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Volume 18, Module 2, Article 4, pp. 257-265, 05-19-22 [copyright by author]

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

Revisiting the Case of "Chloe": Reflections on the Treatment of a Survivor of Complex Trauma

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ABSTRACT

In this article, I respond to commentaries by Christine Courtois and Julian Ford (2022), and by Stephanie Lyon (2022) on my hybrid case study of "Chloe," a survivor of complex trauma (Shepherd, 2022). Courtois and Ford, seasoned clinicians in the field of complex trauma and the developers of the sequenced, relationship-based model used in Chloe's treatment, offer intriguing insights and reflections on the application of their model to Chloe's case. In her compelling response, Lyon puts forth an alternative guiding conception, one rooted in a mentalization-based approach, for treating Chloe's complex posttraumatic stress disorder (CPTSD), which raises fascinating questions regarding the nature of treatment for complex trauma survivors. In the following response, I consider these thoughtful commentaries and provide feedback in order to continue the dialogue regarding the need for flexible and integrative approaches to treating CPTSD that differ from those of traditional PTSD approaches.

Key Words: Accelerated Experiential Dynamic Therapy (AEDP); Sensorimotor Psychotherapy (SP); phase-based treatment; complex PTSD (CPTSD); relational trauma; case study; clinical case study

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INTRODUCTION

From the very beginning of my graduate studies, I was drawn to working with individuals who have experienced chronic and prolonged trauma. While the work can be very challenging, it is also extremely rewarding. Quickly, it became clear to me that the effects of prolonged childhood relational trauma— historically labelled in the literature as complex posttraumatic stress disorder (CPTSD) (Herman, 1992)—can result in a clinical presentation that differs from that of someone who has endured a single traumatic event. I felt passionate about learning how to best treat these chronically traumatized individuals in a way that matched the multifaceted

nature of their experiences and struggles. In the case of "Chloe," I aimed to illustrate the benefits of the use of Courtois and Ford's (2013) sequenced, relationship-based approach to the treatment of CPTSD. Their model is flexible and integrative, allowing me to use elements from a variety of approaches, including Ogden's (e.g., Ogden & Fisher, 2015) Sensorimotor Psychotherapy (SP) and Fosha's (e.g., 2000) Accelerated Experiential Dynamic Psychotherapy (AEDP).

Chloe is a composite case example based on my actual, de-identified psychotherapy cases in addition to clinical examples in the relevant literature. My intention was to describe in detail one possible avenue to treatment success when working with clients with a multifaceted clinical presentation typical of those who are survivors of repeated childhood familial abuse and neglect. In humbling and awe-inspiring clinical experiences, I have been able to witness and be a part of the journey toward healing and transformation in the clients upon whom Chloe's case is based; and I have striven to incorporate these experiences in the case study of Chloe.

I want to thank Courtois and Ford (2022) and Lyon (2022) for their very insightful and thoughtful commentaries on my case study of Chloe (Shepherd, 2022). I greatly appreciate the opportunity to engage in a conversation about the case of Chloe with prominent clinicians and researchers in the field. In my response to these commentaries, I highlight relevant clinical and theoretical issues raised by the authors about the use of a sequenced, relationship-based model for treating CPTSD and provide additional commentary with the hope that this will inspire others to further examine how best to treat survivors of prolonged and chronic relational trauma.

COURTOIS AND FORD'S REFLECTIONS AND INSIGHTS ON THE CASE OF CHLOE

One of the most informative and stimulating aspects of revisiting the case of Chloe in this context was receiving feedback from Courtois and Ford (2022). I am honored to have my case commented on, with such detail, insight, and wisdom, by the developers of the ground-breaking treatment model that I used in the case of Chloe. As they note in their response, Courtois and Ford have treated, researched, and trained clinicians and scientists to work with survivors of childhood developmental trauma since the 1970s. The initial section of their commentary is very helpful in bringing their theory and the associated research up to date, and I was particularly excited to hear about their new co-edited book that is a revision and 10-year update of their original treatment book, as they continue to contribute such important knowledge to the field of complex trauma research and treatment.

In their in-depth analysis of my case study, they offer a number of very valuable insights, but due to limited space, I will only be commenting on a few points. In my response, I chose to focus on elements of their feedback in regard to the following three sections: (1) case context and method, (2) pre-treatment assessment, and (3) course of treatment.

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Case Context and Method

One important point that I feel is important to further emphasize is Courtois and Ford's comment about the psychology training clinic in which Chloe's case took place. They explain that this setting allowed for long-term therapy that made it possible for me to conduct psychodynamic psychotherapy, rather than the cognitive behavioral trauma-focused approaches to PTSD treatment that are typically more prioritized in research-based practice guidelines and taught in clinical training settings. They elaborate that this allowed for a "more immersive experience of psychotherapy than is typically the norm" (Courtois & Ford, 2022, p. 217).

I am very grateful for their comments because I strongly agree with their sentiments and deeply believe in the importance of providing doctoral clinical psychology trainees with opportunities early on in their training to provide long-term treatment of a more psychodynamic nature. Courtois and Ford state that this case illustrates the value of trainees 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" (p. 217). While I had not purposefully set out to use this case to provide support for clinical psychology training programs to implement these types of treatment opportunities and settings, I appreciate that Courtois and Ford noticed that this case could do just that.

Pre-Treatment Assessment

Courtois and Ford (2022) also provided helpful feedback in regard to the initial assessment phase of treatment, as they give suggestions of alternative assessment measures I could have used that are more aligned with assessing for complex trauma and dissociative symptoms diagnosis, such as Briere's *Trauma Symptom Inventory-2* (Briere, 2011); the *Dissociative Experiences Scale* (Carlson & Putnam, 1993); and the newly developed *International Trauma Questionnaire* (Cloitre et al., 2021). They also note that I do not discuss why I gave Chloe a PTSD diagnosis without the dissociative subtype and not the ICD-11 Complex PTSD diagnosis (World Health Organization, 2019). I think if I were to have used the aforementioned suggested assessment instruments, I would have been better equipped to make a more accurate diagnosis, namely, by adding the dissociative subtype to the standard PTSD diagnosis. As such, I agree with and appreciate their suggestion, and I think that moving forward, I will use these measures when assessing clients with complex trauma.

I chose not give the ICD-11 Complex PTSD diagnosis because of the unfortunate reality that the DSM-5 is still the diagnostic manual that my training clinic adhered to and a complex PTSD diagnosis was not an option at the time, as it is still not in the DSM-5. Courtois and Ford's (2022) comment, however, highlights the limited nature of the DSM-5 and how restrictive

diagnoses in general can be. Hopefully, future American Psychiatric Association (APA) diagnostic manuals will follow in the footsteps of the World Health Organization to include CPTSD.

Course of Treatment

Courtois and Ford provide a very insightful step-by-step analysis of my use of their model throughout Chloe's course of treatment. One noteworthy comment that I am particularly grateful for is when they point out my use of the term "regression" when describing the choice to return to Phase 1 work after Phase 2 trauma processing appeared to cause Chloe to experience significant dissociation and emotion dysregulation. They state that characterizing Chloe as "regressing" could be stigmatizing and inaccurate. I appreciate this comment, and I do think that I could have used a different term to describe what was happening, one that does not have the potential to stigmatize a client who already is in a vulnerable and confused space. My use of the term "regression" was chosen initially purely as a way to organize and describe the progression of treatment through the different phases, but I had not considered the potential harm that this word could cause. As such, I believe that instead of using "regression" I could have used the word "return" (e.g., return to Phase 1) when describing the movement between phases throughout the stages of Chloe's treatment.

Additionally, I wholeheartedly agree with their comments that Chloe's reaction to 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" (Courtois & Ford, 2022, p. 224). They go on to say that Chloe "was not regressing, but instead was revealing a psychosomatic expression of the dilemma with which she was coping" (p. 224). I believe that this analysis is a much less potentially stigmatizing way to describe what was happening for Chloe. Also, and also, by understanding the process in this way, I am able to gain new information about Chloe's experience instead of merely concluding that treatment was moving backwards to a previous place.

Lastly, towards the end of their commentary, Courtois and Ford (2022) state:

> The case illustrates clearly how this [therapeutic] 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 (p. 232).

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I think this quotation beautifully captures the complicated nature of my work with Chloe, and I believe that the opportunity to describe Chloe's case in such an in-depth and specific way, depicting the progression of treatment over two years, allowed for this "quantum" progression to truly shine through.

LYON ON THE USE OF "MENTALIZATION" IN COMPLEX TRAUMA TREATMENT

In her commentary, Lyon (2022) offers an alternate guiding conception for the treatment of Chloe's CPTSD, one that views the case through the lens of mentalization. She posits that shifting Chloe's treatment to fall under a mentalization framework would leave many details of the work unchanged but would "streamline and demystify the process of working with CPTSD presentations in a manner that could embolden tentative clinicians to approach this clinical population with the confidence encouraged by a solid yet simple theoretical grounding" (Lyon, 2022, p. 238).

While I am not very familiar with mentalization-based treatment approaches, I was impressed with how Lyon was able to interpret my clinical data with a distinctly different theory, but one that was consistent with the treatment outcomes and raised some very intriguing alternative therapeutic approaches at various clinical choice points. In my response to Lyon, I will first comment on her insightful analyses about how mentalization could have been used at certain moments in treatment. I will then review sensorimotor-based interventions and explain how I believe that Sensorimotor Psychotherapy (SP) was the element in Chloe's treatment that is unique and cannot be accounted for in a mentalization-based approach.

Mentalization in Chloe's Treatment

Lyon (2022) begins by providing an overview of mentalization-based treatment, explaining that its primary aim is to "strengthen one's ability to reflect upon their own affective states, thoughts, and desires, as well as the affective states, thoughts, and desires of others" (Lyon, 2022, p. 241). Immediately, I can see the similarity between this goal and the AEDP goal of "meta-processing" as well as the SP focus on increasing one's awareness of their bodily experiences (Fosha, 2000; Ogden & Fisher, 2015). Lyon (2022) gives multiple examples of interventions I use that had the unintentional consequence of stimulating mentalization, such as the SP "contact statements" I used to track changes in Chloe's physical state that inadvertently stimulated Chloe's ability to mentalize. She also states that the AEDP "portrayal" intervention could be viewed as strengthening Chloe's ability to mentalize the self. I find this very intriguing and find myself wondering similarly as Lyon does, if mentalization is, in fact, a common factor of most trauma treatments. I agree with Lyon that clearly Chloe's ability to mentalize increased throughout treatment and was an important therapeutic gain.

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In addition to explaining how certain interventions used in Chloe's treatment could be understood from a mentalization-based perspective, Lyon provides examples of moments in Chloe's treatment in which the use of specific mentalization interventions could have potentially added to Chloe's treatment gains. One such moment was when Chloe was emotionally dysregulated during a session early in treatment, and I responded by asking if we could take a deep breath together. Lyon (2022) posits that it may have been helpful if I had approached this interaction with more curiosity, slowing it down and wondering together with Chloe about what triggered this experience of being emotionally overwhelmed. I find this suggestion helpful, and I think Lyon makes a good point about the need for explicit curiosity in treatment.

Another moment that Lyon suggests could have been an opportunity for a mentalization intervention is in relation to my decision to no longer assign Chloe homework. Lyon states that I could have brought into the room for exploration the dynamic I believed was occurring in which Chloe felt the need to be the "good client." I think this is an astute observation and definitely could have been a useful intervention that would have aided in deepening Chloe's capacity for understanding her mental states and transferential reactions.

Overall, while I did not plan to do so, I am glad that my case study provided support for the notion that a focus on mentalization can have benefits for clients with complex trauma. I feel passionately about the need for more research and investigation into what really can help this population, and Lyon (2022) puts forth a compelling case for the usefulness of mentalization-based approaches in treating CPTSD.

Beyond Mentalization—Using the Body in Trauma Treatment

While I do agree that aspects of Chloe's treatment and elements of AEDP and SP can be understood in a mentalization framework, I disagree, in part, with Lyon's claim that "Shepherd's body-based interventions (techniques she attributes to SP and AEDP) are, in fact, examples of deep and complex mentalizing" (2022, pp. 248). While I agree that elements of SP do fit well within a mentalizing approach (such as the focus on tracking Chloe's body language and a focus on increasing Chloe's awareness of her own physical experiences), there are other elements of SP that are outside the realm of mentalization.

Specifically, after a client is more attuned to their bodily experiences (something that may be able to be accomplished through mentalization interventions), the body is then 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. As Fisher (2011) explains, in SP, the body is used both as a source of information about "procedurally learnt tendencies" and as a vehicle for intervention (p. 104). While mentalizing may enable a client to be better aware of

these "procedurally learnt tendencies," only SP provides methods to help disrupt those tendencies by practicing alternative somatic responses or engaging defensive movements that were inhibited at the time of the traumatic experience (in Chloe's case, she acted out the movement of throwing her mother's gun out the window).

Chloe's complex trauma presentation included severe dissociative reactions and somatic symptoms that were a major reason why I believed adding techniques from SP would be integral to treatment. One concern I have about mentalization-based approaches with severely dissociated patients is that the level of disconnect between mind and body is so significant that mentalization interventions would not be sufficient in addressing this split. However, I am also aware that there is currently no formal group effectiveness research to attest to the efficacy of SP in individual psychotherapy, so it remains to be proven whether these body-based interventions that are designed to truly bypass the mind are essential components of complex trauma treatment. On the other hand, based on my clinical experience and support from emerging basic research in the field of psychology and neurobiology, I believe there are certain elements of trauma stored in the body as sensory fragments or physical patterns that can only be accessed through creative and innovative movement techniques.

While I think Lyon poses an interesting argument for the need for future research looking at the effectiveness of mentalization-based therapy for treating complex trauma survivors, I do believe that the phase-based structure to my treatment model, as well as techniques provided from AEDP and SP, were very helpful and important to the success of Chloe's treatment. Nevertheless, future research examining mentalization-based approaches as compared to SP, AEDP, and/or phase-based models could yield important and useful results for the field of CPTSD treatment.

CONCLUSION

In sum, the ideas and analyses provided by Courtois and Ford (2022) and Lyon (2022) offer valuable insight into the case of Chloe and provide thought-provoking considerations for the field of complex trauma as a whole. By giving such a detailed commentary, Courtois and Ford were able to provide specific feedback and suggestions for particular clinical encounters, allowing me to think about these situations in different and clinically useful ways. Their comments provided me with invaluable knowledge for moving forward in my work with complex trauma clients.

Lastly, these commentaries allowed me to reflect on the value of the pragmatic case study approach. As Fishman (2013) explains, the overall goal of a pragmatic case study is to describe and interpret what happened in the treatment of a particular client, not to primarily depict or

confirm a single theory, strategy, or intervention. As such, the model allows for flexibility, enabling clinicians to describe the complexity of real-world cases and the use of multiple interventions and theories. Through this approach, I was able to write up a case study with such descriptive clinical detail that it not only allowed me to provide one interpretation of the clinical data but also allowed for new, alternative interpretations to emerge, such as Lyon's (2022) mentalization-based interpretation. I believe that this provides support for the benefits of writing up in detail systematic case studies with extensive amounts of qualitative data, and I am grateful that this case was able to spur new and exciting ideas and conversations in the field.

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