verbalizing her feelings. While this was due, in part, to her dissociative symptoms, by week 11, her dissociative symptoms had appeared to decrease, and she was often able to stay present during entire sessions. Thus, I hypothesized that Chloe's difficulty identifying and expressing feelings was not always due to dissociation but was due to her reliance on defenses of avoidance and her resulting phobia of emotions. I began to use Sensorimotor Psychotherapy (SP) and AEDP techniques to challenge Chloe's frequent avoidance of affect in sessions. For example, I tried to enable her to stay with emotions that were difficult for her to express by consistent attempts to slow her down, as I asked, "What are you feeling in your body right now? Can you notice any physical sensations?"

At times, Chloe was able to notice certain sensations such as feeling "heavy" in her chest. I would frequently ask her to do a brief mental scan of her body, paying attention to any physical sensations, such as tension, tightness, warmth, or tingling. This exercise would be important for Chloe to learn, as I knew that later on in treatment, during trauma processing in Phase 2, awareness of body sensations would be a useful intervention for Chloe to access certain trauma-related emotions and memories that she cognitively could not access.

Even though Chloe still struggled with some dissociative symptoms, she appeared to be improving in her ability to recognize when she was about to dissociate and was starting to use the emotion regulation skills practiced in sessions. Her depressive symptoms also appeared to have decreased, evidenced by her reports in session and her scores on the BDI-II (see Table 3).

In session 12 (week 14), Chloe and I began discussing the possibility of moving on to Phase 2, and Chloe was very clear that she wanted to start "dealing with" her traumatic memories because she really wanted to "feel better." However, while she verbalized her enthusiasm, her affect and body language expressed hesitation and anxiety. I commented on this discrepancy, which allowed space for Chloe to recognize that she may be more nervous than she thought.

Our discussion led to my explanation of the Subjective Units of Distress Scale (SUDS). I explained that this scale ranges from 0-10, with 0 indicating that she is feeling no distress and 10 indicating the highest level of distress, and that using this scale would allow me to remain attuned to her emotional state throughout trauma processing. Chloe told me she liked the idea of using this scale and was thankful that I brought it up. Also, Chloe had become acutely aware of her constant desire to avoid and suppress her emotions, particularly feelings of sadness, and had

begun to understand that those defenses are not always helpful and may be exacerbating her posttraumatic stress reactions and depressive symptoms. Thus, she appeared motivated and engaged to begin to address the traumatic experiences and associated emotions that she had been avoiding.

Stage 2: Progression to Phase 2, Weeks 16–21

Weeks 16–17: Processing Trauma-Related Memories and Emotions

Chloe attended the next two scheduled sessions (sessions 14 and 15), the first of which targeted the Phase 2 treatment goal of processing trauma-related memories and resolving their emotional and cognitive aftermath. I used SP and AEDP techniques throughout this process. The following is an excerpt from session 14 that illustrates the start of trauma processing related to Chloe witnessing of her mother's suicide attempt:

Phoebe: (in a soft, gentle tone) Do you feel comfortable closing your eyes?

Chloe: (timidly) Ok, yea. (closes eyes)

Phoebe: I'm here. You're not alone. You're safe. Can you picture yourself in your house the night of your mom's suicide attempt?

Chloe: (with blunted affect) I'm in my house.

Phoebe: Where in your house are you?

Chloe: (still without much affect or emotion) I'm downstairs, in the living room. My mom has a gun to her head. She's crying.

Phoebe: Can you notice any sounds? Any smells? What are you feeling?

Chloe: I hear my mom screaming that she is going to shoot herself. That she can't take it anymore. I'm scared. I freeze.

Phoebe: (I notice her breathing becoming more shallow, fast) Chloe, I'm here. You're safe. You're safe. You're not alone. I'm with you. Deep breaths. You're safe. What happens next? What are you doing? Are you standing still or moving?

Chloe: (appears to hear me, takes a breath, begins to tear up) I'm grabbing her gun and running upstairs. I lock myself in my room. My mom is banging on the door. I need to call 911, but I can't do it.

Phoebe: Can you feel the gun in your hand? The metal? Did you put it down or are you holding it?

Chloe: It's so cold. The gun. I'm holding it. My hands are shaking. I got my phone from my pocket. I'm trying to dial 911, but it's hard. I try to put the gun down, to hide it, but I'm frozen, I can't move. (starts sobbing, her face becoming flushed, red, she starts shaking)

Phoebe: Chloe, Chloe, can you hear my voice? (Chloe doesn't respond). Chloe, can you hear me? Do you want to open your eyes? I'm here. You're here in this room with me. At the clinic.

Chloe: (She opens her eyes, looks at me, crying slows down) I'm here. Okay. I was so scared. Alone. I was so alone. (she tears up again, tears slowly streaming down her face, but her breathing is steady).

Phoebe: (I pause, allowing her to access and stay with this painful feeling) This is so, so much. That must have been so terrifying. You were so alone. You're not alone anymore. I'm here with you now. How are you feeling in your body right now?

Chloe: My hands are tingling, it's like I can still feel the gun, holding it.

Phoebe: Can you bring awareness to that tingling? Just noticing the sensations. Remembering that you are here in this room, with me, you are not alone.

Chloe: (Pause) Okay.

Phoebe: If your hands could do something, what would they do?

Chloe: (After a long pause) Throw the gun out a window.

Phoebe: Yea, of course, that makes so much sense. How about we throw it out the window together right now? (Chloe slowly nods her head in agreement, though with a confused look on her face, and I lift my arm and make a 'throwing' motion as Chloe does the same)

Chloe: (Appearing more alert, her posture straightening) That actually felt pretty good. I pictured glass breaking as I chucked the gun out the window.

Phoebe: Yea, that is so powerful. What do your hands feel like now?

Chloe: They aren't tingling anymore. I feel a little lighter.

I then asked Chloe if we could stay with that "lighter" feeling together, if we could just allow that feeling to be here in the room with both of us. Chloe and I sat in silence for a few moments. The silence felt different than in prior sessions; in this silence I felt truly connected to her, even feeling lightness in my own body. At the end of the session, I asked Chloe to rate her emotional distress using the SUDS, and then asked her what this session was like for her. She rated her distress as a 2 on the SUDS and then said that she was glad to feel like she was starting to deal with and address some of her traumatic experiences, even though the session was really hard.

The above example illustrates an integrative approach to trauma processing, as it involved both an AEDP emphasis on undoing the client's aloneness in the face of overwhelming emotions (shown when I consistently reminded Chloe that she is not alone and my use of language such as "we" and "together") and SP techniques (my contact statements and interventions aimed at focusing Chloe's attention to her immediate experience of her inner body sensations and five-sense perception). Once Chloe was able to become more aware of her body, I encouraged her to take the next step in SP: to see how movement and action might aid in changing the attachment memories in her body (Fisher, 2011).

The goal was for Chloe to begin to develop a sense of empowerment and safety as her body was able to act out the movement of her protecting herself during the traumatic experience by throwing that gun out of the window. Because Chloe initially froze during the actual traumatic event (understood in SP as a *failed active defensive response*), this movement was intended as a way in which Chloe could alleviate some of her distressing bodily experiences (and frequent dissociative reactions) through experiencing the somatic sequence of an active defensive response (throwing the gun out the window) (Ogden & Minton, 2000).

The following session, session 15, went very differently. At the start of the session, when I asked her what last session was like for her and how she felt after the session, she said, "Last session was fine, and I felt fine after." I then asked her what "fine" means, and she replied, "Well I didn't feel anything really. I mean I had a migraine when leaving the session last week, but I just went home and did my homework and went to sleep. Honestly, I don't even really remember what we talked about in the session."

When I reminded Chloe that we talked about her witnessing her mother's suicide attempt and that she appeared to experience some pretty painful emotions, she smiled and began to laugh. She then said, "Oh yea, grabbing the gun from my mother's hand sucked." Reflecting a SP approach, I tracked the changes in Chloe's physical state and made "contact" statements such as, "I notice that you're smiling and laughing while telling me some pretty painful things." I aimed to invite Chloe to mindfully notice her body experiences without dysregulating or shaming her. I recognized that her defense of avoidance was very heightened, exhibited by her efforts to change the topic away from anything related to her mother or emotions and her fast rate of speech. She was also not very amenable to my attempts to slow her down and quickly brushed off the "contact" statements mentioned above.

As she talked, I felt confused and disoriented, as she presented with incongruent affect and body language. I was also having trouble following or understanding her train of thought and what she was talking about. I soon realized that my feelings were possibly indicative of Chloe regressing into a somewhat dissociative state. As Courtois and Ford (2013) note, clients who are

highly dissociative are often incoherent or dysfluent in their self-presentation and their ability to recount autobiographical information; as such, the therapist can often become confused as they listen to the client, "losing the thread of what is being said" (p. 263). Thus, even though Chloe's dissociation was not severe in this session, it seemed that she still had a dissociative element to her presentation.

Weeks 18–21: Addressing Session Cancellations and Emotion Dysregulation

Chloe cancelled the next three sessions by sending me a text message the day before each scheduled session. The first time she cancelled, I responded by sending a text message back saying, "Thank you for letting me know. I hope everything is okay, and I'll see you next week." When she cancelled twice more in the next two weeks, I called her, but each call went straight to voicemail. She finally agreed to come back once I reached her on the phone.

We were able to discuss the meaning of her cancellations at the next session (session 16/week 21 of treatment). Chloe told me that she was avoiding our sessions because she was avoiding talking about a recent distressing incident that occurred with her mother. I responded by validating why she would want to avoid discussing this and empathizing with her hesitation to come to therapy. She also told me that recently, she had been having migraines on the way to sessions and would have migraines sometimes during our sessions, which was another reason why she did not want to come to therapy. Lastly, she reported that she had been struggling to manage her time well and was often forgetting what day it was. It appeared that Chloe's session cancellations resulted from a combination of both an increase in her dissociative symptoms and her heightened defense of avoidance.

After this session, I thought a lot about the treatment plan moving forward because Chloe was clearly exhibiting resistance to treatment, and I wanted to ensure that she would remain in therapy. If I continued to push her to process her trauma too soon, there was also the possibility that our therapeutic alliance would be threatened. Also, the recent increase in migraines and dissociative episodes in and out of sessions suggested that she was becoming too emotionally dysregulated to continue in this phase. As such, while I had initially believed that she was ready to delve into trauma work, after these cancellations and the subsequent discussion with Chloe, it became apparent that we needed to go back to Phase 1 work. As I made this decision, it was important for me to remember that this regression did not negate the treatment gains from the trauma work in session 14, as treatment with survivors of complex trauma is usually not linear, and different goals can be addressed and worked on simultaneously.

Stage 3: Regression to Phase 1, Weeks 22–34

Weeks 22–27: Strengthening Emotion Regulation Skills and Enhancing Readiness to Change.

Chloe attended all six scheduled sessions during this time period. In this stage, I went back to Phase 1 targets and treatment goals. I realized that I may not have focused enough on the Phase 1 goal of enhancing readiness to change, as Chloe's avoidance may, in part, have been because she did not believe that therapy could truly help her and/or did not think the benefits of trauma processing outweighed how difficult it would be. Throughout this stage, Chloe and I also continued to practice the emotion regulation skills she learned in Stage 1 (e.g., breathing techniques and grounding exercises), and I frequently checked in with her about whether she was using these skills outside of our sessions.

Keeping in mind the goal of enhancing Chloe's readiness to change, I used AEDP interventions aimed at restructuring her defense of avoidance. These restructuring strategies involved recognizing the defense, understanding its origin and historical function, and encouraging and helping Chloe to choose a different experience. For example, in the first week of Stage 3 (session 17), as Chloe and I were discussing her ambivalence about treatment and her use of avoidance as a main coping strategy in her life, I asked her, "I wonder what this tendency to avoid distressing experiences does for you? I imagine it developed for a reason, to protect you in some way?" Through these questions, I was recognizing her defense, affirming it as a strategy for self-protection, and then opening the possibility of restructuring the defense in a curious and nonjudgmental way. As Chloe began to realize that her defense of avoidance was not really working for her anymore, while simultaneously gaining awareness and appreciation for how her defense mechanism helped her survive in the past, she became more willing to challenge her avoidant reactions.

I also targeted Phase 1 treatment goals using SP interventions. As aforementioned, Chloe's body language often seemed to express a desire to hide or a lack of energy, as she frequently slouched in her chair. Aligned with SP, I tracked Chloe's body language throughout sessions and noticed that her body positioning would change depending on how depressed she was or how present in the room she was. During session 19 (week 24), I used a movement intervention from SP in an attempt to help Chloe feel more energized and engaged in the session.

In this session, I noticed that Chloe's body language started off as slouched in the chair. However, as the session progressed, there were moments where she would lean forward and appear more engaged. I commented on those changes and at one point, she noticeably began to slouch back in her chair and appeared to lack energy. She then said, "I'm suddenly feeling pretty tired, kind of hopeless actually. I don't know what just happened." I asked her, "I'm wondering

what it would be like for us to both stand up right now? Would it be okay if we stood rather than sit?" When we both were standing, I asked her, "If your body could speak right now, what would it want to do?" She responded, "I think it wants to do jumping jacks." We did jumping jacks together and within moments, Chloe appeared more energized and present in the room, her face suddenly breaking into a smile. I commented on this change, and after a couple more seconds of standing, Chloe decided she wanted us to sit back down.

Toward the end of this session, I asked Chloe what it was like for her to stand up with me in session today, and she replied that she was surprised at how different and better she felt just by that small movement and change in her body position. Then, in an effort to help Chloe better identify and label her emotions (an important goal of Phase 1), I said, "I'm wondering what 'better' feels like? What tells you that you're feeling better?" She had trouble answering, saying "I don't know, I just feel better. A little less alone, I don't know."

Using the AEDP strategies of affective self-disclosure followed by meta-processing, I responded, "Yea, I felt more energized from standing up and more connected to you, even feeling warmth throughout my body. What's it like to hear me say that?" She replied, "That feels really nice and gives me some hope." Through this combination of SP and AEDP interventions, Chloe was able to transform her internal experience, with her new body language and my statements communicating that she was not alone and that there was hope. Also, by enabling Chloe to have a new positive experience in our therapy session, I was enhancing her readiness to change by showing her that therapy can increase her feelings of hopefulness and connection.

It was clear that Chloe's body often expressed her emotions even when she could not identify her feelings verbally, a phenomenon that did not surprise me given the common neurobiological effects of complex trauma. As such, I used SP interventions aimed at helping her become more mindful of, and curious about, her physical sensations, asking questions such as, "What do you feel in your body? Where exactly do you experience that tension? Does the sensation change at all when you draw your awareness to it?" I also brought up the earlier session where I had asked her if her hands could do something what would they do which led to her acting out the motion of throwing her mother's gun out a window. I explained that this was another example of how her body speaks for her and can often express her feelings when she does not have the words to describe her emotions.

Aligned with the SP understanding that mindfulness is key to increasing one's capacity for self-regulation, mindful awareness of her body was intended to be another emotion regulation tool Chloe could use. As she became more mindful, Chloe also began to understand and connect her body sensations to her emotional experiences, enabling her to learn how to better identify and label her emotions.

In week 27, I began thinking about the possibility of progressing back to Phase 2 with Chloe, and I decided to bring it up with her in our session that week. During this session, Chloe brought up a recent experience where her father called her and wanted to meet. She said that after she hung up the phone, she felt very depressed and cancelled dinner plans with her friends that night.

Up until this point, Chloe had not mentioned her father much, but I remembered her telling me at the beginning of treatment that he had recently contacted her for the first time in ten years. Chloe told me that she did not know if she felt comfortable meeting up with him, and then we talked about how it would be helpful for treatment to not only address her relationship with her mother and resulting traumatic experiences but also her past memories of, and experiences with, her father. During this conversation, Chloe was able to make the connection that her father's phone call most likely triggered her depressive symptoms, and then she expressed her willingness to more specifically address her relationship with her father in future sessions. Our plan at the end of this session was to start more targeted trauma processing work in the following week.

Weeks 28–34: Addressing a Gap in Treatment

Treatment did not progress as planned because Chloe cancelled the next session due to being sick, and then the clinic was closed the following three weeks (due to a snowstorm, the university's spring break, then another snowstorm). During the first session back after the four-week gap in treatment (session 23/week 32), Chloe and I discussed how it was hard for her. When I asked her what it was like to be back with me after four weeks, she said, "To be honest, I wasn't even sure if therapy was happening this week. I kind of expected you not to be here." I then asked her why she expected I wouldn't be here, and she replied, "I guess it's really hard for me to trust that someone is still there when I don't see them physically for a long time." I responded by saying, "It is totally understandable that you would have difficulty trusting me, and it must have taken a lot of courage to come back to therapy after there was such a long gap." We then explored how Chloe's relationships and experiences with her parents may have led to this belief that people cannot be trusted.

During this session, I also left space to meta-process the experience, as I asked, "What is it like for you that I'm still here? That even after we didn't see each other for a month, I didn't leave?" She stated, "It feels good to realize that you're still here, that you didn't disappear." Overall, while the gap in treatment was difficult, it ended up being therapeutic because it provided an opportunity to address Chloe's struggles with trust and abandonment. By not abandoning her, I could provide her with a different and corrective emotional experience. Also, Chloe was able to see the progress she had made regarding her increased trust and security with

me because she still showed up to therapy even when she was afraid that I would not be there. Chloe's recognition of her progress and our strengthened therapeutic alliance further contributed to enhancing her readiness to change.

Once our therapeutic bond had strengthened and I began feeling comfortable pointing out Chloe's use of avoidance without fear that she would stop coming, I thought about progressing to Phase 2 again. Chloe was better able to stay present in the therapy session, and if she felt herself beginning to dissociate, she was able to recognize the signs and start taking deep breaths to regulate herself. She was better able to identify and label her emotions and was becoming mindful of the connection between her body sensations and her emotions, often letting her body first "speak" for her when she could not find the words to describe her experience. Chloe had recently begun reporting a decrease in the frequency of her migraines as well. As such, after two more weeks of sessions, our treatment progressed to Phase 2.

This decision was made based on the progress Chloe had made throughout this stage and her willingness to further solidify these changes. For example, through psychoeducation, frequent validation and empathy, and the strengthening of our therapeutic alliance, Chloe's belief that she was "crazy" and her belief that "people cannot be trusted" had started lessening. Chloe also told me that she started attending a weekly yoga class and was more consistent in socializing and engaging in activities that enhance her mood. She had also begun to become aware of how much her mother influences everything she thought and did, and how relationships with others were influenced by the assumption that everyone is like her mother. Moreover, she had become acutely aware of her constant desire to avoid and suppress her emotions, particularly feelings of sadness, and had begun to understand that those defenses are not always helpful. Chloe's increased insight and these tangible changes enabled her to be more willing to progress to Phase 2. The additional stresses related to her father's presence in her life, and her insight into how her relationship with, and trauma related to, her father affected her struggles further contributed to her increased willingness to process her trauma.

Stage 4: Progression to Phase 2, Weeks 35–60

During the next 26 weeks (~6 months) of treatment, Chloe attended 23 sessions (sessions 26-48) and missed three sessions. During this time period, we went back and forth addressing different goals related to Phase 2, and there were instances where multiple goals were interwoven and addressed simultaneously. At times we focused on specific memories and emotions related to particular traumatic events; however, because Chloe had so many instances of trauma, it was impossible to address and process each specific memory. I remained mindful throughout this stage and noticed certain themes emerging and which memories appeared to come up most, paying closest attention to any early childhood memories. In this stage, Chloe

continued to practice emotion regulation skills and the SUDS was continuously used to assess her degree of distress. Throughout all of these sessions, I made sure that attachment phenomena remained a focus, keeping in mind the AEDP assumption that the very attachment experience itself, and processing trauma while in the presence of this security, is a transformative experience and healing for people with histories of complex trauma of a relational nature.

Weeks 35–52: Processing Trauma-Related Memories and Emotions

In the first few weeks of this stage, we continued our Phase 2 work from Stage 2 – targeting Chloe’s memories related to witnessing her mother’s suicide attempt in an effort to resolve their cognitive and emotional aftermath. At times, our trauma work focused on her specific memories and related thoughts. However, when Chloe’s defenses of avoidance and intellectualization would arise, or when she was experiencing dissociative symptoms, I used more body-based techniques, targeting the emotions or physical reactions associated with her traumatic experiences. For example, when Chloe would talk about her mother with little affect, rather than reflecting back what she was telling me, I mirrored her experiences in simple words by saying, “I notice when you’re talking about your mother, your face becomes flushed and red, and your body seems to slouch.”

In line with SP, these mirroring statements were intended to invite Chloe to mindfully notice, rather than interpret or analyze, her internal and body experiences or movements that occur when talking about an event. All of this was designed to foster her ability for “dual awareness,” a key feature of SP and understood as one’s ability to attend to multiple states of consciousness simultaneously (Fisher, 2019, p. 160; Ogden & Fisher, 2015). The ability to maintain dual awareness in the face of posttraumatic dysregulation would be integral to the achievement of Phase 2 treatment goals, as it would allow Chloe to observe images from past traumatic experiences while simultaneously feeling the associated feelings, thoughts, sensations, or movements, all while staying mindfully in the present moment. As such, Chloe would learn how to differentiate the past from the present, which is a key component of trauma processing and effective resolution of posttraumatic symptoms.

By week 39, Chloe was reporting a decrease in symptoms specifically related to her mother’s suicide attempt, as she no longer had frequent flashbacks of the event or avoided things that reminded her of the event, and she was no longer suppressing associated thoughts and feelings. However, she still was experiencing many CPTSD symptoms, such as persistent negative beliefs about herself and others, emotion regulation difficulties, and disturbances in relationships. Also, she was still having trouble remembering her early childhood and was often only able to express fragmented images or bits and pieces of events that occurred when she was young.

In week 40, the focus of our treatment began shifting toward Chloe's feelings and experiences related to her father, who had just come back into her life. While Chloe had some memories related to her mother, she had more trouble accessing clear, coherent memories related to her father. I did not see this as a treatment hurdle though because, reflecting my guiding conception, the goal of trauma processing is not remembering; rather, it is repair of the injuries suffered as a result of the traumatic events. This repair can occur either by remembering explicitly as narrative or implicitly as feelings, reactions, and physical sensations and bodily expressions (Fisher, 2017). As such, in ensuing sessions, our treatment veered away from a focus on describing and experiencing specific memories. Instead, I used guided imagery techniques involving Chloe's different parts of self that had fragmented as a result of her early childhood relational trauma, with the goal of integrating her overall sense of self. The following examples and session descriptions illustrate this process.

In week 45, Chloe came to the session and immediately started talking about a recent encounter with her father. She then abruptly stopped talking and said, "My mind is fuzzy, it's like cloudy. I can't think or put words together." I recognized that Chloe may have been beginning to dissociate, so I conducted a brief grounding exercise before proceeding. I said, "That's okay, I'm here, you're safe. Can you hear my voice? I'm wondering if you can hear anything right now? Any sounds?" Chloe responded by naming sounds, and once I was confident that she was present in the room, I said, "I'm wondering if any images are coming up right now? Moving away from trying to express thoughts, just noticing if any images come into your mind. Or any colors?" She said she saw the color red. I then asked her, "If you were to think of a feeling associated with the color red, what would that feeling be?" After a long pause, Chloe responded, "I mean the obvious answer would be anger I guess, but I don't know if I'm angry. Maybe I'm mad at the world, like I'm pretty sure all humans are inherently evil."

After validating and empathizing with her experience, I said, "You came in talking about your father. I'm wondering if there is any connection between the color red arising and the subject of your father?" She responded, "I don't know. I imagine I'm a little mad at him." It appeared that initially, Chloe may have been defending against her anger toward her father by expressing anger at the world in general. However, by connecting the color red to the subject matter Chloe was discussing prior to seeing that color, I was able to help her bypass this defense.

While Chloe was becoming aware of how angry she was at her father and was able to name and acknowledge the feeling, she still had trouble connecting and staying with her affective experience. She was able to talk about how her father "abandoned" her when she was 10 years old, but she was resistant toward my attempts to slow her down. Also, toward the end of the session, Chloe's appeared to defend against the painful feelings associated with her father by

internalizing her anger and blaming herself, saying that she felt "guilty" because her father "did the best he could." Chloe evidently still relied on these negative parts of self that developed to protect her when she was young, most likely because it was not safe to feel anger as a child. I hoped that by beginning to release some of her anger in a safe environment, she would no longer feel the need to internalize her anger and blame herself.

Trauma processing through use of portrayal. Throughout this stage, I continued to use moment-to-moment tracking to notice subtle emotional and physical changes in Chloe in an effort to bypass her intellectualizing defenses, allowing her to become mindful of her body and access core affect. For example, in session 39 (about a year into treatment), Chloe was talking about her father, and for a brief second her cheeks became flushed, but then the redness disappeared. I said, "I noticed your cheeks became very red." She tried to keep talking. I asked, "Could we slow down and take a deep breath together? Can you notice any sensations in your body right now?" We took a deep breath. She replied, "My face feels hot. My hands are tingling." I asked, "Can we stay with this feeling?" We sat in silence for a moment, and she began to tear up. She said that she just had an image flash into her mind of herself at 8 years old checking out a book about helping alcoholics. She was trying to figure out how to fix her father's drinking problem. She stopped tearing up and started trying to understand why that image came up and what it had to do with her current difficulties, suggesting the re-emergence of her intellectualizing defense.

To help Chloe connect to the affect associated with this traumatic experience, I used *portrayal*, an AEDP experiential-affective strategy where the client has an imagined experience of interacting with parts of the self or with the representations of significant others (Fosha, 2000). Portrayals can be real or imaginary scenes from the past, present, or future in which the client is invited to have a reparative experience through the use of their imagination. Portrayals can be particularly useful when processing dissociated or fragmented traumatic material because the imagery and metaphors of portrayals activate different areas of the brain and allow for a different level of experience. The following excerpt illustrates my use of portrayal, as I guided Chloe through an imagined experience of interacting with her 8-year-old self during the scene at the library where she is checking out the book on alcoholism.

Phoebe: Let's go with that image that just flashed into your mind. Can you picture that little girl right now? That 8-year-old girl at the library? (Chloe closes her eyes and nods her head 'yes')

Phoebe: How is that little girl feeling?

Chloe: (voice trembling) I don't know. I don't know. I can't. [attempts to avoid the affective experience]

Phoebe: Can you imagine your adult self in the library with her? (Chloe slowly nods her head 'yes')

Phoebe: Is it hard to look at her? To be there with her?

Chloe: (in a low tone of voice) Yea. She's just so small, so alone, so scared.

Phoebe: Yea, this is so much. So much. What does that little girl need right now?

Chloe: (tearing up) I think she wants a hug.

Phoebe: Can you imagine yourself right now, in that library, giving that little girl a hug?

Chloe: (crying deeply, powerfully) Yea, yes.

Phoebe: What would you like to say to your younger self, to that little girl?

Chloe: I don't know. (stops crying but still present in the room and affectively engaged)

Phoebe: I feel sadness when I picture that little girl, she must have been so scared, in so much pain, what else was she supposed to do? Wow, she is really strong, so brave.

Chloe: (face flushes red and starts to cry again, then takes a deep breath and whispers) I'm so sorry, I'm so sorry you were so alone. You didn't deserve that. I'm here. I'm here for you now.

Phoebe: Mmm, so powerful. She was so alone, and that little girl isn't alone anymore. You're with her. What is she feeling now? (Chloe opens her eyes and looks at me)

Chloe: Sad. But a little less alone.

We stayed with that feeling of sadness and feeling of being less alone for a bit. Then, in order to deepen and solidify Chloe's affective experience and attachment with her younger self and with me, I asked her, "What's it like to have had this experience, to have come through all of this to being present here, now, with me?" She replied, "It was good," and had difficulty elaborating more. I also asked Chloe what it was like to hear me say I felt sadness and to hear me say that the little girl was strong and brave. Chloe responded by saying that it was a bit hard to hear that from me because she was still having trouble having compassion for her younger self. However, after a pause, she continued by telling me that she felt some lightness in her chest and a feeling of warmth, and she posited that maybe that's what compassion feels like. While still tearing up slightly, she said,

Now my heart hurts. It aches. I think I'm getting in touch with what I must have felt back then, all alone, scared. It's really hard. I don't know if I want to feel compassion for that girl. It's too painful.

I validated why she may not want to have compassion for that little girl, but I also had us stay with this affective experience for a while, as I believed that she was feeling compassion in that moment, even if it was too hard for her to verbally acknowledge that.

While Chloe had accessed feelings of anger in earlier sessions, in this session Chloe was able to access deeper, painful feelings related to grief, loss, and sadness. By using a portrayal, I intended to enable Chloe to access her younger wounded self or child self and then elicit help from her adult self (or, in AEDP terms, her *resilient self*), in order to not only feel the painful emotions but also have a reparative experience where she is able to provide her younger self the comfort and safety that was never provided by her parents (Fosha, 2013).

While there was significant treatment progress made in this session, it also highlighted the fragility of Chloe's sense of self and how difficult it was for Chloe to have compassion for her younger, wounded self. She still expressed negative thoughts about herself, telling me that she feels like it's partly her fault that her dad left and that she should have figured out how to get him to stop drinking. However, she was able to acknowledge that if that were a different little girl in the library, she would tell that girl, "Of course it's not your fault." During this session, Chloe also began to understand how she had to be the caretaker for her parents when she was a child and how the need to take care of others manifests in her current relationships and contributes to her struggles and presenting problems.

Weeks 53–60: Addressing Rupture/Repair of the Therapeutic Alliance

Three weeks later, our therapeutic alliance was threatened during a session that began with Chloe talking about her recent difficulties sleeping. In prior sessions, we had discussed sleep hygiene strategies to try when she experienced insomnia, and she stated that those strategies have not been working lately. I responded with validating and normalizing statements, as I said that it made sense that she would be having difficulty sleeping because of everything that we had been processing and discussing in our sessions.

I then mentioned the possibility of seeing a psychiatrist, and she responded that she had already been taking sleeping pills prescribed by her primary care doctor. She said that was taking the pills frequently at night and that they made her "feel good." In that moment, I became aware of my own strong internal reaction of concern that she may be abusing substances. I said to Chloe, "I can understand why you would want to take those pills, especially because you're having so much trouble sleeping. At the same time, I'm not sure if you know this, but those types of pills can be extremely addictive." She became very quiet. Eventually, I asked, "What was it like to hear me say that? For me to express my concern about the pills you've been taking?" Her initial response was, "It's fine."

However, later in the session, she was able to tell me that she felt judged by me in that moment, and that she felt like I assumed she was addicted to drugs when in reality, she did not want to keep taking the medication which is why she brought up her insomnia in our session. I responded first by saying that I was so glad she told me how she felt and by emphasizing that all feelings towards me, especially any negative feelings, are welcome and important. After taking a moment to mindfully check in with myself, I ended up apologizing to her and saying that I could see how my statements came off as judgmental. I explained that I think I said what I said out of fear, and that I should have left more room for us to discuss and explore her experiences and feelings about the medication before deciding whether to express any concerns I had.

Chloe appeared very surprised and said, "I really appreciate you saying that. Like, that you're human too and can acknowledge your own mistakes. I didn't expect that." At the end of the session, we meta-processed the experience. We talked about how this rupture/repair was a new experience for Chloe because growing up, her family rarely resolved conflict. Even though this session was difficult for me, and I was initially plagued with feelings of self-doubt, I eventually realized that this rupture/repair was actually a therapeutic tool that allowed Chloe to have a reparative experience with a secure attachment figure.

Discussing treatment progress. We spent the next two sessions talking about the progress Chloe had made and all of the changes in her life since the start of treatment. She no longer met full criteria for posttraumatic disorder, and she was experiencing a decrease in complex posttraumatic stress disorder symptoms as well. She began expressing more positive beliefs about herself and hope for the future. Also, she was setting more boundaries with her mother, and she was not feeling as pulled to go home to take care of her, as her deep-rooted beliefs that she was responsible for her mother's safety and well-being began to weaken. Chloe was experiencing fewer depressive symptoms, she was no longer isolating as much, and she had made a few close friendships. I then made the decision to progress to Phase 3 based on my observations that Chloe was able to recall the past without dissociating, was beginning to understand her traumatic experiences in a coherent narrative, putting words and feelings to those experiences, and overall, was beginning to understand her current life and struggles in the context of her past.

Stage 5: Progression to Phase 3, Weeks 61–75

Weeks 61–64: Consolidating Therapeutic Gains

Chloe attended every session for the next four weeks. Consistent with Phase 3 goals and targets, I aimed to help Chloe articulate and consolidate the gains she had made in treatment and apply that knowledge to her daily life and the future. This involved frequently discussing our

therapeutic relationship and how important it had been for Chloe to realize she could feel safe and secure around another person. I kept in mind the AEDP emphasis on co-creating secure attachment and the positive valuation of the self, asking questions aimed at deepening and solidifying these transformational processes.

For example, I asked Chloe, "What's it like to have been through all of this with me, to see how the relationship between us and with yourself has transformed through the last year and a half?" Chloe responded by bringing up the prior session about sleeping pills. She said that the moment when she told me she felt judged and I responded by apologizing was when she stopped seeing me as "a blob" and saw me as an actual human. I was struck by her use of the word "blob" to describe me.

We explored what the word "blob" meant to her, and Chloe realized that she initially needed to see me as a blob in order to be open and honest with me. In the past, Chloe had expressed concern that I treated her "the same as every other client" and would not believe me when I said that I saw her and cared about her as a unique individual and treated her as such. Thus, it appeared that our rupture/repair enabled Chloe to believe that I did not treat her the same as everyone else. My acknowledgement that I may have made a mistake and the subsequent apology allowed her to trust that I was being myself in the room with her, not just a "therapist robot" (a phrase she had used in sessions early in treatment).

Chloe's ability to understand and validate her defenses while also realizing that she no longer needed that protection was significant progress. In AEDP terms, as she felt more safety, her *compromised self* no longer dominated. She was developing compassion for herself. Chloe also told me that because of her experiences with me in therapy and the friendships she had developed over the past year, she no longer believed that "all people are evil." As a result, while she used to vehemently believe that she was never going to get married and did not want to have children, she was now becoming open to the idea of marriage and children one day. I asked what that felt like for her to say, and Chloe said,

I feel hopeful but also, it's scary to think about the future. I've always been so focused on just surviving, just making it through the day. I never considered that there could be more to life, that my life could be meaningful. It's easier to expect the worst because then I'll never be disappointed.

We then processed her fears related to feeling hopeful, as she realized that her tendency to expect the worst was protective when she was young. This insight led Chloe to feel sadness and loss, as she began to understand on a deep emotional level the difficulties she experienced throughout her childhood.

Our work related to grief and loss continued in week 63 (session 51), when Chloe told me she felt sad that she never had the "typical" childhood experience. When I asked her if any images came to mind as said this to me, she replied, "This is weird, but I'm thinking of a failed state, like a failed government." She described the image as a piece of land, freestanding, a shape floating in darkness. The ground was all dirt, and there was dust in the air. After staying with that image, sitting in silence in the room together for a bit, I asked her if she could imagine herself in that failed state, standing there on the dirt. She nodded her head "yes."

I asked her what she was feeling as she stood there, and Chloe replied, "I'm feeling cold. Not scared, but really sad. Just defeated and alone." I said, "I wonder what it would be like to bring me into that failed state. Can you imagine that I'm standing right next to you? What's that like?" She said that she felt a little less alone, and then I asked, "As you stay with that feeling of 'less alone,' what happens?" Chloe started to cry. We sat together as she let herself cry deeply. When Chloe stopped crying, she said,

It's painful because I'm realizing that my parents will never be who I needed them to be. But that doesn't mean my life is a failure. I'm not alone. It's really sad and painful, but I can create my own state now. They failed to be the parents I needed, but now I can be that for myself.

Feeling deeply connected to her and moved by her statement, I said, "Wow, that is so real, so much, so powerful. You can create your own state. What does that new state look like?" She responded, "The darkness surrounding the failed state is getting lighter, and there are some flowers blooming from the dirt. There's a garden. It's bright, with a lot of grass and sunlight." I continued, "What do you want to do in that new state?" She replied, "You're there with me. I'm running around laughing, feeling the breeze and dancing. I know you're there, but I'm also okay with being on my own. It's nice that we can both be there."

Toward the end of the session, I asked her, "What's it like to be here with me now and to have had me in that state with you?" Chloe replied, "It felt good to not be alone, relieving." To deepen her affective experience, I said, "Can you say more about 'good' and 'relieving'? What in your body gives you that experience?" After she responded by describing various body sensations, I said, "I feel honored that I could be a part of that experience with you. That we were in that failed state together. That I got to witness how that state transformed into a beautiful garden."

Reflecting an AEDP approach, by self-disclosing my own affective experience and by meta-therapeutic processing, I intended to deepen and solidify Chloe's emotional experience and transformation of self in the context of a secure attachment with me. It was important for Chloe to not only have the experience of walking through these trauma-related images and emotions in

the presence of a secure attachment figure, but also to know that she had that experience and to reflect on it. Of note, this example illustrates that Phase 2 interventions can be blended into Phase 3 at times. In this case, the integration of Phase 2 interventions, such as the aforementioned portrayal, allowed for Chloe to process feelings of grief and loss from a place of more stability and security.

Weeks 65–75: Addressing a Gap in Treatment.

During the next 11 weeks of treatment, Chloe came to four sessions. Part of this decrease in session attendance was due to my own cancellations, as I cancelled our session in week 65 because I was sick, and I went on vacation for two weeks (weeks 67-68). However, after I came back from vacation, Chloe's attendance became very inconsistent, as she missed four out of the next seven sessions. Specifically, she attended the session following my return from vacation (week 69) where she denied that she had any feelings about me having gone on vacation, but she cancelled the next session and then no-showed the following week. I was concerned, as we had been working together for almost a year and a half and she had never no-showed prior to that week. I called her after the missed session, leaving a voicemail saying that I was worried and hoped everything was okay. Chloe called me back later that night and said she forgot about our session. She apologized profusely and confirmed she would be at the next session.

Chloe did attend our next session (week 72/session 55), and I brought up how the prior week was the first time she had ever missed a session without reaching out beforehand. Speaking very quickly and appearing anxious, Chloe explained that she forgot about the session because she was studying for multiple exams. Trying to slow her down, I posited that perhaps she was experiencing some hesitation or anxiety about coming to therapy that contributed to her no-show. She immediately denied this possibility.

Approaching the topic from a different angle, I asked her what it was like to hear on my voicemail that I had been worried about her, and she replied that she felt guilty that she made me feel that way. I then told her that I understood why she would feel guilty, and at the same time, I worried because I care about her and that worry does not have to indicate that she did something wrong. She was surprised to hear me say this and said that she had not considered that it is okay for people to be worried about her sometimes. We were then able to explore how this connected to Chloe's need to take care of others' emotions, including mine. While I thought our session had been productive and was optimistic about our treatment moving forward, Chloe no-showed again to sessions for the next two weeks.

Finally, in week 75, she came back to treatment. Our session began with Chloe denying that her recent no-shows and inconsistent attendance had any important meaning, repeatedly

saying that she just "forgot" but it's "not a big deal" and "doesn't mean anything." However, as our session progressed, Chloe told me that she had been more forgetful than usual lately, saying that she went to the wrong class the other day because she thought it was a different day of the week. I asked her what it was like to tell me that, and she replied that she felt really embarrassed.

She went on to tell me about a recent distressing incident that occurred when her dad was helping her move to a different apartment. I was surprised to hear that she spent time with her dad, as she rarely saw him. She explained that she decided to let him help because he drove a truck, and she needed help carrying things. Also, he had been asking to see her a lot in recent weeks, so she told me she "finally gave in." She said that they were at her new apartment and, according to her dad and roommate, she started kicking a door repeatedly to the point where she actually broke the door. With tears in her eyes, she looked at me and said,

I was so confused. I must have blacked out. I don't remember kicking a door at all. One moment I was in the apartment, just standing there. Maybe I was feeling a little stressed because of the move, but I don't remember feeling really upset or anything; and the next moment, I'm looking at a broken door in front of me.

After a brief pause, she continued, "I feel crazy, is there something wrong with me? Why can't I remember? I'm not an aggressive person, not the kind of person who would break a door." I validated how scary that situation must have been for her. Then, I provided psychoeducation in an effort to help Chloe understand that she was not "crazy" but that her reaction was most likely a dissociative response to a trigger that reminded her of something traumatic in her past, possibly related to her father. I also brought up what she told me about going to the wrong class and said that could have been a dissociative reaction as well. She was noticeably relieved, as she told me that she thought she was going to have to go to a neurologist because there was something "cognitively wrong" with her.

We proceeded to explore how her breaking down the door may have been a way for her body to express anger even though she could not consciously access or feel it in that moment. In Stage 4, when she began processing trauma related to her father, her feelings of anger toward him emerged, so it made sense that she had this aggressive reaction when around her father. We discussed whether Chloe wanted to have her father in her life and that she may not have been ready to spend so much time with him. We also examined her statement that she "finally gave in," and she came to realize that she may have based her decision to see him on his needs and desires rather than on what was best for her.

After this session, I thought a lot about the treatment plan moving forward, because, while exposure in session to the memory of a traumatic event can be an important treatment component, the goal of complex trauma treatment is not remembering what happened, but the

ability to be *here* in the present moment, and not *there* (Van der Kolk, 2014). Remembering the past is only helpful to the extent that it helps to heal rather than to open old wounds (Fisher, 2017). Because Chloe was dissociating outside of sessions and, at times, during sessions, encouraging her to remember and process traumatic events would not be healing or reparative. If I continued to push her to remember, I knew there was potential to actually cause more harm.

I had to make a decision whether to blend Phase 1 interventions into our ongoing work of Phase 3 or to formally reinstate Phase 1. I chose the latter, based on guidance from Courtois and Ford (2013), as they explain that a formal reinstatement of Phase 1 is particularly helpful with clients in Phase 3 who become so emotionally dysregulated in their "attachment working models (with the therapist or in other key relationships)" that their stability or ability to remain engaged in therapy is threatened (p. 185). Given that Chloe was dysregulated and her ability to remain engaged in therapy was threatened (evidenced by her no-shows), I made the decision to temporarily go back to Phase 1.

Stage 6: Regression to Phase 1, Weeks 76–79: Safety, Stabilization, and Engagement

Chloe came to all four of our scheduled sessions in the next four weeks. Notably, this regression to Phase 1 occurred about a year and a half into treatment, supporting the notion that treatment for complex trauma is not typically linear. Moreover, a regression is not necessarily an indicator that treatment progress has stalled, rather it could indicate an increase in Chloe's feelings of closeness and safety with me and a weakening of her defenses. As Courtois and Ford (2013) emphasize, dissociative symptoms are likely to become more prominent as enough safety develops and as defenses begin to give way. For people with CPTSD, therapy and/or a strong therapeutic alliance can actually be a trigger. Thus, during this stage, there was less of an emphasis on our therapeutic relationship and more of a focus on providing a space for Chloe to strengthen her ability to support and regulate herself.

In this stage, we addressed Chloe's dissociative symptoms by reviewing the skills learned in Stage 1 and more explicitly practicing them in sessions. Also, Chloe was experiencing a lot of shame about the missed sessions. As such, I used frequent validation and empathic statements, and I provided psychoeducation in order to remind her how her dissociative reactions protected her in the past. This was helpful, as Chloe began to have compassion for herself. We also continued to work on Chloe's ability to access and understand her feelings through the use of imagery and metaphors.

In one session, Chloe was talking about a recent stressful interaction with her mother, and without my prompting, she said that she was feeling "empty, like a flag blowing through the wind." When I asked her if she could tell me more about what the flag looked like and to

describe it to me, she said it was a "transparent flag." I asked her if there were any physical sensations in her body as she pictured that flag, and she stated that her chest hurt, her eyes hurt, and her body felt "pent up." She then said, "I'm sad right now but I'm smiling, and I don't know why." After exploring more about the meaning of the "transparent flag", Chloe was eventually able to discover what the sadness was about, as she connected the image to her difficulties truly feeling like she has an identity or sense of herself as a person. Even though Chloe did not cry at all during the session, I felt more connected to her emotionally than I ever had, and I felt tingling sensations in my body. Toward the end of the session, Chloe said, "The flag is blowing less now. It's more stable" and, after a long pause, she continued, "I feel more stable."

During these four weeks, it was clear that Chloe's ability to identify and understand her defenses and her emotions improved greatly. Additionally, I was able to connect with her emotionally in sessions again, as her dissociative symptoms were decreasing. She also was using the mindfulness techniques we had practiced throughout treatment and did not need prompting from me anymore. Her description of herself as a "transparent flag" suggested that there was still much work to be done regarding her fragmented sense of self and identity. Because she was demonstrating that she could regulate her emotions more, I thought it was important to progress to Phase 2 again in order to specifically address her difficulties illustrated by the flag imagery.

Stage 7: Progression to Phase 2, Weeks 80–88-- Trauma Memory and Emotional Processing

During the next nine weeks of treatment, Chloe came to all of our scheduled sessions. This stage focused a lot on loss and mourning. Courtois and Ford (2013) denote that loss and mourning are "special issues" in Phase 2 processing, as emotion processing of trauma inevitably evokes the recognition of what has been lost (p. 178). Through this grief work, the specific Phase 2 treatment goals of integrating and improving Chloe's sense of self and processing trauma-related memories to resolve their emotional and cognitive aftermath were simultaneously addressed, as Chloe began to develop a coherent, cohesive autobiographical narrative of her life and a more integrated understanding of her identity.

In AEDP, these two goals (the integration of self and the development of a cohesive narrative) are not seen as separate occurrences. Rather, they are both achieved through facilitating a secure attachment and the positive valuation of the self, which leads to a transformational process where the client begins to integrate their sense of self. This process allows the client to understand how their life was *then* and how their experience is *now*, in order to make sense and meaning of their lives. While Chloe and I had begun this work in earlier stages, we continued in this stage through a variety of AEDP and SP techniques.

Throughout this stage, Chloe continued to grieve the loss of the childhood she never had, a deep, painful recognition that had emerged in Stage 5. Other losses that arose during this stage included the loss of her trust in herself and others, the loss of self-esteem, and the absence of healthy and attentive parents. Also, as Courtois and Ford (2013) highlight, in order to process and heal trauma memories and emotions, one must both grieve past losses and stop the self-sacrifice involved in trying to heal the family or take care of others. Chloe began this process months prior as she was learning to set more boundaries with her mother. Also, her belief that she was responsible for others' emotions and well-being was weakening. As she took care of herself more and addressed her own needs, she began to feel pride in herself. However, this naturally led her to mourn, because the more she gained self-esteem and compassion for herself, the more she grieved and felt deep emotional pain for her younger self.

In week 81 (session 62), Chloe became immersed in the meta-therapeutic process of *mourning the self*, understood in AEDP as one of four transformational processes that lead to healing (Fosha, 2006). In this session, Chloe was coming to terms with the impact of the painful reality that resulted in her suffering, becoming more aware of what she did not have in her childhood, what she lost, and what she missed as a result of her traumatic experiences and unavailable caregivers.

At one point in the session, using moment-to-moment tracking as Chloe talked, I noticed a subtle affective change in her and said, "Something shifted." Chloe paused, and then teared up as I said, "Let's stay with this feeling." She then told me that the memory of checking out the book about helping alcoholics just came to mind and that she was picturing her 8-year-old self. She proceeded to say,

I'm thinking about how that 8-year-old girl spent her afternoon at the library trying to figure out how to cure her dad's alcoholism, and how sad that is. It wasn't her responsibility to try to fix him. None of it was her fault. She never got to be a kid. She lost so much.

Chloe started crying more. I stayed silent, being with her in that moment.

Then, I gently asked, "What are you feeling toward your younger self right now?" In a very soft, quiet tone, she said, "I'm feeling for her...so much love and sadness. It hurts...my chest is so heavy." I replied, "It's so painful, so much. I'm here with you. Let's make more space to grieve the loss of so many years." Chloe was able to use that space to mourn, to let out those deep, painful feelings without backing away, dissociating, or defending against any of the emotional pain. The associated affect triggered when mourning the self is this experience of emotional pain, "a grief whose object is the self" (Fosha, 2000, p. 162).

After the portrayal, Chloe and I discussed how her experience in this session differed from that of a prior session (~8 months ago in Stage 4) involving a similar exercise focused on this same memory. While Chloe had some difficulty recalling specific details about that session, she did remember that, in general, it was difficult for her to have compassion for her younger self. I added that I noticed a difference in regard to her negative beliefs about herself, noting that she said in the previous session that she still believed that it was partly her fault that her dad left and that she should have been able to get him to stop drinking. In this session, when she told her younger self that it was not her fault, she appeared to really believe it.

In the following session, I continued to use AEDP meta-processing techniques as I asked Chloe, "What is the experience of having come through all of this to being here now?" She responded, "This past week, I've been thinking of all that I've been through, that I survived it. I did it. It feels really good. I can give myself the love and protection that I deserved and never got back then." Then, reflecting an AEDP approach, in order to facilitate, affirm, and process this experience of healing affect, I said, "Let's be with these feelings, it's so moving. There's so much you've been through. It's such a deep relief to feel the difference now."

I proceeded by disclosing my own experience, saying to Chloe, "Wow, my heart feels so warm, I feel so much love right now, and such happiness for you, as you are right now in this moment. What it's like to hear me say that?" She responded, "I feel that warmth too; and not just toward that little girl, but toward myself, right now, and toward you." Our interaction helped further solidify the positive transformation and integration of her sense of self in the context of the secure attachment. This is an example of how the process of mourning from the previous week led to transformation and healing.

A couple of weeks later, Chloe and I discussed how her belief that she was to blame for everything and the resulting self-criticism had been a defense, a survival mechanism, because it was so painful to imagine that none of it was her fault, that her parents failed to keep her safe, and that she could not have changed the way they acted toward her. She then came to the realization that it was not just her parents who failed to keep her safe, but her maternal grandparents as well, as a memory arose of breaking her collarbone when she was 7 years old. Her grandparents were watching her and her sister while their mom was at work. Chloe was climbing on furniture to reach a book off the top shelf of a bookcase in the living room when she fell and seriously hurt herself. She remembered being in immense physical pain, crying and unable to get up off the floor. Chloe's sister ran to tell their grandparents, but they did not get her medical help following the incident. Instead, they told her, "Your mother will handle this when she gets home." Chloe waited for hours with a broken collarbone until her mother came home and took her to the hospital.

Following Chloe's description of the memory, I guided her through portrayal where she imagined her adult self in that living room with her 7-year-old self with the broken collarbone. She imagined her adult self picking up her younger self, comforting her, and bringing her to the hospital. At the end of the session, Chloe expressed that her adult self now has the capability to take care of that little girl, to give that girl the love and protection that she deserved, and to keep her safe. Chloe also told me that she noticed recently that she has more confidence in her daily life and that she has not been as hard on herself as she used to be.

Thus, by connecting to her younger self and learning how to have compassion for that little girl, Chloe was able to have more compassion for herself as an adult. Throughout treatment, there were instances where Chloe would come in and tell me she received a B on a test or did not work enough that week, and while she noticed how much she criticized herself and that she was very hard on herself, she would be unable to challenge those thoughts or have any compassion. Thus, fostering empathy for her younger self was a tactic that bypassed her defenses, leading her to having compassion for her adult self.

Chloe was seemingly beginning to weave together themes of how her life was then and how her experience was in the present, and drawing upon her capacity to utilize her resources, all of which are important Phase 2 goals and are emphasized in an AEDP treatment approach. Following the "younger self" imagery exercises described above, I also asked reflective questions such as, "How would you welcome that very young part of you, that little girl, into this life that is now here for you?" Through using these AEDP techniques, I intended to aid Chloe in integrating her younger self with her adult self, in order to strengthen the process of healing and integrating her sense of self and creating a more coherent, cohesive autobiographical narrative of her life.

Another powerful experience, occurring in week 87 (session 68), depicts the AEDP transformational meta-therapeutic process of *receiving affirmation* which is the flip side of mourning the self (Fosha, 2000). During this session, Chloe brought up the memory of her mother's suicide attempt. Chloe did not talk about this traumatic experience much anymore, and when she did, it was in regard to the progress she has made, as she would say that the night no longer "haunts" her. This time, however, she said that when the memory came up this past week, she felt afraid and briefly dissociated. While she was able to regulate herself using grounding and breathing techniques, she said she was surprised and frustrated that she reacted that way.

After validating her feelings of surprise and frustration, I asked, "What was it like to tell me that?" She replied, "I don't know," so I asked her what physical sensations she felt in her body right now. Chloe said that she felt tingling in her hands. Accordingly, keeping in mind the past effectiveness of SP techniques, I asked, "If your hands could speak or do something what

would they say or do? What do they want?" Chloe teared up and said, "They want someone to hold them." After a brief moment of silence, I offered to hold Chloe's hand. She looked at me and reached out to hold my hand. We sat there for a few moments, my hand holding hers.

As with most of our sessions, I made sure to meta-process with Chloe at the end of this session. Consistent with the affective markers associated with the AEDP process of receiving affirmation, after the experience of holding my hand, Chloe disclosed feelings of gratitude, and appreciation toward the affirming other (me). I also self-disclosed feelings of "being moved" and "honored" that she let me be there with her in that moment. Overall, this moment was very powerful for both of us and signified a major treatment gain in which Chloe was able to ask for what she needed and allow me to help and comfort her. I believed that my offer to hold her hand during this moment helped to undo aloneness when my words and presence were not enough.

When reflecting on this session, I was struck by the similarities and differences between the processing of this traumatic memory in this stage and when we processed it in Stage 2. In Stage 2, I used similar SP techniques, which led to Chloe acting out throwing the gun out of the window to protect herself. In this session, more than a year later, her hands wanted to reach out to someone else for support and comfort. The emotions that emerged in this session versus in Stage 2 felt different as well. She did not become dysregulated at all during this session; while she was very emotional, she was also calm. Also, she was able to receive my affirmation in a way that she could not in earlier stages, and she expressed new feelings of gratitude. This stage showed that the temporary reinstatement of Phase 2 was able to provide a "bridge back to Phase 3" (Courtois & Ford, 2013, p. 185). I decided to progress to Phase 3 in part for the same reasons as the last progression to Phase 3 in Stage 5. Another factor in this decision was my knowledge that I had to end treatment in three months, so I wanted to focus on consolidating treatment gains and preparing for termination.

Stage 8: Progression to Phase 3, Weeks 89–100—Consolidating Therapeutic Gains and Preparing for Termination

During the final 12 weeks of treatment, Chloe came to 11 sessions. This stage focused primarily on preparing for termination, which involved developing a relapse prevention plan and processing the end of treatment as it related to themes of grief and loss. In addition, throughout this stage, we frequently reflected on and celebrated Chloe's treatment gains and the positive changes in her life. Much of this information about treatment gains is presented in greater detail in Chapter VIII, where I review Chloe's quantitative and qualitative assessment outcomes.

From the beginning, Chloe was aware that our treatment was time-limited, given that I was a graduate student in a 5-year doctoral program and would have to leave the training clinic

after my fourth year. I reminded Chloe of this fact about six months prior to our ending because even though I told Chloe in Stage 1, she may not have kept this in mind throughout the course of treatment. At the beginning of this stage (three months before treatment ending), I broached this topic again in order to leave ample time and space to prepare for the upcoming termination.

Under optimal circumstances, I would have chosen to continue working with Chloe. While Chloe had made enormous treatment gains throughout the course of treatment, there were still areas of difficulty to address, as she was still exploring what kind of relationships (if any) she wanted to have with her parents, and she was continuing to learn more about herself and discover what she wanted. Further, while her depressive symptoms had lessened significantly, she still had a tendency to isolate and was only just beginning to learn how to ask for help and achieve deeper intimacy in her relationships with others. Therefore, I thought that Chloe would benefit from continuing therapy elsewhere after we ended, a sentiment that Chloe agreed with. Continuing with a new therapist ended up being an explicit component of her relapse prevention plan.

When developing this relapse prevention plan, we revisited the safety, stabilization, and self-regulation interventions from Phase 1 and discussed how Chloe could use these tools on her own after our therapy ended. Chloe and I also discussed possible events or situations that she could anticipate may trigger symptom regression or difficulties so that we could proactively plan ways for her to apply self-regulation and interpersonal skills in those situations. For example, we discussed how she may handle distressing situations involving her parents and reviewed what behaviors or feelings may signal that she is becoming dysregulated.

Chloe wrote these strategies down on paper in session with me; however, as Courtois and Ford (2013) note, in Phase 3, "safety planning, self-care, and emotion regulation become a way of life rather than preventive or ameliorative tactics used primarily for coping" (p. 182). Thus, while it was helpful for Chloe to have a written plan with strategies to use in case of emergency, by this point, Chloe had demonstrated that she was already using these skills in her daily life. As such, we did not spend that much time on the relapse prevention plan once Chloe expressed confidence in her ability to regulate herself and use relevant skills when needed.

During this final stage of treatment, it was evident that Chloe had made significant progress in integrating and understanding her identity, and Phase 3 themes began to emerge organically in our sessions. For example, in week 90 (session 71), Chloe started talking about possible future career goals, as she considered pursuing a master's degree in social work. Early in the session, she said,

I've been thinking a lot about what I want my life to look like and how to go about doing that, and what kind of impact I want to make on the world. I think I actually may be able to help people someday, to make a difference. Maybe all the horrible stuff I've been through is one of the reasons I can be helpful. But it feels different now. I don't feel guilty and overly responsible for helping others. I'm learning that I deserve help too, that I can put myself and my needs first. I feel like for the first time, I have a choice. I get to reclaim my life back.

Chloe then began to tear up a bit, as she smiled and said, "These are happy tears I promise. I'm just so grateful...for you, for this therapy, for all the ways I've changed."

This was one of the first times I witnessed Chloe truly interested in and excited about her future. Moreover, her statement illustrates how much her self-esteem had improved, as she believed she had something to offer the world. I could tell that she was having a "true self experience" and accessing her "core state." In order to stay in this core state, this transformation and integration of self, I said, "What you said just now in the room felt really real and true to me. That really touches me, Chloe. It's so amazing how much you've accomplished. You're speaking your truth in such a deep, honest, heartfelt way." Chloe responded, with a wide smile, "I know. Me too."

This exchange shows the AEDP meta-therapeutic processes of *receiving affirmation* and *acknowledging mastery*, as Chloe was able to acknowledge and take in my positive affect and affirmation as well as her own, and she was processing her success in overcoming many obstacles, feeling pride and happiness (Fosha, 2000). This example also demonstrates how Chloe had created a new autobiographical narrative of her life, as she was making sense of her past experiences and how she can use those experiences and her newfound understanding to have a purpose in her life moving forward. She was making sense and meaning of her life from a new place of stability, strength, and understanding.

As the weeks went on and it got closer to the end of treatment, I thought about the idea of ambiguous loss, defined as "an indistinct loss lacking a clear ending" (Courtois & Ford, 2013, p. 178). Chloe clearly had experienced considerable ambiguous loss throughout her life, and I hoped that this ending could allow for Chloe to have a corrective experience with loss. In session 74, about six weeks prior to termination, Chloe talked about how the approaching end of treatment brought up feelings of grief, as she was reminded of her dad leaving her unexpectedly when she was 10 years old. I validated her feelings, and we then explored how the loss of our therapeutic relationship, while painful, was different than her prior experiences with loss. I posited that our treatment ending could be an opportunity for her to have a new experience with loss or the ending of a relationship. This loss would not be ambiguous. She knew when we were ending, and she could plan this ending. I was not unexpectedly leaving her like her father did.

Chloe agreed that there could be benefits to this termination, and she said she was appreciative that she knew when it was going to end and felt like she had some control.

Two weeks later, during our session, Chloe told me that she had starting dating someone and that even though she was very sad about ending therapy with me, she felt like she had close relationships in her life now. She also repeated the powerful remark she had stated a few weeks prior, saying "I really get to reclaim my life." She said she was going to miss me but that she also knew, with certainty, that she was going to be okay.

A few weeks before the end of treatment, I asked Chloe if there was anything she wanted to plan for our last session to say goodbye. Chloe asked if we could write each other letters, to which I enthusiastically replied, "I think that's such a great idea!" During our final session (session 80), almost two years since our first session, we gave each other these cards. Chloe gave me her card first. The front of the card said, "Thank you." As I opened her homemade card, I saw that on one side, Chloe had drawn two pictures. One picture was an amorphous object that had two eyes and a mouth, with a caption above saying, "Phoebe the blob," and the other picture was a woman, with the caption, "New and improved Phoebe the human!" I smiled as I remembered the session when she told me she used to see me as a blob and reflected on how much had changed throughout our work together. On the other side of the card, Chloe had written the following message:

Dear Phoebe,

I will always remember how it felt when, on one especially hard day, you offered to hold my hand. The compassion that you extended to me serves as a reminder of the compassion I can show for myself and others. Thank you for being such a wonderful therapist to me for the past two years. Looking back, our relationship has grown exponentially and of course, so have I. When we first started, I never could have imagined where I am today, but I am thrilled at the level of peace you have helped me cultivate even in the midst of chaotic moments. While I'm sad that our sessions are ending, I am so grateful for our time together. I'm sure that I now have the tools to continue on with a greater sense of ease and will continue to keep growing on my own path. From the bottom of my heart—thank you for everything.

-- Chloe ☺

I instantly teared up, as I was filled with feelings of gratitude, love, and appreciation. Consistent with AEDP, I shared my emotional reaction with her and asked what it was like to hear me say that. Chloe just smiled as she began tearing up as well. I was so moved in that moment, feeling so connected to Chloe, as we sat in silence for a few moments, taking in this positive emotion. I asked Chloe what it was like to see me tear up and she replied, "It's really nice...to see you so emotional also. I feel so connected to you and so thankful...and I know that

you feel those things too." I then gave Chloe my card, and upon opening it, she read the following message silently to herself:

Chloe,

I am so grateful for the opportunity to have gotten to know you over the last two years. It has truly been an honor to work with you and see you change and grow. While I'm sad that our work together is ending, I'm also excited as I think about what the future holds for you. You will always hold a place in my heart and mind. Thank you for allowing me to be part of your journey, and I wish you all the best.

Sincerely,

Phoebe

Chloe looked up at me and said, "Words can't express what I'm feeling right now after reading your letter. But I think you can tell what I want to say and how I'm feeling." I simply nodded my head "yes," as I agreed that words could not do this moment justice. At the end of the session, Chloe asked if she could hug me. We hugged, and I felt that this embrace, coupled with the cards we had just given each other, symbolized the strength and healing power of our therapeutic relationship and the secure attachment. As I watched Chloe open the door and leave the therapy room, I was humbled and in awe of everything I witnessed and was able to be a part of during the past two years.

7. THERAPY MONITORING AND USE OF FEEDBACK INFORMATION

During the course of Chloe's treatment, I received weekly individual supervision from a licensed clinical psychologist. During these meetings, my supervisor and I conversed about my clinical work with Chloe, and we often watched and discussed portions of the video recording of my session from the previous week. The ongoing weekly supervision allowed for continuous tracking of Chloe's changing clinical presentation and progress, which was integral in helping me modify the treatment plan as needed, and fluidly move back and forth between the phases of the treatment model to meet Chloe's needs at each stage of our work together. My supervisor's training in AEDP and SP, her knowledge of Courtois and Ford's (2013) sequenced, relationship-based approach to the treatment of complex trauma, and her extensive experience treating patients with complex trauma were invaluable assets throughout my work with Chloe.

Additionally, I sought guidance from the previously mentioned, weekly psychoanalytic supervision group led by Nancy McWilliams. The group was comprised of approximately seven advanced doctoral students who presented cases on a rotating basis. I presented Chloe's case

multiple times over the course of two years and was offered feedback from the supervisor and other group members. This group supervision afforded me the opportunity to broaden my perspective related to my work with Chloe, as everyone brought their own unique experiences, clinical specialties, and theoretical backgrounds to the supervision. It also provided a space for me to understand my countertransferential reactions throughout treatment. For example, I was able to process my feelings about and reactions to Chloe stating that she saw me as a "blob" as opposed to a human being for the first year of our work together. The group helped me understand the clinical relevance of this statement, as we explored the meaning and purpose of Chloe's need to see me as a "blob" and how it relates to her dissociative personality dynamics and defenses.

Also, the act of presenting Chloe's case to the group was, in and of itself, useful. I was able to see the dissociative elements of her presentation more clearly because of how difficult it was for me to present her case in a linear way, as I had trouble giving a specific timeline of her presenting problems and trauma history. I could provide bits and pieces of information about Chloe's history, but sometimes I missed certain details or would forget aspects of her case. The group helped me realize that my difficulties presenting her history were indicative of the difficulties Chloe has had when trying to tell me about her life and history, as many of her memories were fragmented.

Similarly, when I would have difficulty remembering what occurred in our sessions, group members were very supportive and helped me examine how my forgetfulness may have been an indicator that Chloe was in a dissociative state during that session. In general, this group offered much needed support during times where my treatment with Chloe was challenging or when I felt doubt and uncertainty, and overall, it enhanced my clinical work with Chloe in many ways.

Chloe's therapy was also continually monitored via two quantitative self-report measures: the PTSD Checklist for DSM-5 (PCL-5) and the Beck Depression Inventory-Second Edition (BDI-II). Chloe completed each of these measures every four sessions beginning at her intake, and additionally at the last session. At times, these two measures helped my supervisor and me gauge Chloe's progress and determine whether I needed to adjust the focus of our sessions or move to a different phase of the treatment model in order to match Chloe's specific needs. However, as mentioned in Chapter IV, while results of these measures were helpful to an extent, there were limitations to their usefulness because Chloe often appeared to under-report her symptoms on measures. Nevertheless, I believe that the process of completing these measures helped Chloe reflect on her behaviors, thoughts, feelings, and experiences throughout treatment.

8. CONCLUDING EVALUATION OF THE THERAPY'S PROCESS AND OUTCOME

The Outcome of Chloe's Therapy

The quantitative and qualitative data (see below) from Chloe's case indicate a favorable treatment outcome. I believe that Chloe's willingness and motivation to engage in very emotionally challenging work despite experiencing significant discomfort contributed greatly to the success of treatment and allowed her to make considerable therapeutic gains by the end of treatment.

Quantitative Results

Table 1 presents Chloe's scores on the PCL-5 throughout treatment. During the initial assessment session, Chloe's PCL-5 score of 40 was indicative of clinically significant PTSD symptoms (as it exceeded the recommended clinical cut-off point of 31). By the end of treatment, Chloe's PCL-5 score was 17, falling below the clinical cut-off point of 31; this 23-point score reduction would likely represent a clinically meaningful change. Moreover, while Chloe continued to report and rate some of her symptoms as moderately impairing, she no longer met full DSM-5 criteria for a PTSD diagnosis at the end of treatment per her responses on the PCL-5. In contrast to her first session PCL-5 response profile, where she rated enough cluster B through E symptoms as "moderately" or higher to meet full criteria for a DSM-5 PTSD diagnosis, her last session PCL-5 response profile indicated that she no longer met criterion C or E (see Table 2).

Table 3 presents Chloe's scores on the BDI-II throughout treatment. At the beginning of treatment, Chloe's initial score of 28 was indicative of moderate depressive symptoms (as categorized by scores of 20-28), though on the cusp of severe depressive symptoms (scores 29-63). Over the course of therapy, her BDI-II scores decreased to the mild depressive symptom range (scores 14-19) and then eventually to the minimal depressive symptom range (scores 0-13) as her BDI-II score at the end of treatment was 4, all of which indicates significant improvement.

Qualitative Results

As described in Chapter VI (Course of Treatment), Chloe and I reviewed and summarized her treatment progress and gains during the last stage of therapy. The following reflects a summary of the qualitative results of Chloe's treatment:

- Chloe was no longer reporting many depressive symptoms at the end of treatment. Although she still reported experiencing some episodes of a depressed mood, intermittent difficulty concentrating and sleeping, and moments where she felt disconnected from others, she no longer endorsed passive suicidal ideation, fatigue, decreased appetite, or anhedonia. Further, she was consistently engaging in activities that interested her, and she reported experiencing happiness while engaging in these activities. Although she still struggled with her self-esteem in certain domains, she no longer reported feelings of worthlessness. By the end of treatment, she demonstrated hopefulness, increased optimism, and excitement about the future.
- Chloe had learned emotion regulation skills and was integrating those skills into her daily life. She experienced fewer somatic symptoms (e.g., decrease in migraine frequency and asthma symptoms), and, in general, she was no longer experiencing any severely disabling symptoms in her life.
- Chloe was better able to experience, label, and tolerate both positive and negative emotions without dissociating or using avoidance strategies, while simultaneously having more compassion for herself if she did dissociate, as she was able to better articulate and understand her trauma and posttraumatic reactions.
- Chloe experienced a significant decrease in her PTSD symptoms related to her mother's suicide attempt, as she no longer reported experiencing nightmares or flashbacks and was not avoiding external reminders of the event. She also no longer experienced periods of depersonalization or other extreme forms of dissociation.
- Chloe had formed a more cohesive, coherent autobiographical narrative of her life. She was able to place her traumatic memories and associated emotional reactions in the context of the past, having respect for how they have created a present and future template. She had fewer fragmented memories and was making sense and meaning of her life.
- Chloe was now more compassionate toward herself and experienced less shame and guilt. She no longer frequently felt like a "burden" to others, and she no longer blamed herself for the abuse and neglect that she suffered throughout her childhood. With this transformation, Chloe was able to see and understand that she had been extremely resilient and strong and was now able to give herself the love and protection that she never received as a child. She exhibited less self-criticism, fewer negative beliefs about herself and others, and a dramatic increase in her confidence and trust in herself.

- Chloe had a more integrated and positive sense of self and an increased understanding of her identity. As she became more in touch with who she is and what she wants, she became eager to explore what she wants her life to look like in the future. For instance, she was thinking about possible career paths and considering pursuing a graduate degree in social work.
- Chloe had an increased desire and willingness to socially interact and build connections with other people, and she had achieved a greater capacity for relational intimacy. She was dating someone, and she had a few close friends who were people she trusted and relied on, at times, for emotional support. This was in stark contrast to how she presented at the beginning of therapy, when she reported that none of her friendships were meaningful or supportive, and she perceived all relationships as untrustworthy and all people as inherently mean.
- Chloe was setting more boundaries with her mother, as she was now able to make decisions based on what was best for her, rather than what she thought her mother needed or a need to take care of and protect her mother. She also felt more confident in her ability to decide whether she wanted a relationship with her father and, if so, what that relationship would look like.
- Chloe was able to respond to life events and make choices from a position of self-knowledge, self-respect, and mindful awareness. She was better able to put her needs first and ask others for help when she needed it. She was no longer “compulsively self-reliant.” She had more agency, a sense of empowerment, and a feeling of security and safety in the world. She had achieved an overall sense of calmness, peacefulness, and stability.

Results in the Context of the Original Treatment Plan.

Based on the quantitative and qualitative results detailed above, it appears that Chloe met most, if not all, of the treatment goals (described in section 5, Case Formulation and Treatment Plan):

GOAL 1: Ensure safety and build a therapeutic working alliance.

GOAL 2: Stabilize disabling symptoms.

GOAL 3: Enhancing readiness for change through psychoeducation.

GOAL 4: Process trauma-related memories and resolve their emotional and cognitive aftermath.

GOAL 5: Integrate and improve Chloe's sense of self.

GOAL 6: Consolidate treatment gains and apply that knowledge and the skills to daily life and the future.

GOAL 7: Review coping skills and develop relapse prevention plan.

GOAL 8: Provide Chloe with the space to process treatment termination.

In summary, Chloe experienced several changes from the beginning to the end of treatment. Her trauma-related and depressive symptoms had decreased and were no longer affecting her on a daily basis. Her ability to tolerate intense affect increased immensely, and she gained confidence in her ability to use skills to regulate her emotions when needed. Chloe was able to genuinely connect and experience trust and safety with me as her therapist as well as with others outside of therapy, as she began developing and fostering meaningful and intimate relationships. She processed complex traumatic experiences related to her childhood abuse and neglect, understood their impact on her distress, and grieved the losses resulting from those experiences.

Chloe achieved a better understanding of herself, her past, and her complex posttraumatic reactions, forming a more cohesive narrative of her life experiences and a more integrated sense of self. As she developed compassion for all parts of herself, she blamed herself less and viewed herself in a more positive light. Chloe learned to set boundaries with her parents, put her needs first, and ask for help, and she was more equipped to make choices and respond to life from a place of self-respect, calmness, and stability. Chloe also exhibited increased optimism and expressed excitement about her future.

Discussion of Broader Issues Raised by Chloe's Case

As Briere and Scott (2013) succinctly convey, given the multifaceted nature of complex trauma, the disruptions in normal child development, and the unique profile of each individual, treatment must also be multifaceted and adapted to each individual. In this case study, I put forth a multifaceted treatment approach that allowed me to tailor interventions throughout Chloe's treatment to meet her distinctive profile. Though my particular combination and integration of Courtois and Ford's (2013) approach with behavioral activation, AEDP, and SP is unique, in this case, they seemed to complement each other and lead to positive treatment outcomes.

When reflecting on how the guiding conception materialized in chapters IV through VII, I believe my integrated model worked for Chloe for the following reasons. First, behavioral activation served an important function in Phase 1 by providing tools to decrease Chloe's

depressive symptoms. For example, the activity monitoring and scheduling intervention appeared to quickly decrease Chloe's depressive symptoms and increase her positive interactions with others.

Second, both AEDP and SP proved valuable in achieving Phase 2 treatment goals. The combination of SP and AEDP was particularly helpful in addressing Chloe's dissociative symptoms and fragmented sense of self because SP provided mindfulness tools and other techniques to foster dual awareness, or the awareness of her different parts of self. Once Chloe had this awareness, she was able to participate in the AEDP interventions aimed at integrating and transforming those parts of self, namely, her compromised and resilient self. Without the initial focus on mindfulness, I do not think the AEDP techniques (such as the portrayals employed) would have been as effective, as Chloe may have become too immersed in one self-state instead of being able to integrate them.

Additionally, by adding SP, the sensorimotor processing component of Phase 2 was emphasized and amplified. In general, I believe that SP was necessary due to the severity of Chloe's dissociative symptoms and her often inability to access her memories or experiences on an emotional level. Further, the emphasis in SP on engaging defensive responses or movements that were inhibited at the time of one's traumatic experience contributed to Chloe's positive treatment outcome, as the moment where she acted out the process of throwing her mother's gun out of the window was very powerful. I believe this movement intervention and resulting therapy interaction was a major part of our trauma work together that would not have occurred if I had not integrated SP into Chloe's treatment.

Lastly, I believe that the use of Courtois and Ford's (2013) approach was a vital component that pulled everything together into a synthesized, organized treatment plan. All three of the aforementioned treatment modalities lack specific phases, and the three phases included in this approach provided me with a structure from which I could base treatment decisions. For example, the phases were integral in ensuring Chloe remained in treatment, as her no-shows or frequent cancellations proved to be indicators that I needed to regress to a prior phase.

The ability to organize the course of treatment by phase, regressing or progressing accordingly, proved particularly useful during episodes when Chloe presented as primarily dissociated. As Courtois and Ford (2013) explain, clients with CPTSD who have a presentation in which dissociation, more than other trauma symptoms, predominates have a fragmented sense of self which leads a correspondingly fragmented memory, as some knowledge is only accessible to one or a few of the parts of self. They emphasize that this difficulty is "ultimately shared by the therapist" (Courtois & Ford, 2013, p. 248). I definitely resonated with this concept in my work with Chloe, particularly in Stage 1, as there were moments when I noticed myself

forgetting things from sessions or having trouble staying present. Having Courtois and Ford's (2013) approach as a guide provided me with validation, stability, and understanding during these difficult times. Also, the relationship-based element, when combined with AEDP, provided me with ample tools to emphasize the therapeutic alliance and importance of attachment security throughout Chloe's treatment.

In sum, it seems that in Phase 1, all four treatment models were used to an extent, with an emphasis on behavioral activation initially as it served an important function in reducing Chloe's depression so that she was stable enough to engage in trauma work. However, once the element of giving Chloe homework proved no longer helpful, SP was used more and provided mindfulness and self-regulation tools to achieve Phase 1 goals. AEDP and SP then served important functions in targeting Phase 2 goals. In particular, the combination of AEDP experiential interventions (such as portrayals) and SP movement interventions proved to be effective for Phase 2 trauma processing, addressing Chloe's complex trauma in a comprehensive way and at an emotional, cognitive, and somatosensory level. In Phase 3, AEDP was used the most in addition to guidelines and suggestions denoted in Courtois and Ford's (2013) approach. AEDP allowed for a deepening and meta-processing of the therapeutic relationship which, while particularly evident in Phase 3, was a major component throughout all the phases, ensuring that treatment never strayed too far from attachment phenomena. Overall, it appears that AEDP was emphasized and used the most throughout treatment in order to implement Courtois and Ford's phase-based approach, with BA and SP providing supplemental guidance and tools when needed.

Given Chloe's positive response to treatment, I believe that my integrative approach shows strong promise and merits further investigation. If additional cases were presented with similar outcomes using the approach described in this study, the positive treatment outcomes of this case would be even more credible. This is an important consideration given that case studies are inherently limited as a basis for drawing conclusions about treatment effectiveness.

Other areas of future research could include investigating whether both AEDP and SP are needed in order to achieve Phase 2 trauma processing goals or if one approach or the other is sufficient, especially because other case studies in the literature that describe treatment of complex trauma have shown positive treatment outcomes using different integrative approaches than mine. For example, Lawson (2017) used a three-phase, relationship-based, cognitive-behavioral therapy model to treat "Susan," a 25-year-old woman with a history of complex trauma who was formally diagnosed with dissociative identity disorder and PTSD. His three phases were also based on Courtois and Ford's (2013) approach, and as such, identical to mine in name and primary treatment targets. However, in contrast to my use of AEDP and SP techniques, Lawson (2017) used primarily cognitive-behavioral methods in Phase 2 to achieve the goal of

trauma memory and emotional processing. Two case studies outlined by Courtois and Ford (2013) provide more examples of different modalities used to achieve Phase 2 goals, as they describe the cases of "Hector" and "Doris." Hector found treatment success in Phase 2 through the use of PE while Doris engaged in eye movement desensitization and reprocessing (EMDR) (Shapiro, 2001). Of note, Hector's most distressing problem upon initial presentation was suicidality, not dissociation.

Contrastingly, Gonzalez (2018) found treatment success through using only AEDP, without a three-phase structure, to treat relational trauma, as she describes the case of "Rosa". However, while Rosa, similarly to Chloe, had a diagnosis of MDD, she appeared to not have as many dissociative symptoms as Chloe. Thus, other possible areas of inquiry could include examining whether there are particular presentations of CPTSD that respond better to certain interventions.

Also, it may be beneficial for future research to further examine the use of BA in the treatment of CPTSD. When considering my use of BA in this case, I think I could have better integrated BA into Chloe's treatment instead of just using it briefly in Stage 1. As previously mentioned, I decided to stop using BA techniques due to my belief that Chloe viewed it similarly to schoolwork and was thus re-enacting her need to be the "perfect student." However, I did not consider other ways in which BA could still prove useful in our treatment. While I did integrate the general concept of BA into sessions throughout treatment, such as discussing with Chloe the impact of certain events on her mood and how she can change her activities to change her mood, I could have used BA more overtly.

For example, early in treatment, Chloe cancelled multiple sessions and when she returned, she said she cancelled our sessions following a distressing incident with her mother. We briefly talked about how this behavior was rooted in avoidance, but BA could have been a way to address her avoidant defenses more thoroughly. Also, later in treatment, when Chloe told me about her dissociative episode where she broke a door, we discussed how that was related to Chloe visiting her father. BA could have been useful to use here as a tool to help Chloe figure out if she wanted to see her father and, if so, how frequently.

I could have revisited BA strategies in Phase 3 as well, particularly when developing Chloe's relapse prevention plan, as relapse prevention is a component of the traditional BA treatment approach. It involves reviewing and consolidating gains the client has made and focuses on anticipating situations in the client's life that may trigger depressive feelings and behaviors and generating plans for coping with those situations (Dimidjian, Martell, Addis, & Herman-Dunn, 2008). While Chloe and I did include this discussion informally and briefly when creating her relapse prevention plan in Stage 8, I think it could have been beneficial to use BA

more has a guide. If BA were more integrated into treatment, Chloe may have been able to use it as a self-help strategy once treatment terminated. Thus, future studies examining the use of BA throughout the phases of CPTSD treatment could provide valuable insight and possibly improve treatment outcomes, particularly when treating those with CPTSD and comorbid MDD.

I hope this case study demonstrates the need to continue to investigate the pervasive effects of complex trauma, particularly childhood relational trauma, and how best to clinically address and treat the many different manifestations of CPTSD. Although this hybrid case study of Chloe can serve as one example of an approach to treating CPTSD that had positive results, her case is not intended to generalize to all people with a history of complex trauma. While the hybrid case study design allowed for a more comprehensive description of many possible themes and experiences that could arise in CPTSD treatment, as I was not constrained by specific facts relevant to one case, the ways in which different clients can present to treatment and the difficulties they may experience will vary depending on race, ethnicity, sexual orientation, location, religion, and other important cultural and contextual factors. Yet, I describe in detail the hybrid case of Chloe with the hope that its nuances and complexities generate further reflections on, and investigation of, psychotherapy for individuals with CPTSD.

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Table 1. *Chloe's Scores: PTSD Checklist for DSM-5 (PCL-5)*

Session Number	Score^a
First Session	40
5	30
9	20
13	13
17	15
21	8
25	9
29	20
33	21
37	8
41	22
45	18
49	14
53	14
57	19
61	19
65	18
69	17
73	17
77	17
Last Session	17*

^a A score of 31 has been suggested as a cutoff for probable PTSD, thus scores above 31 reflect the likely presence of PTSD. While preliminary research is currently being conducted to develop clinical norms for the PCL-5, it is expected that score reductions of 5-10 points represent reliable change (i.e. change not due to chance) and score reductions of 10-20 points represent statistically reliable and clinically meaningful change (Weathers, Litz et al., 2013).

*This score represents a statistically reliable and clinically meaningful change from first session.

Table 2. *Chloe's PCL-5 raw data*

DSM-5 Cluster	Item Number	First Session	Last Session
B	1	3^a	1
B	2	2	0
B	3	1	0
B	4	3	2
B	5	0	1
C	6	3	0
C	7	3	1
D	8	0	2
D	9	3	1
D	10	2	1
D	11	3	2
D	12	3	0
D	13	3	1
D	14	2	1
E	15	0	0
E	16	0	0
E	17	2	1
E	18	1	1
E	19	3	2
E	20	3	0

Note. A provisional PTSD diagnosis can be made by treating each item rated as 2 = "Moderately" or higher as a symptom endorsed, then following the *DSM-5* diagnostic rule which requires at least: 1 B item (questions 1-5), 1 C item (questions 6-7), 2 D items (questions 8-14), 2 E items (questions 15-20).

^a **Bolded scores** indicate symptoms endorsed as "moderately" or higher.

Table 3. *Chloe’s Scores: Beck Depression Inventory—Second Edition (BDI-II)*

Session Number	Score	Score Categorization ^a
First Session	28	Moderate depression
5	26	Moderate depression
9	15	Mild depression
13	13	Minimal depression
17	14	Mild depression
21	13	Mild depression
25	8	Minimal depression
29	14	Mild depression
33	14	Mild depression
37	6	Minimal depression
41	12	Minimal depression
45	13	Minimal depression
49	7	Minimal depression
53	7	Minimal depression
57	14	Mild depression
61	7	Minimal depression
65	6	Minimal depression
69	5	Minimal depression
73	4	Minimal depression
77	4	Minimal depression
Last Session	4	Minimal depression

^a Score categorization as noted by Beck et al. (1996) in the *Manual for the Beck Depression Inventory – II*. Scores range from 0-63, where 0-13 is indicative of minimal depression; 14-19 suggests mild and 20-28 implies moderate depression; and 29-63 reflects severe depression.

Table 4. *Diagnosis at Beginning and End of Treatment*

DSM-5 Diagnosis at Beginning of Therapy		DSM-5 Diagnosis at End of Therapy	
F32.1	Major depressive disorder, single episode, moderate	F32.4	Major depressive disorder, single episode, in partial remission
F43.10	Posttraumatic stress disorder		

Table 5. *Treatment Timeline*

Stage #	Phase #	Month #	Week #	Session #
Stage 1	Phase 1	Month 1	Week 1	1
			Week 2	2
			Week 3	3
			Week 4	4
			Week 5	5
		Month 2	Week 6	<i>Chloe cancelled</i>
			Week 7	6
			Week 8	7
		Month 3	Week 9	8
			Week 10	<i>Holiday</i>
			Week 11	9
		Month 4	Week 12	10
			Week 13	11
			Week 14	12
			Week 15	13
Stage 2	Phase 2		Week 16	14
			Week 17	15
Month 5			Week 18	<i>Chloe cancelled</i>
			Week 19	<i>Chloe cancelled</i>
			Week 20	<i>Chloe cancelled</i>
			Week 21	16
Stage 3	Phase 1		Week 22	17
			Week 23	18
Month 6			Week 24	19
			Week 25	20
			Week 26	21
			Week 27	22
			Week 28	<i>Chloe cancelled</i>
			Week 29	<i>Clinic closed- snow storm</i>
			Week 30	<i>Clinic closed - spring break</i>
			Week 31	<i>Clinic closed- snow storm</i>
			Week 32	23
			Week 33	24
Month 7			Week 34	25
			Week 35	26
Stage 4	Phase 2		Week 36	27
			Week 37	28
Month 9			Week 38	29
			Week 39	30
			Week 40	31
			Week 41	32
Month 10			Week 42	33
			Week 43	34
			Week 44	35
			Week 45	36
Month 11			Week 46	<i>Chloe cancelled</i>
			Week 47	<i>Chloe cancelled</i>
Month 12			Week 48	37
			Week 49	38
			Week 50	39

Table 5—continued

Stage #	Phase #	Month #	Week #	Session #
Stage 4	Phase 2		Week 51	40
			Week 52	41
		Month 13	Week 53	42
			Week 54	43
			Week 55	<i>Chloe cancelled</i>
			Week 56	44
		Month 14	Week 57	45
			Week 58	46
			Week 59	47
			Week 60	48
Stage 5	Phase 3	Month 15	Week 61	49
			Week 62	50
			Week 63	51
			Week 64	52
			Week 65	<i>I cancelled</i>
		Month 16	Week 66	53
			Week 67	<i>I was on vacation</i>
			Week 68	<i>I was on vacation</i>
			Week 69	54
		Month 17	Week 70	<i>Chloe cancelled</i>
			Week 71	<i>Chloe no-showed</i>
			Week 72	55
			Week 73	<i>Chloe no-showed</i>
		Month 18	Week 74	<i>Chloe no-showed</i>
			Week 75	56
Stage 6	Phase 1		Week 76	57
			Week 77	58
			Week 78	59
		Month 19	Week 79	60
Stage 7	Phase 2		Week 80	61
			Week 81	62
			Week 82	63
		Month 20	Week 83	64
			Week 84	65
			Week 85	66
			Week 86	67
			Week 87	68
		Month 21	Week 88	69
		Stage 8	Phase 3	
	Week 90			71
	Week 91			<i>Chloe cancelled</i>
Month 22	Week 92			72
	Week 93			73
	Week 94			74
	Week 95			75
Month 23	Week 96			76
	Week 97			77
	Week 98			78
	Week 99	79		
	Week 100	80		

Figure 1. *Sample Activity Scheduling and Monitoring Sheet from Sessions 7 and 8*

Activity Scheduling and Monitoring Sheet

Week of: _____

Engage in scheduled activities and record all positive and/or social activities (including texts, calls, meals with people, hobbies etc.)

	<u>Monday</u>	<u>Tuesday</u>	<u>Wednesday</u>	<u>Thursday</u>	<u>Friday</u>	<u>Saturday</u>	<u>Sunday</u>
<u>Morning</u>		<ul style="list-style-type: none"> - <i>Gym for 45 minutes</i> • Went to gym for 45 minutes 					<ul style="list-style-type: none"> • Called mom, talked for 1 hour
<u>Afternoon</u>	<ul style="list-style-type: none"> • Went on 15-minute walk 		<ul style="list-style-type: none"> • Talked to classmate during Economics class, chatted for 5 minutes 	<ul style="list-style-type: none"> • Asked girl sitting next to me in class a question about the lecture 	<ul style="list-style-type: none"> - <i>Text a friend</i> • Texted friend, exchanged 8 messages back and forth 	<ul style="list-style-type: none"> - <i>Lunch with classmate</i> • Lunch with classmate, lasted 1 hour 	<ul style="list-style-type: none"> - <i>Call a friend</i> - <i>Go for a 15-minute walk</i> • Called friend, talked for 15 minutes • Went on 20-minute walk
<u>Evening</u>	<ul style="list-style-type: none"> - <i>Read for 30 minutes</i> • Read for 1 hour • Mom called me, talked for 30 minutes 	<ul style="list-style-type: none"> • Watched TV for 1 hour 	<ul style="list-style-type: none"> - <i>Play guitar for 30 minutes</i> • Played guitar for 45 minutes 	<ul style="list-style-type: none"> - <i>Call a friend</i> • Called friend, talked for 20 minutes 	<ul style="list-style-type: none"> - <i>Gym for 45 minutes</i> • Went to gym for 1 hour • Read for 45 minutes 	<ul style="list-style-type: none"> • Watched a funny movie (2 hours long) • Song writing for 30 minutes 	<ul style="list-style-type: none"> • Texted a classmate to ask about homework, 4 messages back and forth • Played guitar for 30 minutes

Notes: Chloe's handwriting is typed out for legibility.

Italics: denotes activities scheduled in session 7 that Chloe committed to engaging in. **Bold**: denotes activities in Session 7 that Chloe actually engaged in.

APPENDIX 1. OUTLINE OF THE CASE STUDY OF “CHLOE”

1. CASE CONTEXT AND METHOD

Rationale for Selecting this Particular Client for Study

The Clinical Setting in Which the Case Took Place

Sources of Data Available Concerning the Client

Confidentiality

2. THE CLIENT

3. GUIDING CONCEPTION WITH RESEARCH AND CLINICAL EXPERIENCE SUPPORT

The Nature of Complex Posttraumatic Stress Disorder

Early Childhood Relational Trauma

Effects of Complex Trauma and Clinical Implications

Courtois and Ford’s (2013) Sequenced, Relationship-Based Approach

Phase-Oriented Model

Phase 1: Safety, Memory and Emotion Processing

Phase 2. Trauma Memory and Emotion Processing

Phase 3: Consolidating Therapeutic Gains

Incorporated Therapy Modalities

Cognitive-Behavioral Therapy

Accelerated Experiential Dynamic Psychotherapy

Sensorimotor Psychotherapy

4. ASSESSMENT OF THE CLIENT’S PRESENTING PROBLEMS, GOALS, STRENGTHS, AND HISTORY

Presenting Problems

Relevant Personal History

Medical History

Presentation at the Beginning of Therapy

Quantitative Assessment

Diagnosis

Goals and Strengths

APPENDIX 1. CONTINUED

5. CASE FORMULATION AND TREATMENT PLAN

Formulation

Treatment Plan and List of Treatment Goals

Phase 1: Safety, Stabilization, and Engagement

Phase 2: Trauma Memory and Emotion Processing

Phase 3: Consolidating Therapeutic Gains

6. COURSE OF TREATMENT

Stage 1: Phase 1, Weeks 1-15

Weeks 1-3: Ensuring Safety and Building a Therapeutic Working Alliance

Weeks 4-15: Stabilizing Depressive and Dissociative Symptoms

Stage 2: Progression to Phase 2, Weeks 16-21

Weeks 16-17: Processing Trauma-Related Memories and Emotions

Weeks 18-21: Addressing Session Cancellations and Emotion Dysregulation

Stage 3: Regression to Phase 1, Weeks 22-34

Weeks 22-27: Strengthening Emotion Regulation Skills and
Enhancing Readiness to Change

Weeks 28-34: Addressing a Gap in Treatment

Stage 4: Progression to Phase 2, Weeks 35-60

Weeks 35-52: Processing Trauma-Related Memories and Emotions

Weeks 53-60: Addressing Rupture/Repair of the Therapeutic Alliance

Stage 5: Progression to Phase 3, Weeks 61-75

Weeks 61-64: Consolidating Therapeutic Gains

Weeks 65-75: Addressing a Gap in Treatment

Stage 6: Regression to Phase 1, Weeks 76-79— Safety, Stabilization, and Engagement

Stage 7: Progression to Phase 2, Weeks 80-88—

Trauma Memory and Emotional Processing

Stage 8: Progression to Phase 3, Weeks 89-100—

Consolidating Therapeutic Gains and Preparing for Termination

APPENDIX 1. CONTINUED

7. THERAPY MONITORING AND USE OF FEEDBACK INFORMATION

8. CONCLUDING EVALUATION OF THE THERAPY'S PROCESS AND OUTCOME

The Outcome of Chloe's Therapy

Quantitative Results

Qualitative Results

Results in Context of Original Treatment Plan

Discussion of Broader Issues Raised by Chloe's Case