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

# Sequenced Relationship-Based Psychotherapy for Complex Posttraumatic Stress Disorder: Commentary on the Application of the Model to the Hybrid Case of "Chloe"

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## ABSTRACT

In this commentary, as authors of the Sequenced, Relationship Based Treatment Model—developed for complex posttraumatic stress disorders—we respond to its detailed application to the hybrid case of "Chloe," reported by Chloe's therapist, Dr. Phoebe Shepherd (2022). Shepherd reviewed different treatment approaches before choosing our model, due to its sequenced and hierarchical approach, comprehensive description in the literature of its application in a primary text by the model's authors, and flexibility of utility and choice of technique. The latter are based on the judgment and training of the therapist and on the client's unique situation and needs, as well as preference.

As in the model, Chloe's treatment takes place in a sequenced and chronological form over a two-year period while Shepherd worked at a psychological training clinic. Shepherd received ongoing expert supervision while conducting this treatment. She not only described the model and the techniques she selected, but also how they were applied and adapted to the client's status over the course of the treatment. She also described her own process over the course of the treatment, as she addressed its challenges and its starts and stops as she experienced the client. Appropriately, Shepherd began the treatment with assessment, which was repeated several times over its course to document progress and change. As discussed in descriptions of the model, although it is linear on paper, the actual progression of treatment is instead flexible and recursive, returning as needed to the tasks of the early phase of treatment (i.e., emotional regulation skills and personal stabilization).

In this commentary, we support Shepherd's primary interventions and their rationale while also offering cautions and re-direction for some of them. All told, the case description offers endorsement of the sequenced, relationship-based treatment model, and how it guides the therapist in working with the multi-problem and challenging population of Complex PTSD as represented by the hybrid case of Chloe. Chloe's history encompassed adverse and potentially

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traumatizing experiences in childhood, including: father's alcoholism; mother's emotional instability and unavailability and ongoing threats of suicide; parental divorce at age 10 with custody awarded to Chloe's mother; paternal abandonment post-divorce; and suggestions by grandparents that Chloe was responsible for her mother's problems and their lack of appropriate intervention on her behalf. These adverse experiences resulted in Chloe's mistrust of and detachment from others and emotional fragility, including a tendency towards isolation and depression. Her major trauma occurred a year prior to the treatment when she interrupted her mother's attempt to shoot herself in the head to commit suicide, the effects of which ultimately led Chloe to seek counseling. The treatment was directed not only at the effects and symptoms of the recent trauma (using trauma-focused, evidence-based techniques), but also more broadly at Chloe's prior traumatic exposures and her developmental and skills deficits. The case description also demonstrates the impact of the therapeutic relationship as the context and as a healing factor in the treatment.

*Keywords:* trauma; trauma treatment; complex trauma; sequenced relationship-based treatment model; case study; clinical case study

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We welcome the opportunity to comment on the application of our sequenced relationship-based meta-model of psychotherapy (Courtois & Ford, 2013) to a hybrid case of Posttraumatic Stress Disorder (PTSD) and Complex Posttraumatic Stress Disorder (CPTSD). We appreciate that Phoebe Shepherd, the author, chose our model as a framework for her clinical treatment and investigation. Components of the model have been studied; however, we are unaware of any other research that covers the application in its entirety or in the detail provided by this clinician/researcher. (A possible exception is Brand, McNary, et al.'s [2012] study of therapy with Patients with Dissociative Disorders (TOP DD), which used a tri-phasic model of hierarchical tasks to assess progress in a naturalistic study of the treatment of individuals with dissociative disorders, most of whom would also likely meet criteria for Complex PTSD and the Dissociative Subtype of PTSD.)

## DEVELOPMENT OF THE SEQUENCED RELATIONSHIP-BASED TREATMENT MODEL

We developed this model, based originally on the tri-phasic model of treatment for individuals with complex traumatic stress disorders originating from childhood abuse and other adversities, which was first introduced by Judith Herman (1992a & 1992b). Herman's approach was in turn based on the original model developed by Pierre Janet at the beginning of the 20th Century.

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Independently and jointly, we have treated, researched, and trained clinicians and scientists to work with survivors of childhood developmental traumas since the 1970s. From early on, we held a viewpoint like Herman's, namely that the triadic diagnostic criteria of re-experiencing, numbing, and hyperarousal for PTSD as originally delineated (American Psychiatric Association, 1980) were not expansive enough to encompass the additional symptoms expressed by adult survivors of childhood domestic abuse as their original delineation was based on two different trauma populations (Courtois, 2004; Ford, 1999). Like other clinicians and researchers, we found that survivors of childhood abuse often suffer from the classic triad of symptoms of PTSD, but many had a host of additional developmental impacts and deficits and were more prone to the use of dissociation.

We joined with many colleagues to advocate for the inclusion of Complex PTSD as articulated by Herman (1992a) as a freestanding diagnosis in the *Diagnostic and Statistical Manual-IV, IV-R* and *5,* and we were disappointed each time it was accepted only as an associated feature of standard PTSD. It was only in 2018 (fully 26 years after Herman's formulation) that a scaled-down version of the diagnosis (including 3 primary criteria: emotional regulation, identity, and relationship ability, known as Disorders of Self-Organization or DSOs) was included in the *International Classification of Disorders 11* (*ICD-11*; World Health Organization, 2021) as a "sibling diagnosis" of standard PTSD (using a scaled down set of diagnostic criteria from those included in the *DSM-5)*.

Research had provided substantiation for differences between PTSD and CPTSD that made the diagnosis possible (Cloitre et al., 2020). A Complex PTSD diagnosis has the obvious advantage of providing clients with a complex trauma history with an overarching "diagnostic home" (van der Kolk, 2009) rather than multiple, distinct diagnoses.

In the mid-2000s, along with our like-minded colleagues, we developed a special issue of the *Journal of Traumatic Stress* on complex trauma and its treatment (2005). In the issue we highlighted differences between child-onset and adult-onset trauma populations, symptoms, and treatment; and between trauma that was of short-duration versus trauma that was repetitive to the point of becoming chronic. We opined that trauma-focused treatments that had been developed and shown to be efficacious for the symptoms of PTSD due to adult-onset, non-interpersonal, and short-term types of trauma *should not* be applied right at the start of treatment of survivors of child-onset repetitive trauma. Rather, for the latter, treatment should focus first on helping the client (a) to be clearly able to self-regulate when distressed, autonomously or with some scaffolding provided by therapist co-regulation; and (b) to be relatively safe from further victimization. Also, given the relational nature of these clients' psychological traumas, it was especially important that a positive therapeutic alliance was established before trauma memory

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processing was undertaken. The timing and duration of preparation is highly variable ranging from a few sessions to many months, depending on the client. This preparation does not delay the therapy, but instead provides a psychosocial foundation that maximizes the safety and success of treatment.

The principle of attention to safety and psychological and relational preparation is the foundation of the three-phase treatment model. Interestingly, it became a point of contention for developers of what have come to be known as Trauma-Focused Therapies (TFTs), with most being in the Cognitive Behavioral tradition (Cahill et al., 2009; DeJongh et al., 2008).

These therapies that have been the most researched and have the strongest evidence base to date as efficacious for ameliorating symptoms of PTSD. Researchers and developers argue that due to their efficacy, these techniques should be offered to all trauma patients, regardless of their clinical or life status or their ability to manage their emotions. Complex trauma proponents, in contrast, argue that such a strategy has the downside to potentially destabilize clients by overwhelming them with trauma material they are unable to metabolize safely. This remains an open controversy at the time of this writing.

During this same time period, we were both appointed as members of a Complex Trauma Task Force (CTTF) within the International Society for Traumatic Stress Studies (ISTSS) with the following mission: 1) to study complex trauma to determine its similarities to and differences from other forms of trauma; and 2) to develop a treatment guideline based both on both a survey of clinicians considered expert on the treatment of a complex trauma response as articulated by Herman (1992b), and on the treatment of more standard PTSD.

This survey process was to parallel the strategy used to develop the original set of consensus guidelines based on a survey of clinicians published by the ISTSS in 1999 (Foa et al., 1999). The complex trauma survey included 50 identified expert clinicians in the treatment of standard PTSD (n= 25) or complex PTSD (n=25). A compilation of their treatment recommendations was published (Cloitre, et al., 2011) and adopted by the ISTSS in 2012. The guideline defined complex trauma as including core symptoms of PTSD *plus* a range of developmental disturbances in self-regulation in several life domains including emotion regulation, relational difficulties, attention and consciousness (dissociation), belief systems, somatic distress, and/or disorganization and medical illness.

Treatment recommendations included sequenced or phased treatment customized to the client and specific symptoms. The Complex Trauma Guideline recommended the following "first line" treatment approaches: emotional regulation, narration of trauma memory, cognitive re-structuring, anxiety and stress management, and an interpersonal approach. Meditation and

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mindfulness were recommended as "second line" approaches and it was acknowledged that the course and duration of treatment were unclear but were generally longer than treatment for PTSD symptoms alone.

The Complex Trauma Task Force members also noted the need for textbooks outlining the defining characteristics and treatment of complex traumatic stress disorders. We volunteered and this is how we came to write our books. Our first co-edited book (Courtois & Ford, 2009) presented an overview of complex developmental trauma and best practices for its treatment in adults. The book includes chapters from developers who had adapted their individual, group, and system treatment methodologies to complex trauma presentations. Each chapter contains the theoretical basis and explanation of the approach, an overview of available evidence, and a transcript of a session in which the approach was applied, along with an author commentary.

With some exceptions, few of the included approaches had an evidence base for their efficacy as applied to complex trauma symptoms (although some did for PTSD symptoms), but most had achieved some degree of clinical consensus about applicability and effectiveness. This volume was followed by another co-edited volume using the same format for the treatment of children and adolescents who experienced complex trauma (Ford & Courtois, 2012). The evidence-base for treatment efficacy was similarly limited for this population.

Our final co-edited book on the topic is a revision and 10-year update of the original adult treatment book (Ford & Courtois, 2020). What was most evident as we conducted research for this revision was how the study of complex trauma had developed over the course of the decade. The long-term adverse impact of experiencing complex forms of psychological trauma in childhood was recognized both by clinicians (DePierro et al., 2018; Ford et al., 2013) and by clinical researchers (D'Andrea et al., 2012; Karatzias et al., 2017) as an essential focus for assessment and psychotherapy.

The finding of negative and potentially lifelong consequences of complex trauma in childhood had gained significant support from the findings of the Adverse Childhood Experiences (ACES) studies (Hughes et al., 2020; Humphreys et al., 2020; Jia & Lubetkin, 2020; Lund et al., 2020). These studies documented the correlation between number of childhood adversities and later psychophysiological and medical consequences. Clinicians were becoming increasingly cognizant that many clients had a history of complex trauma in their childhood that had persisted and later morphed into mental health and medical symptoms as well as widespread life distress. They were searching for guidance on effective treatment of a population with a considerable range of problems besides their trauma symptoms and, oftentimes, pronounced comorbidity and symptom and life complexity.

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In response to and in parallel to our model, a variety of approaches to psychotherapy developed or were adapted for survivors of complex childhood trauma and their correspondingly complex traumatic stress symptoms. Some of these had strong evidence bases (Briere & Lanktree, 2011; Frewen & Lanius, 2008; Paivio & Angus, 2020; Paivio & Pascual-Leone, 2010); and others were based on research findings and extensive clinical experience (Barrett & Fish, 2014; Briere, 1989; Chu, 2011; Greenberg, 2019; Hopper, et al., 2018). These provided us with the opportunity to compare approaches to determine clinical agreement, which we included in our revised text.

What also become more evident is that many forms of adult-onset trauma resemble complex trauma as we had originally defined it. This resemblance embodied a number of characteristics: (a) the presence of interpersonal and intentional traumatic intrusions and maltreatment up to and including direct abuse and assault (most often perpetrated by someone known to the trauma victim/survivor, who had responsibility for that individual's welfare, and in the context of that relationship, created betrayal and attachment trauma); (b) repeated trauma to the point of chronicity in many cases; (c) having a significant power differential between perpetrator and trauma victim that results in helplessness, entrapment, and even conditions of captivity; and (d) creating a vulnerability for later and ongoing revictimization (what we have described as layered trauma).

As the relational context and attachment dynamics received more investigation, it became apparent that the trauma survivor's identity and self-worth, ability to self-regulate, and ability to relate to and trust others were often severely compromised. There was further recognition that many of the standard comorbidities associated with the complex trauma client—such as dissociation (up to and including the dissociative disorders), substance abuse and addictions, eating disorders, non-suicidal self-injury, other risk-taking behaviors, and suicidality—were attempts to cope with the ongoing abuse that, while they may have been initially successful as coping mechanisms, later became symptoms and life impediments.

Between the publication of these conceptual and scientific texts and in response to clinician need, our editor suggested we co-author a more clinically oriented book that described and "walked" the reader through the application of the sequenced meta-model we advocated. Conceptualized as the "therapist's guide and companion," it was designed to address topical, process, and relational issues common in the treatment of this population by following two composite clients as illustrative.

We placed emphasis on the relational component of treatment in response to the rapidly emerging literature on many developmental, attachment, and relational topics. These included (a) the impact of early life attachment security on a child's development and attachment style and

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capabilities; (b) corresponding neuroscientific findings about brain development; (c) the unique imprint of betrayal trauma by significant others who use the relationship to groom and entrap the victim; (d) significant research in support of evidence-based relational variables on treatment efficacy; (e) advances in relational psychodynamic and psychoanalytic conceptualizations and treatments; and (f) treatment applications collected under the heading of interpersonal neurobiology (Ford, 2020; Ford, 2021).

These research advances all strengthened our clinical observations about the importance of the treatment relationship to the healing process of this population in particular. We strongly subscribe to the statement "relational healing for relational injury" as the context and container in which the treatment takes place. This stance places the therapist front and center to the client's healing, as necessary but not sufficient. Instead, the relationship is the crucible within which the treatments are selected and applied to meet the unique needs of the client. Even the most technically oriented approaches to psychotherapy for complex traumatic stress symptoms give recognition to the importance of engaging the client in a collaborative therapeutic alliance as the "container" or secure base for the treatment.

## THE CASE OF CHLOE AND THE STRUCTURE OF THIS COMMENTARY

Phoebe Shepherd's (2022) case of "Chloe" provides a vivid illustration of the importance of both relational attunement and flexibility within a specific sequencing of the therapy as the foundation for the entire treatment. These aspects of therapeutic work often are described as "non-specific" factors. However, they are very specific ways in which therapists develop a working alliance with their client that provides a sense of trust, security, and hope while also preparing clients for trauma processing and work on other therapeutic goals. A strong therapeutic alliance is essential for all aspects of the psychotherapy process, including making the processing of traumatic experiences of greatest therapeutic value by providing a secure relational base and carefully titrating the emotional intensity that the client experiences in this processing.

The desired outcome of the case report was stated by Shepherd as follows:

> 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 … [and] to better understand this clinical population and develop and disseminate more intervention techniques to best help them and lead to beneficial treatment outcomes … [while] also add[ing] to the growing amount of support for the need to include CPTSD as its own, separate diagnosis in future diagnostic manuals (p. 126).

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Our plan for the rest of this commentary is to follow the sequence and structure of Chloe's case study that Shepherd outlines in making our remarks on her strategies and process.

# 1. CASE CONTEXT AND METHOD

### *The Rationale for Selecting this Particular Client for Study*

This hybrid case was developed from the treatment of several clients to

> 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 (p. 124).

We support this creative format and believe that it is an effective means of presenting a de-identified case study. The author further described her efforts in treating complex trauma clients to find a consolidated treatment model for the treatment population; hence, her choice of our Sequenced, Relationship Based Model for this purpose. She stated:

> 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 (p. 125).

### *The Clinical Setting in Which the Case Took Place*

A psychology training clinic and a doctoral clinical psychology trainee might seem to be under-prepared to handle the compounded issues in a case involving a client with a childhood complex trauma history as well as a recent adult-onset trauma. However, this setting is one in which relatively long-term therapy (80 sessions over two years in this case) is more feasible than in many clinics and practices in which institutional and insurance constraints often mandate brief manualized therapy. In this training clinic, with the supervision of a "scholar and master

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therapist" (Nancy McWilliams, e.g., 2004, 2021), it also was possible for the therapist-trainee to conduct psychodynamic psychotherapy, rather than the cognitive behavioral, trauma-focused approaches to PTSD treatment that typically are more prioritized in research-based practice guidelines and taught in both pre-professional and continuing clinical training.

As such, this case study author/therapist in training had a more immersive experience of psychotherapy than is typically the norm. The case illustrates the value to trainees of being able to experience the trajectory of a client's life over a longer period than just three to at most six months of most manualized PTSD treatments. This permitted the therapist not just to master a set therapeutic protocol, but instead to learn ways to attune to and learn from the client while reflecting on the interplay of transference and countertransference as the therapeutic relationship and the client's life issues emerged and trauma memory processing unfolded.

Structured, time-limited cognitive behavioral therapy concepts and interventions can provide a solid base for therapy with clients with PTSD and complex trauma histories. However, in addition this training setting provided the essential experience for the trainee-therapist (a) of understanding how her client's inner and outer experience was influenced by prior traumatic experiences; and (b) of how finding meaning in trauma (and associated) memories could enable the client to replace trauma-related ways of protecting herself with adaptations based on core strengths and values. This is an aspect of therapist training that we believe may get overlooked or shortchanged when clinical trainees only gain experience with evidence-based trauma-focused practices for trauma treatment.

The hybrid client (Chloe) is a woman who has many advantages: youth, access to higher education, personal motivation, and the privileges associated with not being of a marginalized race, ethnicity, and sexual minority. Given this context and her apparently "garden variety" symptoms of depression with limited suicidal ideation, she might seem to warrant straightforward therapy for depression (e.g., cognitive-behavior therapy, interpersonal psychotherapy, and/or behavioral activation). However, she has experienced a recent traumatic exposure (witnessing her mother's attempted suicide one year ago) that was highly unsettling for her, which then that layered on (a) adversities of neglect and family turmoil throughout her childhood and adolescence; and (b) unspecified stressors related to her parent's divorce 10 years ago, with her unstable mother as having sole custody, and abandonment by and no contact with her father from age 10 until recently.

The trauma-informed assessment identified multiple PTSD symptoms, including dissociative depersonalization and derealization, suggesting that Chloe may be experiencing the dissociative sub-type of PTSD (American Psychiatric Association, 2013; Lanius et al., 2013).

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Additionally identified were (a) symptoms of emotion dysregulation and altered relationships, and (b) self-perception symptoms of the "disturbance of self-organization" (DSO) features of the Complex PTSD diagnosis (Brewin et al., 2017; World Health Organization, 2021). Thus, a trauma-informed approach to the psychotherapy—which would have been missed if only the depression symptoms and Chloe's evident protective factors (i.e., gender, race/ethnicity, education, sheltered college residence, and para-suicidality) were attended to—was clearly indicated in this case. Therefore, beyond being trauma-informed, a treatment directed towards complex trauma-related symptoms was needed and implemented.

## 3. GUIDING CONCEPTION WITH RESEARCH AND CLINICAL EXPERIENCE SUPPORT

Shepherd demonstrated an impressive grasp of the research literature supporting the complex PTSD formulation. In particular, she provided a detailed description of the Adverse Childhood Experiences Studies (ACES) studies and their influence in understanding the psychophysiological consequences of adverse experiences in the course of childhood; and showed how its findings correlated with other research. From this point of understanding, she found our description of a sequenced, relational-based model as suitable to her needs and emphasized its flexibility in incorporating various treatment modalities.

Specifically, she demonstrated how she selected treatments according to the needs of her clients and her judgment of what would be the most effective of treatments among those she was familiar with (Accelerated Emotional Dynamic Psychotherapy [AEDP; Fosha, 2000]); Somatosensory Psychotherapy [SPI; Ogden, Minton, & Pain, 2006; and Behavioral Activation (BA; Martell, Dimidjian, & Hermandunn, 2013 ). She seemed quite comfortable in taking this approach and in demonstrating how it worked to the benefit of this client. This provides substantiation of this individualized approach as applied to this clinical case and in accord with recent research findings and clinical guidelines.

## 4. PRE-TREATMENT ASSESSMENT AND PHASE 1 OF PSYCHOTHERAPY

We applaud the assessment strategy employed by the author, the use of an unstructured clinical interview with three standardized measures that she then re-administered every 4 months to monitor symptom changes and progress.

Although these instruments were appropriate and useful in assessing Chloe, we wonder if it might have been informative to supplement them with Briere's *Trauma Symptom Inventory-2* (Briere, 2011), the *Dissociative Experiences Scale* (Carlson & Putnam, 1993) for screening for

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dissociation and the newly developed *International Trauma Questionnaire* (Cloitre et al., 2021) for assessing symptoms of complex trauma. These would have provided Shepherd with additional information about Chloe's symptoms and diagnosis. Shepherd also does not discuss why she only gave the diagnosis of standard PTSD (without the dissociative subtype) and not the newly available Complex PTSD.

That said, with this trauma-informed assessment, the therapist was able to discern that Chloe's initially obvious presentation of depression symptoms and her minimization and avoidance of discussion of her childhood experiences made it crucial to begin the therapy with a focus on present-day symptoms. This is a common mode of presentation among complex trauma clients who tend to minimize or detach themselves from past painful experiences; and it is usually only when they have settled into the treatment that they are able and willing to address these issues in more detail.

In this case, settling involved helping Chloe feel a sense of safety, validation, and hope; and initiating treatment for her depression and isolation, rather than focusing immediately on her traumatic experiences and PTSD symptoms. Shepherd clearly was conscious of wanting Chloe to experience her as a caring human being who was interested in understanding her experience, rather than as an intrusive inquisitor or a didactic authority. The repeat assessment at four-month intervals throughout the treatment also led to an astute observation by the therapist—namely that Chloe was not forthcoming in how she completed the questionnaires but was more forthright in her verbalizations during sessions. This certainly called for a need to interpret the assessment instruments with this information in mind.

Although the therapist's intentions and rationale for developing a therapeutic relationship with Chloe were clear, several cautions require consideration when engaging initially with such a client. First, when Shepherd talked about "making sure to bring my personality and humanity into the room in as genuine a manner as possible" (p. 152), this must be done very carefully because Chloe is likely to have had both too much (i.e., abuse, dysphoria, conflict) and too little (i.e., neglect, separation) of each of her parents' authentic "personality and humanity." It is tempting to assume that, as a genuinely good and caring person that this "niceness" will be so refreshing and reassuring for clients who have experienced negative aspects of relationships that they will automatically feel a sense of trust, hope, and gratitude. However, fear-based hypervigilance, avoidance, and emotional detachment (often associated with a detached/avoidant or disorganized style of attachment) are a persistent self-protective frame of reference that become deeply and chronically ingrained when children need to survive the trauma of emotional and physical abuse and personal invalidation. And emotional numbing and dissociative

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detachment (and self-stimulation/harm) also are ways that neglected children develop to stay emotionally alive despite feeling profoundly empty.

Experiencing kindness, genuine caring, and respect therefore can be triggers for both intrusive re-experiencing of memories of traumatic abuse or neglect (likely in an implicit rather than explicit form). This can occur with increased rather than decreased hypervigilance, avoidance, and dissociation in anticipation of "niceness" that may have been the prelude to familiar and exquisitely painful kinds of betrayal experienced in the turmoil of family trauma. In fact, many abusers lead with and offer the hope of "niceness" only to reverse it and use it as a means of misrepresentation and entrapment. Of course, these paradoxical relational responses can be very confusing, if not vexing, to the therapist who is attempting to engage in good faith.

Caution also is needed when conveying empathic concern such as by Shepherd saying, "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" (p. 152), along with Shepherd's intimations of a willingness to join with the client using "we" in statements such as "we are here together" or "Can we be with this together?" The intention to communicate empathy and collaboration is well-grounded, but the message may be received as an empty or shaming statement connoting sympathy and condescension rather than empathy, and the imposition of a forced joining and enmeshment rather than collaboration. Clients who have been traumatically harmed or neglected as children also do not simply have altered beliefs about self, others, and the world, but carry with them in their bodies, emotions, and perceptions a fundamentally altered sense of self, relationships, and external reality that can only be partially understood by another person—and only incrementally over time, not immediately or in one fell swoop. Exactly what Chloe has "been carrying" and what Chloe needs to know in order to feel able to feel sufficiently safe and trusting to "be with this together" is precisely what the therapist must learn from Chloe by helping Chloe to discover this for herself.

Empathy and a therapeutic alliance are distal endpoints that can only be gradually approximated, not the starting point, in psychotherapy with clients who have complex trauma histories. The timing and nature of true empathic validation and the forming of a genuinely trusting and collaborative alliance differ for each client and treatment, but they are the result and not cause of a successful psychotherapy. This is illustrated in the case study by Chloe's dissociative withdrawal when the therapist attempted to "maintain a holding environment … and [help] her feel validated and understood" (p. 153). Good idea, but Chloe understandably was not ready or able to experience this as helpful and may have felt cut-off or silenced when from her perspective she wanted to just tell her story and be heard. This is a clear illustration of how the application of a particular technique (in this case from AEDP which encourages "joining"

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verbalizations on the part of the therapist to lessen the patient's isolation) needs to be adjusted to meet the client where they are.

Shepherd does an excellent job of describing her own personal dissociative experience as an example of what can occur when therapists are "drawn into the world of the dissociative client" (p. 32)—and how quickly this can happen right from the start of the therapy. Using these reactions as a signal to mindfully engage in physical and psychological grounding (i.e., self-monitoring and self-regulation) can be an important way for therapists to both maintain their awareness of and contact with the client while also serving as a role model of self-regulation and "integration rather than … dissociation." (p. 153).

What is not noted in the case study, but is of equal or greater importance, is that a therapist's dissociative reactions can provide clues as to when, how, and why the client is experiencing dissociation. This is not necessarily a one-to-one equivalence, but the therapist's dissociative reactions suggest that she may be experiencing confusion as well as countertransference or psychophysiological reactions that mirror important aspects of the client's dissociative states. For example, she described how her distraction and confusion seemed to coalesce around self-devaluation ("I was doing something 'wrong,'" or "I was an 'unskilled therapist,'" p. 153). In addition to recognizing the need to "put on my own oxygen mask before helping others to put on theirs" (i.e., to ground oneself first and to be mindful about self-regulation), the therapist also might make a process comment to Chloe about the potential connection between receiving compassion, validation, and encouragement and engaging in emotional shutdown and dissociation. This is in vivo evidence that experiencing those apparently facilitative therapeutic conditions may be distressing. Exploring how and why that happened is likely to be an essential part of helping Chloe to therapeutically process trauma (and other) memories.

## 5. CASE FORMULATION AND TREATMENT PLAN

Initially, Chloe was unable to identify goals other than to feel better, a worthy goal for someone who is severely depressed and increasingly isolated. As this was her first experience in psychotherapy, the therapist was wise to follow her lead and to focus initially on helping her to feel better using behavioral activation strategies developed for the treatment of depression. The treatment plan developed rather organically from there within the structure of the sequenced meta model as Chloe began to feel less depressed and was able to focus on other issues. The list of treatment goals that the therapist provided were straightforward, focused, sequenced, and were directly targeted to Chloe and her needs. The provided an overall structure within which the treatment would unfold.

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## 6. COURSE OF TREATMENT

The flexibility of the model was demonstrated with the author's breakdown of the three treatment phases into eight that were described chronologically by week. Chloe was shy and soft-spoken during these early sessions and Shepherd used part of the time to acclimate her to the treatment process and expectations, part to reassure her, and part to further evaluate her safety.

During this time period, the therapist noted Chloe's tendency to avoid and dissociate by noting Shepherd's own responses of losing her train of thought, being confused, and having difficulty remembering material from the previous sessions. The example from Session 4 offers several instructive examples of ways to help a client who is dissociating to re-gain present orientation relationally, cognitively, and somatically. The addition of psychoeducation provided by the therapist when she defined what seemed like a "crazy" state to Chloe as an understandable survival reaction to trauma that is known as dissociation, was a good example of how therapy can help clients to not only feel less stigma but also to make a crucial developmental leap from feeling confused and ignorant to feeling competent and knowledgeable.

It seems likely that it was that subtle and apparently minor insight, and the resultant shift in Chloe's view of herself—from being a person who was crazy and deficient to someone who is psychologically intact and competent—that provided the basis for Chloe's becoming "better able to remain present in sessions" and having "increased her capacity for self-reflection" (p. 35), in the next sessions. The most effective therapeutic interventions are sometimes simple statements that are timed and tailored to help a client to experience a shift in their sense of self, and subsequently in their experience of relationships and the world. We often think that we are teaching our clients by teaching textbook lessons about trauma and recovery, but the real teaching is often done by brief comments that help clients gradually to change their fundamental way of experiencing themselves from being confused, damaged, and struggling to survive to feeling competent and resilient and in the process of healing and recovery. Shepherd's initial focus on stabilizing Chloe's depression and teaching ways to manage her avoidance/dissociation and to begin to focus on herself were precursors to moving into the next treatment segments.

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

By the 14th session, Chloe is described as "motivated and engaged to begin to address the traumatic experiences and associated emotions that she had been avoiding" (p. 159) because she "wanted to feel better"—but, also, her "affect and body language expressed hesitation and anxiety" (p. 158). Although 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" (p. 158-159) and "may be exacerbating her posttraumatic stress

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reactions and depressive symptoms" (p. 159), she still struggled with some dissociative symptoms. Based on Chloe's preference, and the therapist's assessment of Chloe's increased awareness of her emotions and how her tendency to avoid those emotions could exacerbate symptoms, the decision to move forward to memory work seemed well-advised but, in hindsight, may have been premature. It is not clear from the case report that Chloe understood how processing trauma memories could help her to "feel better." Nor had therapist and client specifically developed an approach for pacing and actively regulating distressing emotions without becoming overwhelmed and dissociating. More preparation seems to have been warranted.

Chloe's response in her initial memory processing reflected her mixture of readiness and vulnerability. She was able to become emotionally engaged in re-experiencing the shock and terror that she felt seeing her mother holding a gun to her head, and in recalling her own immediate reactions of grabbing the gun, running to her room and locking herself in, while attempting to call for help. However, she described this complicated sequence in a pressured manner, making only brief comments about her perceptions and feelings when cued by the therapist. Chloe rushed through describing the events, and quickly seemed on the brink of being emotionally overwhelmed. The therapist is carefully observing Chloe's physical state, and immediately interjects grounding comments that seem to help Chloe contain the distress until she finally shut down (both in the session and in the memory) and appeared extremely dissociated. Shepherd helped Chloe to move out of the dissociative state by focusing on being together in the present moment, and by physically as well as mentally regaining a sense of agency imagining enacting her wish to throw the gun out the window.

While the session transcript reveals the sensitive and skillful way in which the therapist helped Chloe engage emotionally in the memory processing and recover from dissociation, with 20-20 hindsight, it is not surprising that "the following session, session 15, went very differently" (p. 161). Chloe's description of having a migraine after the prior session and "not recalling what was talked about" in that session, as well as her apparent indifference and incongruous laughter when reminded of processing the memory of her mother's suicidal incident, are recognized as consistent with PTSD-related avoidance as well as dissociation. We would add that Chloe's reactions also reflected a subtle form of emotional numbing, and she exhibited both somatoform (e.g., migraine) and psychoform (e.g., forgetting the memory work) forms of dissociation.

Additionally, the defensive detachment and laughter were indicative of reaction formation and minimization. The therapist wisely took a cue from her own sense of confusion to recognize Chloe's reaction as dissociative. What is less clear is how severe Chloe's dissociation

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was at that point. The therapist viewed the dissociation as "not severe," consistent with Chloe's presentation as fully oriented and euthymic. However, from a structural dissociation perspective (Steele et al., 2005), Chloe's presentation is consistent with the "apparently normal personality" that can be a hallmark of significant dissociation in traumatized individuals. This hypothesis is supported by Chloe's disclosure in the next session after this hiatus that she had been having "migraines" on the way to several of the prior therapy sessions, as well as generally having problems with concentration and disorientation to time.

Thus, Chloe's apparent indifference about the trauma memory and avoidance of therapy and the therapist for three weeks may have been due to a slide into her previous habit of avoidance and dissociative fragmentation when she was unsuccessfully attempting to cope with distress of which she herself was largely unaware. This is a different interpretation than that made by Shepherd, who viewed Chloe's back slide as resistance. It was likely more an attempt at self-protection, using the method that had previously been "tried and true." Chloe acknowledged the surface features of this dilemma in their next session, and the therapist concluded that more Phase 1 work was needed before embarking on trauma memory processing. The therapist describes this as "regression" on Chloe's part, in reaction to being "push[ed] to process her trauma too soon" (p. 162).

We agree with the therapist's decision to resume therapeutic work on emotion regulation skills, with two important caveats. First, characterizing Chloe as "regressing" is potentially stigmatizing and inaccurate: Chloe was consistently having difficulty with both somatoform and psychoform dissociation, which both she and the therapist were overlooking. Chloe's reaction to the memory processing work was not a backslide but a red flag that communicated (unconsciously) to the therapist that she needed help in understanding and managing distress—most likely due to intrusive re-experiencing of confusing traumatic memories and feelings, although this remains to be determined—that she was barely able to cope with by using distraction and compartmentalizing to avoid awareness of the distressing feelings. Chloe was not regressing, but instead was revealing a psychosomatic expression of the dilemma with which she was coping.

Secondly, the therapist may have felt eager and enthusiastic about moving "forward" to Phase 2, but this is not the same thing as "pushing" her client to engage in trauma memory work. The therapist had been careful to develop a working alliance with Chloe and waited until she spontaneously expressed willingness to work on the trauma memory. Given Chloe's surface presentation as relatively high functioning and having a tendency toward avoidance, anxiety and at times being somewhat "spacey," it is not surprising that her therapist might assume that she was not experiencing dissociative fragmentation that could be intensified by trauma memory

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processing. Thus, the therapeutic impasse was definitely an indication of the need for additional preparation prior to initiating Phase 2, with a focus on both the therapist and Chloe gaining a fuller understanding the complexity of Chloe's internal state of mind so that Chloe could recognize why she (and not the therapist) was both pushing herself to "get over" her trauma memories while simultaneously desperately avoiding facing those memories.

What might have prevented this upsurge in avoidance and dissociation on Chloe's part? In the first place, this might have been inevitable due to the unavoidable shock of confronting this extremely distressing memory after having avoided it for a year. However, the therapist might have been able to help Chloe experience the distress as more manageable by making some adaptations to the memory processing, including the following:

(1) more fully preparing Chloe for the intense emotions. (These emotions could have been seen as a positive, although uncomfortable, sign of working on the memory by experiencing feelings that Chloe was unable to feel during the actual event. The therapist could also have set up a plan to ensure that the emotions were manageable by creating a nonverbal or verbal signal that Chloe could use to tell the therapist when she needed help).

(2) actively titrating the intensity of Chloe's distress by slowing down the narrative with grounding comments and a reminder to take the time to pay attention to what she was (and is currently) experiencing, rather than simply rushing through the events.

(3) purposefully pausing and "re-winding" the narrative at key transition points (e.g., when Chloe first took the gun from her mother, as she was running to her room, when she shut the door to her room, when she got her phone, while she was "frozen") to help Chloe focus on her inner state at each of those moments before going on to the next action/event.

(4) helping Chloe to recall how she had actually gotten help and put the gun in a safe place—to balance her sense of powerlessness and freezing with a focus on her agency and what she was able to accomplish, even when highly stressed.

(5) helping Chloe to identify when she considered the incident to have ended, for her to complete the telling of the narrative with a sense of at least partial closure by defining a distinct endpoint. (For example, when Chloe's mother was no longer "screaming" outside her door but was calmer—or had been provided with emergency care—and Chloe was able to leave her room knowing that her mother was safe and there was no longer an immediate crisis.

(6) because the "end" of a traumatic incident often involves at most partial closure for the individual, with many loose ends typically still incomplete, helping Chloe to identify an end

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point that could assist Chloe to complete the memory narrative (and thereby reduce re-experiencing of the traumatic events). To do this, the therapist can help her to continue the narrative past the "endpoint" by walking through what she did and what happened in the ensuing hours or days up to when she felt able to carry on or re-engage with typical daily activities and routines before the traumatic incident (even though she probably will still have had felt some residual distress). This would also involve discussion of whether her mother received any assistance in the aftermath of the crisis and whether she and her mother were able to discuss the event and how it had impacted each of them.

(7) engaging Chloe to process some of her more distal traumatic experiences from childhood *before* addressing the more emotionally loaded suicide attempt by her mother. (Note that whether to address and process trauma by starting with the most severe and intense episode(s) or starting with the least severe, differs by therapeutic approach. The therapist should carefully discern what to work on first.) Successfully addressing and processing some of these more distal events might have given Chloe experiences of success that underscored her ability to face these difficult events and experiences.

The above seven suggestions for making some adaptations to the memory processing are all options that may not have been relevant or possible in Chloe's therapy. But these are ways that therapists in similar circumstances might consider for helping their clients who have difficulties with emotion regulation and dissociation prepare for and engage in trauma memory processing by focusing on less emotionally loaded events first.

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

Interestingly, when resuming a focus on bolstering Chloe's emotion regulation abilities and reducing her reliance on avoidance, the therapist did so by helping Chloe to feel more "energized" by standing up and moving rather than just sitting in sessions. The therapist astutely noted that Chloe's spontaneous movements resembled those she had described when she recalled wanting to throw the gun out the window after taking the gun from her mother. Helping Chloe to stand up and move vigorously thus could be understood as a somatic form of memory processing—enabling her to experience the sense of physical and psychological agency and completion (as described by Ogden, Minton & Pain, 2006; and Levine, 2008) that was missing for her when she was relatively immobilized, lying on her bed, feeling overwhelmed, terrified, and incompetent.

Although those interventions probably were helpful to Chloe in increasing her awareness of her body's capacities as the basis of her feelings, as the therapist noted, they could also provide an opportunity for Chloe to experience a shift more specifically in her self-perception as helpless and powerless to one that was instead active and helpful. But it could be

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useful to Chloe for the therapist to reinforce how her response in the therapy sessions to the encouragement to tap into her energy and stand up and move demonstrates her ability to be active and achieve important goals even when she is feeling depleted or stuck. This also could increase Chloe's awareness of positive as well as negative emotions, which is an important aspect of mindful emotion awareness and emotion regulation.

Another important piece of therapeutic work was initiated in the return to Phase 1. This was the beginning of exploration of Chloe's relationship with adult caregivers. An important event such as her mother's suicide threat does not occur in a relational vacuum. Chloe had previously described her attempts to take care of not only her mother (especially after her parents divorced and her father was out of contact), but also of her father (due to his alcoholism). With her mother repeatedly making references to suicide, her father essentially abandoning her and their family, and her grandparents reinforcing both the sense of abandonment and that it was *her* responsibility to be sympathetic to (and by implication to be the caretaker of) her mother—it is not surprising that Chloe would have felt afraid, alone, and burdened.

Chloe's intense bond with her younger sister was an understandable means of gaining some security on both their parts, but it apparently took the form of "two of us against the world" that left her with difficulty in forming other emotional attachments. These are precisely the traumatic features that characterize complex developmental trauma: a combination of ongoing victimization and a rupture or absence of secure emotional bonding with primary caregivers— both of which may occur, as apparently was the case for Chloe, not due to any intentional maltreatment or violence, but unintentionally or negligently by caregivers impaired by their own psychological, relational, and addictive problems (Ford et al., 2022; Ford et al., 2018). Although her mother's near suicide clearly was traumatic for Chloe, it occurred in a larger context of ongoing complex developmental trauma and past threats that involved all of Chloe's primary family members across three generations, and that evidently left her feeling relatively alone and detached from her family and friendships as well as primary romantic relationships (i.e., no close friends, repeated infidelity).

A question that arises prior to returning to Phase 2 work (in what is designated in the case study as Stage 4), is how exploring Chloe's "struggles" in her relationship with her mother and father "further contributed to her increased willingness to process her trauma." It is important to distinguish between "willingness" versus readiness to engage in trauma memory processing.

From the case study narrative, it appears that Chloe was ready to engage in trauma memory processing due to her trust that the therapist would assist her to pace herself to not

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become overwhelmed as she addressed the memory. The nonjudgmental mirroring of her bodily reactions by the therapist probably helped Chloe to not only have a more integrated awareness of her body and her emotions, but also to provide her with the secure attachment that she had needed but not received previously. In that respect, her bond with her therapist may have recapitulated some of the positive aspects of her bond with her sister, with the important proviso of being able to receive the care without having to also provide caring and security for the caregiver (as she had to do with her parents, and probably with her sister).

So, it seems that Chloe's "readiness" for Phase 2 trauma processing was based on having developed a secure relationship and collaborative working alliance with her therapist—which had been missing, or infused with a sense of threat and obligation, in her primary attachment relationships. This in turn seems to have helped Chloe to engage in co-regulation with her therapist, following her therapist's lead in focusing on body awareness when she needed help in managing intense distress. Thus, it was not the development of Chloe's emotion regulation skills in isolation from her relationship with the therapist, but rather in interaction with her, that then helped Chloe to face the previously overwhelming trauma memory and to relinquish avoidance as her preferred way of coping.

It is noteworthy that 23 sessions (and six months) were devoted to the second period of preparation for formal trauma memory processing. Although this involved helping Chloe to "continue to practice emotion regulation skills," much more than stabilization appeared to be occurring: "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" (p. 166). The latter statement reflects a view of memory processing as only occurring if the memory is formally walked-through and addressed in detail, but this overlooks the value of gradually unpacking memories through repeated re-visiting of different aspects of the memory by narrative and cognitive means. Bailey (2021) discussed how such naturalistic discussions of traumatic circumstances are a component of processing that is often either overlooked by the therapist or not recognized for their value. Indeed, by following Chloe's lead as she spontaneously recalled a variety of potentially traumatic incidents, it was possible for the therapist (and Chloe herself) to "notice certain themes emerging and which memories appeared to come up most" (p. 166).

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

When the processing of her mother's near suicide was formally resumed, it appears that Chloe was able to engage with manageable emotional intensity and only brief dissociative episodes that resolved with the therapist's help through co-regulation (e.g., mirroring of unspoken bodily and affective reactions). Shepherd astutely observed that Chloe's reduced

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distress as related to her focal memory did not constitute a full resolution of her PTSD or her Disorder of Self Organization symptoms.

Of note, in a clinical trial study in which reduction or resolution of PTSD symptoms were the primary outcome, this treatment would most likely have been rated as a fully successful outcome and therapy would be considered complete (probably based on documenting remission of PTSD related to that focal memory). In real life, however, Chloe continued to be experiencing distress and impairment, which the therapist noted as potentially related to amnesia and fragmentation of her memories from her childhood and a continued need to expand her emotional discrimination and management.

Therefore, the focus shifted to Chloe's anger (and hurt) related to her father regarding both his alcoholism and his abandonment after the divorce, virtually leaving her alone to deal with and in the care of an unstable mother. Although not conducted as formal memory processing, this was an important continuation of Phase 2 processing. Despite not being an overtly traumatic relationship, Chloe's father's abandonment through his alcohol impairment and later his actual absence in her life involved major invalidation and betrayal and thus constitutes adverse childhood experiences. Her father appears to be a major contributor to Chloe's sense of aloneness and psychological burden—as well as her confusion about who she is as a person and how to be in a genuinely trustworthy, mutual, and caring relationship. His recent re-emergence in her life and his request to have dinner—which she reported triggered depression and avoidance on her part--provided present-day material to work with in accessing and processing his abandonment. Chloe's tendency to blame herself for the failure of her caregivers came to the fore during this period of treatment, as did her tendency to not have compassion for her younger self. The use of the AEDP technique of *portrayal* assisted Chloe in reworking some of her feelings about her younger self and sense of culpability. With the therapist's support and noticing of somatic expression, she was able to identify previously unrecognized feelings, especially anger.

Additionally, had Chloe not recalled and re-worked the memory of trying as an 8-year-old to find a book about helping alcoholics recover, she might well re-live or replay the associated sense of confusion, powerlessness, aloneness, detachment, and emotional burden for the rest of her life. This demonstrates how processing developmentally formative memories, including ones that do not meet formal criteria as traumatic but are emotionally foundational, can be crucial. Resolving the impact of the larger context of developmental adversity and attachment disruption—so often the background for other traumatic injury or loss—can have significant positive outcomes on DSOs. Processing memories that have left an emotional imprint on the client's sense of self provides an opportunity to help them—as adults in the current moment—to use their imagination to provide their younger self with the caring and validation that they longed

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for but did not receive (or could not fully take in due to the impact of prior, concurrent, or subsequent traumatic experiences or attachment disruptions).

The therapist's recognition and handling of a countertransference enactment (Ford, 2021) at this stage of the therapy is commendable. Making an assumption that Chloe was misusing her prescribed medication was a classic example of a rupture in the therapeutic alliance due to an empathic failure (Kohut & Wolf, 1978). The therapist's immediate disclosure that implying that Chloe was using the medication addictively was a mistake based on her own (the therapist's) fear, evidently was not only surprising but also significantly reassuring for Chloe.

The therapist self-disclosed—not to Chloe, but for readers of this case study—that she felt "plagued with feelings of self-doubt" (p. 172). This admission also is commendable as a reminder that for a therapist dealing with personal prejudices and misunderstandings that are projected on the client and countertransference and therapeutic relationship ruptures are never easy and often painful on a personal level. When that personal distress can be acknowledged and shared with professional peers and in expert supervision and consultation, it is less likely to seep into this (or other) clients' therapy or into the therapist's personal life. Also, it is reassuring to those of us who, as therapists, need to remember that all of us make mistakes when our personal issues are evoked by our clients, and that to err is simply to be human. And exposing our humanity may be revelatory and healing for our clients and their unrealistic projections.

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

At this point, the therapy shifts from a focus on memories to helping Chloe to become aware of her current internal life and the sadness and aloneness that she has taken for granted as inevitable and irreparable. This marks the beginning of Phase 3, and Chloe's reactions illustrate how complex this seemingly straightforward "wrapping up" or "consolidating of gains" really is. On the one hand, Chloe was able to explicitly say that she experienced the therapist as a person to whom she can look for reliable and genuine support (and not a "therapist robot"), and that her life is not "a failure." Yet, Chloe also taps into profound grief that is just as intense as the fear and aloneness that she encountered in addressing her trauma memories: "It's painful because I'm realizing that my parents will never be who I needed them to be. … They failed to be the parents I needed, but now I can be that for myself" (p. 174). And her vision of playing in a garden with the therapist "there with me" reflects her growing recognition that another person can be a source of safety and comfort rather than a burden or disappointment. These are indeed signs of Chloe's ability "to process feelings of grief and loss from a place of more stability and security" (p. 175) and to develop some hope for the future.

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But then Chloe begins to be irregular in attending sessions, saying she "just 'forgot'" and "it's not a big deal." Of course, it really is a big deal, because this clearly is a repetition of the avoidance, detachment, and dissociation (as indicated by the incident of blacking out and kicking the door when her father was helping her to move to a new apartment) that Chloe experienced at the outset of therapy. The therapist's decision to approach the therapy from the perspective of Phase 1 foundational interventions rather than prematurely pushing Chloe to conclude the therapy was well advised. Although the therapist observed that Chloe was able to recognize and reflect on her emotions and bodily reactions—and that she seemed more fully emotionally present than ever before—the image Chloe had of herself as a "transparent flag" (p. 178) signaled that she still "had much more work to be done regarding her fragmented sense of self and identity" (p. 58). Returning to Phase 2 thus was essential so as not leave Chloe prone to dissociation due to having only the fragile and superficial sense of herself as a happy and free child, when that was not actually how she had experienced herself in her childhood.

To feel safe and secure in herself as an adult, memory processing needed to involve not just compassionately observing herself as a child but actually seeing through her own eyes as a child and mourning the sadness, aloneness, fear, and any other painful emotions that she had had to endure in isolation. Although the therapist began by helping Chloe to view herself as a child from the perspective of an observer watching separately, Chloe spontaneously began to recall her childhood as she had experienced it. She recognized how alone and vulnerable she had felt while waiting for hours for help after falling and breaking her collarbone. She also returned to the memory of her mother's near suicide which she had for months been saying was no longer intrusive or upsetting. Instead of experiencing herself as alone and having no better option than to simply throw away the gun, now she recognized the need for support signifying that she was not alone (nicely illustrated by the therapists offering to hold her hand).

It is important to consider how the therapist's response at that moment of taking Chloe's extended hand could be double edged—on the one hand, conveying compassion and affirming the meta-message that the therapist genuinely cared for her and would not abandon her at a moment of need, yet on the other, potentially blurring the therapeutic boundaries and creating confusion in Chloe's mind about how much intimacy the therapist is offering to (or requesting from) her. The request clearly came from Chloe, unsolicited (implicitly or explicitly) from the therapist, and this reduces the likelihood that Chloe would believe that she could (or should) seek greater physical or emotional intimacy from the therapist. Chloe also does not have a history of sexual or other personal boundary violations, which would be a key indication for extreme caution on the part of the therapist in making physical contact that could inadvertently replicate those violations. The subsequent successful move into Phase 3 and toward closure of the therapy

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further suggest that Chloe experienced the contact as safe and as an affirmation of the therapeutic relationship.

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

In addition to viewing "safety planning, self-care, and emotion regulation [as] as way of life rather than preventive or ameliorative tactics used primarily for coping" (Ford & Courtois, 2013, p. 182), the therapist aptly notes that Chloe was able to spontaneously envision a positive future for herself at this point in the therapy. Although having a sense of self as having worth and power, and not being fundamentally and irreparably damaged, is indisputably of great importance, we would suggest that having a sense of a future in which there is a life worth living (Linehan, 1993) is another robust and sustainable sign of successful psychotherapy. The repeat assessments indicated a diminution of symptoms over the course of the treatment, although this finding must be made with the caveat of Chloe's tendency to underreport her symptoms that had been noted by the therapist. Therefore, the therapist needed to interpret the findings and the client's verbalizations with care and to supplement them with clinical inquiry and observations.

Obviously, this therapy could have continued; however, the therapist's time at the clinic was coming to an end, necessitating then end of the treatment. As we suggested in our text, the wrap-up of treatment can be a fraught time for clients with a history of personal loss and therapists should therefore plan for enough time for review and discussion of the treatment and a plan for the ending and any further treatment. Since complex trauma clients often have histories of abrupt separations from or loss of significant others, usually with little or no discussion or support, a planned ending may be another component of healing by "doing it another way" by jointly acknowledging it and giving it the attention it deserves.

The fact that psychotherapy is a relationship, albeit one with its own boundaries and limits, inherently implies that the bond that is formed should be honored permanently, and not "terminated" when a therapist and client stop meeting. In this case, following a period of discussion and other preparation, the therapist recognized these crucial issues and creatively operationalized them by suggesting to Chloe that they share letters to each other in their final session. This symbolically connoted a continuing relationship that, although no longer in person, is based on an appreciation for one another that has no arbitrary ending. The symbolic affirmation of the relationship may take other forms, tangible and intangible which client and therapist may mutually decide upon, but this is the essential condition of completion that permits the client (the therapist as well) to go forward without a residual sense of unfinished business from the therapy while "keeping each other in mind."

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# CONCLUSION

This case report provides an admirably creative and integrative example of the systematic application of a comprehensive biopsychosocial array of therapy with a client's personal quest to understand and free herself from the binds in which she had become caught due to complex adverse developmental experiences and a more recent major traumatic exposure. In this therapy, Chloe internalized what she learned about herself in terms of her history, coping strategies, symptoms, and about how to manage and emotionally regulate herself in ways that were different from the past. She benefited particularly from the consistent and reliable resonance and caring of the therapist which she was able to internalize to shift her view of herself and the trustworthiness of others.

We appreciate the careful attention paid by Shepherd, the therapist, to where the client was in the phases of this transformational process at each point in the therapeutic progression. The case illustrates clearly how this progression is not linear (nor curvilinear, or quadratic), but instead is more akin to the rapid quantum shifts through which the most basic physical particles move over time. Each of the three essential phases originally described by Judith Herman (and before her by Pierre Janet) can be understood metaphorically as a quantum level in which the client is the same person but the organization of her bodily processes, emotions, beliefs, behavior, and relationships is unique.

The treatment was personalized to Chloe and her needs, and it incorporated and integrated a variety of techniques, including those with a developing evidence base. Thus, as Chloe moved through negative states of detachment, avoidance, dissociation, despair, sadness, anger, and hopelessness, the therapy correspondingly helped her to re-organize her ways of coping—and then her ways of being. In doing this, the therapy employed emotion regulation and trust (Phase 1), memory processing (Phase 2), and reflective self-discovery and relational engagement (Phase 3) as new frameworks for counterbalancing those negative states with the opposite states, such as awareness, hope, curiosity, determination, and affirmation.

We believe that if Chloe had been treated only with trauma focused treatments (those cognitive behavioral approaches with the most developed evidence-base) immediately at the start of the treatment, she would likely have been overwhelmed (as described in this case report) and may have prematurely fled treatment. Instead, as the therapist fluidly moved between phases 1 and 2 work, she focused on strengthening Chloe's ability to tolerate and manage the kinds of feelings her trauma memories elicited while discussing other childhood adversities with her, in the process, dismantling her tendency to avoid and dissociate from uncomfortable events and memories. By doing so, the therapist provided the foundation on which Chloe was able to

successfully face and process her more formidable trauma memory. Chloe was able to further work on the nuances of the issues she was facing and how she was coping in the present in ways that would likely not have occurred using a more manualized and front-loaded treatment.

It remains to be determined through future research if and how such sequencing as we've described assists in the treatment of complex trauma and CPTSD. That being said, Shepherd's case study of Chloe is an illuminating portrayal of how therapy can be conducted in a relatively time-efficient and hierarchical way that is multifaceted enough to meet the needs of clients who have complex (internal and external) lives and trauma histories.

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