

Relational Therapy for Trauma

Amy Banks

ABSTRACT. Childhood physical, emotional and sexual abuse and neglect is often devastating to the brain and body of the victim. When the abuse leads to chronic post-traumatic stress disorder, the destruction can occur in all aspects of life. Physical health, spiritual health, cognitive abilities can all be impaired. However, it is often the destruction of relationships that presents the largest obstacle to healing.

Many models of psychodynamic therapy still strive for objectivity and neutrality from the therapist. The goal is often to help an individual overcome his/her dependency and to “stand on his/her own two feet.” This approach may retraumatize a person who has experienced significant childhood abuse. Relational/cultural theory (RCT), as described by the founding scholars of the Stone Center at Wellesley College, states that all growth happens in and toward relationship. The goal is to develop mutual, growth-fostering relationships. Because of the focus on developing healthy relationships, this model is particularly well suited to the treatment of people who have been abused.

This paper will review the key concepts of relational/cultural theory. It will also review the neurobiology of PTSD to help readers understand the physiological destruction of childhood abuse and how this physiology contributes to the chronic disconnections in therapy. Finally, this paper will review three stages of healing from childhood abuse working within the model of RCT. doi:10.1300/J189v05n01_03 [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <<http://www.HaworthPress.com>> © 2006 by The Haworth Press, Inc. All rights reserved.]

Amy Banks, MD, is affiliated with Jean Baker Miller Training Institute, Lexington, MA.

Address correspondence to: Amy Banks, MD, 114 Waltham Street, Suite #17, Lexington, MA 02421 (E-mail: abanks32@aol.com).

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The relational-cultural model of therapy suggests that human growth and development occurs within relationship and toward relationship. It is a theory that puts isolation at the heart of human suffering and emphasizes the movement out of isolation and back into connection as the primary mode of healing (Jordan et al., 1991). It is this simple focus on connection and isolation that makes the relational-cultural model so potentially powerful in the healing of trauma survivors.

Trauma can be defined as an experience where “an individual is confronted with a situation which is appraised as personally threatening and for which adequate coping resources are unavailable” (Lazarus, 1985). While natural disasters, severe accidents, or the death of a loved one can all be considered traumatic, abuse at the hands of another human being can be the most relationally destructive. Relational violation by humans includes childhood physical and sexual abuse, neglect, domestic violence, assault, and terrorism. A traumatic experience is highly subjective. The presence or absence of secure relationships at the time of the trauma is the most important determinant of long-term damage (Finkelhor & Browne, 1984; McFarlane, 1988).

Any traumatic experiences can cause an “acute stress response” within the first month (APA, 1994). This response includes labile mood with periods of irritability, depression, and anxiety which changes throughout the day or within a week. The traumatized individual may have physical symptoms of stress including gastrointestinal upset, headaches, muscle pain from tension, a decrease in appetite, poor sleep, and feelings of weakness and fatigue. Cognitively, the recently traumatized individual may have poor concentration, difficulty focusing, and poor memory. These symptoms may interfere with his/her ability to work or attend school. Some people who have been traumatized question their faith or desire to be alive. Ironically, this is happening at a time when the person most needs someone to trust. While all of these reactions can be devastating, it is the destruction of relationships that most interfere with recovery and healing.

Violations by other human beings, particularly by someone who is known and trusted, can have a profound impact. The message of betrayal becomes generalized from “this person hurt me” to “all people will hurt me.” As we shall see in the description of the neurobiology of trauma, the memory of the trauma may be held in a different area of the

brain (Schiffer et al., 1995) and may be recalled with more power than other memories (Southwick et al., 1997). The intensity of the memory of abuse can erode trust in even the closest connections.

What do relationships look like to someone who has been violated? For many people who have survived violence, intense longings for safe connection coexist with an equally intense fear of being hurt again. Some may feel intense rage at the perpetrators or situations that left them feeling so vulnerable. There is often a sense of despair at feeling so alone.

Anywhere from ten to twenty percent of individuals who have experienced trauma will end up with symptoms of post-traumatic stress disorder (PTSD) (Breslau, Davis, Andreski, & Peterson, 1991). For those with chronic PTSD, the violation is often “reexperienced” through nightmares, flashbacks, and intrusive recollections of the event. Reexperiencing can happen not only when there is a real external threat present, but also when the person is trying to develop more intimate relationships. The potential for closeness with a friend, family member, romantic partner, or therapist can physically trigger the feeling of violation even when there is an intellectual understanding that little threat exists (Banks, 2001).

The response to the perceived threat, the “fight, flight or freeze” response, makes mutual relating nearly impossible. As a relationship gets closer, one individual may become afraid and flee the relationship to feel safe, while another may respond to closeness by continually fighting within the relationship to protect herself and still another may continually feel frozen and powerless in relationships. For many people who have post-traumatic stress disorder all three responses exist. With little experience in healthy relationships, the individual who has been interpersonally traumatized has a very difficult time recognizing safe people; she may find herself alone and isolated continuously or even in disrespectful or abusive relationships over and over again.

Many people with PTSD try to cope with their altered brain chemistry by adopting maladaptive coping strategies. When safe connection is no longer available to soothe, traumatized individuals may turn to substance abuse, self-mutilation or eating disorders to try to numb themselves. Though these strategies may feel protective, in the long run, they act to further isolate the traumatized individuals.

The initial trauma followed by the chronic reliving of the trauma on a physical and emotional level through nightmares, flashbacks, and intrusive memories keeps the traumatized person locked in a condemned isolation (Miller & Stiver, 1997). It is the tenacity of the isolation that makes healing from trauma so difficult.

Relational-cultural therapy, created by Jordan, Miller, Kaplan, Surrey, and Stiver (1991) at the Stone Center, Wellesley College suggests that people grow in and through connection rather than toward separation and individuation. It is a model that values mutuality and empathy within relationships. Human suffering within this model is seen as the inevitable outcome of chronic isolation and chronic disconnection in people's lives.

The healing process within the relational-cultural model of therapy may be described as the facilitation of movement out of isolation and disconnection and back into healthy connection. The severity of the disconnection will play a significant role in how readily a person is able to move back into connection. It is the relational therapist's job to watch for movement within the relationship and to explore honestly within herself and her client where the movement is coming from.

Empathy is essential to the healing process in relational-cultural therapy. Empathy has been described by Jordan (1989) as a complicated cognitive and affective experience. It is the moment of empathic joining, when the therapist "knows" a client's experience on an affective and cognitive level that the client is most directly pulled out of the isolation. Jordan (2000) stresses that the therapy relationship is characterized by mutual empathy. Mutuality in the therapy context does not mean there is an even exchange of life stories, or even an equal distribution of power, but rather that the client is able to see she has an impact on the therapist; the client can see the therapist moved by her subjective experience. It is these moments of empathic, mutual joining that lift the isolative veil and allow healing to occur.

One goal of relational therapy is to identify and increase the number of "growth fostering relationships" (Miller & Stiver, 1997). A growth-fostering relationship has readily identifiable characteristics. Each person has a sense of energy or zest, each person feels more able to act and does act, each person has a more accurate picture of herself/himself, the other person, and the relationship, each person feels a greater sense of self-worth and each person feels more connected to the other person and has a greater motivation for connections with other people beyond those in the specific relationship (Miller & Stiver, 1997). This model believes that "therapeutic neutrality" or the "blank screen" approach to therapy denies the client direct access to a "growth-fostering relationship" with the therapist. Therapies that use these other approaches run the risk of contributing to an individual's isolation rather than helping in the healing process.

It has long been known that trauma or violence can leave an individual with deep psychological scars (Herman, 1992). It is becoming increas-

ingly clear that the psychological scars and the relational destruction seen with trauma is directly related to the damage that early life stress and chronic trauma can cause in the brains and bodies of people who have been traumatized.

THE NEUROBIOLOGY OF TRAUMA

In order to understand the effects of trauma on a person's brain chemistry, it is helpful to first take a brief look at the stress response system. The human stress response system is centered around a small organ in the limbic system, the amygdala. The amygdala connects the sensory system, which perceives a threat to the motor system, which then responds to the threat (Le Doux, 1990). When a threat reaches a certain threshold, the amygdala sends messages through its many projections to respond to the stress. Projections from the amygdala to the reticularis pontis initiate the startle response (Davis, 1992). Projections from the amygdala to the lateral hypothalamus and then to the rostral ventral medulla stimulate the sympathetic nervous system (Le Doux et al., 1988). Projections from the amygdala to the stria terminalis initiate the hypothalamic-pituitary-adrenal (HPA) axis response (Roozendaal, Koolhaas, & Bohus, 1992). These pathways combine to create the "flight, fight or freeze" response typical of individuals under acute stress.

This stress response system results in the release of both catecholamines (epinephrine and norepinephrine) and cortisol at the time of the acute stress. Catecholamine release causes an increase in blood flow and glucose to skeletal muscles to prepare for fight or flight (Guyton, 1986). Cortisol, which may be thought of as an "anti-stress hormone," shuts down the stress response system. As the need for cortisol decreases, the cortisol feeds back on itself through the HPA axis and turns off the secretions of cortisol releasing factor, ACTH and eventually cortisol itself.

For most stressed individuals the stress response system keeps fear levels within a tolerable range. However, in people who develop chronic post-traumatic stress disorder in response to a traumatic event, the stress response system becomes dysregulated in a number of ways. There is an exaggerated sympathetic response to any ongoing reminders of the traumatic event (Southwick et al., 1997). The HPA axis of individuals with PTSD show a number of "unique changes" (Yehuda, 2000). For individuals who develop chronic PTSD, the level of cortisol or "anti-stress hormone" at the time of the original trauma is decreased rather than increased (Yehuda, McFarlane, & Shalev, 1998; Resnick, Yehuda,

Pitman, & Foy, 1995). Additionally, the pituitary glucocorticoid receptors (where the cortisol binds in the HPA axis feedback loop) are upregulated in number and sensitivity. Yehuda (2000) has called this “enhanced negative feedback” of the glucocorticoid receptors.

For those who have PTSD, during periods of further stress, the norepinephrine released is only mildly opposed by cortisol. This means that the regulation of the warning system is impaired; the warning signals go off with only minimal provocation. Within relationships this can be particularly difficult as any movement either towards intimacy or away from connection can be experienced as an exaggerated threat (Banks, 2002).

Research techniques are now advancing so that we can look directly at the brain with CT scans, MRI's, PET and SPECT scans. There are numerous studies that have looked at the activity of the brain during traumatic recall. Although the specific technique for each research study varies making comparisons across studies complicated, the body of research as a whole suggests some intriguing patterns.

First of all, CT and MRI studies of the brain (which give information about size and volume) have been done comparing clients with PTSD to controls with a history of trauma but without PTSD. Consistently, studies have documented that individuals with PTSD have a decrease in hippocampal volume. Bremner and colleagues (1999a,b) and Gurvitis et al. (1996) found this in combat veterans, while Stein, Koverola, Hanna, Torchia, and McClarty (1997) have shown this decrease in individuals with a history of sexual abuse and PTSD.

The hippocampus plays a crucial role in learning and memory. Within the stress response, the hippocampus interprets the signals of danger sent by the amygdala. The hippocampus provides a context for the warning signals; it differentiates which signals are dangerous and should be attended to. The significance of the decrease in hippocampal volume is speculative at this time. If, however, one assumes that a decrease in volume means a decrease in functioning, then the person with PTSD and a decreased hippocampal volume may have a difficult time interpreting what is actually dangerous. In relationships, this would make it very difficult to know when to feel safe and when to feel threatened. At times traumatized persons may end up in abusive relationships over and over again, not because they are inviting the abuse, but because they have difficulty assessing what relationships are unsafe and therefore are unable to protect themselves.

Functional imaging studies, with more varied results, are more difficult to interpret. A number of studies have documented an overactive or irritable amygdala in response to any recollection of the traumatic event

(Rauch & Shin, 1997; Liberzon et al., 1999). Again, the amygdala is the area of the brain that is sending out the primitive warning signals in response to danger. Relationally, it is this reactive firing of the amygdala that causes people to fear any movement in relationship and respond in ways that are disconnecting.

Another area affected by PTSD is the medial prefrontal cortex (MPFC). This area of the brain has inhibitory input into the amygdala (Sesack, Deutch, Roth, & Bunney, 1989). Multiple studies have shown a decrease in functioning of various MPFC subregions in response to traumatic recall (Bremner, Narayan et al., 1999; Bremner, Staib et al., 1999; Shin et al., 1997; Shin et al., 1999). When a person is “triggered” into traumatic reexperiencing, not only is the amygdala overresponding, but the MPFC is not working well to keep the amygdala in check. The result is often an overinterpretation of stimuli as dangerous, whether the stimulus be a sudden load noise or relational movement.

Therapy with trauma survivors can be particularly intense and confusing. The moments of healing connection can be incredibly precious. However, the sudden dramatic disconnections can feel devastating for both therapist and client. What triggers these traumatic disconnections? The triggering event could be most anything—a perceived empathic failure by the therapist or an old memory that pops back into consciousness. The trigger could also be a moment of closeness between therapist and client when the client has relinquished some of her strategies of disconnection. Without these strategies she becomes more in touch with her longings for connection and hence her intense vulnerability. It is the terror of the vulnerability that also can trigger a chemical, traumatic reaction.

The suddenness and severity of the disconnection may push therapists into their own disconnecting strategies to cope with the feeling of helplessness. They may become highly intellectual and interpret what has happened; they may blame the client, or may become angry. Without a clear understanding of the way that the biochemistry pulls the survivor out of relationship, the therapist is likely to struggle to find explanations for why this has happened. In that moment, therapists will miss the most important task at hand, which is to help the client get grounded back into the safety of the present.

Relational trauma therapy is both psychoeducational and experiential. The psychoeducation includes helping the client to develop a cognitive understanding of how early relational violation creates shame, terror and chronic disconnections in future relationships; to identify destructive relational images that are projected onto current relationships and to understand how these images keep the person trapped in the ex-

perience of chronic relational violation. The final goal of relational-cultural therapy is to begin to build a cognitive template of a “growth fostering relationship” (Miller & Stiver, 1997).

Experientially, within the therapy relationship, the client has the opportunity to be in a new, non-violating relationship based on mutual respect, honesty, vulnerability and empathy. This is a relationship with a clear differentiation of roles but without an exaggerated power imbalance. It is within this relationship that clients begin to develop an awareness of their own patterns of connection and disconnection. Clients will learn to feel the connections and disconnections within the therapy relationship. With this experience they may be able to develop an awareness of relational movement outside of therapy.

Herman (1992) has described three stages of therapy for trauma survivors: (1) safety (2) recovery and mourning and (3) reconnection. The following case example illustrates the stages of healing. All identifying information has been changed to insure client confidentiality

Samantha was a 25-year-old Italian American graduate student referred to me from her college counseling center after having been raped on a blind date one month prior to her entering therapy. At the time of her initial presentation she was suffering from many symptoms of an acute stress response. Samantha felt emotionally labile and was sleeping poorly with frequent nightmares about being attacked. She was not able to concentrate and was already having trouble finishing her course work for the semester. She was spending more and more time alone in her room, turning down opportunities to spend time with even her closest friends. When she would leave her apartment, she became panicky and distracted. She could not carry on a conversation about “everyday” events with her friends. Despite much distress, it was the reemergence of cutting behaviors that led Samantha back into counseling. She had started to cut her arms and legs as a way to escape from the pain, something she had not done since she was a teenager. She was worried others would find out and think she was “nuts.”

Samantha had been forced into therapy as a teenager after repeatedly running away from home. She was bright, attractive and well liked by both peers and teachers, but struggled to feel real in any of these relationships. No one realized she came from a home affected by parental alcoholism. Her father was a binge drinker who filled with rage when he drank. He would physically assault her mother and would beat Samantha and her siblings when they intervened. Samantha ran away because she could not stand the drinking, the fighting and the extreme loneliness. On the streets, she met many kids from troubled backgrounds. It was a re-

lief to be around them. This pattern of leaving home, cutting herself and hanging around with the “wrong crowd” continued until college.

When she left home to go to college, Samantha became less jumpy and fearful. She met new friends, enjoyed her classes, and felt less self-critical. She stopped cutting and became less symptomatic. However, after she was raped, the old fears came back with a vengeance. As is often the case, Samantha’s early life stress at home had predisposed her brain and body to have a more devastating and perhaps more chronic response to the rape later in life.

In the first few sessions Samantha seemed pressured to purge the story of her rape. The words flowed without feeling. As a therapist, I found it difficult to stay connected to the horror of the betrayal without the feeling. I explained to her the stages of therapy and the importance of focusing our initial work on safety. The self-destructive behaviors and the PTSD symptoms were wrecking havoc in her life. She shared both the relief and the shame she felt when she cut. Though cutting temporarily relieved some of her overwhelming emotional pain; she began to understand that by escaping from the pain, she never worked to address any of her difficult life experiences with depth. She also recognized that her need to hide her body kept her from letting anyone get close to her. Though the cutting was not life-threatening, it kept her very isolated. Once we could see together this pattern of isolation, she was able to agree to move forward. We strategized ways to help her stop the cutting. Samantha found that snapping a rubber band on her wrist produced some of the pain, without the cuts, and also reminded her that the cutting left her feeling more depressed, isolated and ashamed in the long run. After a couple of months, she was able to all but stop the behavior.

Given that her PTSD symptoms were quite extreme, we addressed the issue of medications early in the treatment. Samantha had always thought of medication use as a sign of her weakness. She and I talked about the effects of trauma and abuse on the brain and how her earlier abuse at the hands of her father may have set her up to have even a more dramatic PTSD response to the rape. After reading some literature about the neurobiological effects of abuse, she began to feel some relief, that her “out-of-control” patterns of behaving in her life and in her relationships may have had some explanation other than her supposed weakness. It wasn’t that she was “bad,” but that her life experiences had caused her brain to change in a way that it remained constantly on guard, ready to protect her, even when protection was not indicated. That explained the chaotic relationships, her pushing people away, the fleeing from home, the need to cut to change the chemistry. She finally

agreed to a medication trial. After about six weeks on a selective serotonin re-uptake inhibitor, Samantha felt less reactive, less depressed, and less angry. Her concentration and energy improved. She commented that she felt “normal” for the first time in her life. She was able to engage in her graduate studies and found it easier to contain some of the traumatic memories when they surfaced.

When Samantha stopped cutting herself, difficult feelings emerged. During her childhood, her family spent most of its energy trying to stay safe from her father. The abuse was not talked about. She wondered sometimes whether it even had happened. She had spent so much of her life running away from the painful feelings, it seemed crazy now to be trying to bring them up, to identify them and to feel them. Most of the time she didn’t even know what she was feeling. Therapy at this point focused on what her feelings were and where she felt them in her body and in relational space. She noticed that she often felt fearful, anxious, and short of breath in the therapy relationship. She and I talked about the fact that cognitively, she did not think I was going to hurt her, but much of the time she was worried that I was going to change suddenly, to become nasty and critical, possibly even abusive.

It was at this point that we talked about what a “healthy relationship” looked like and felt like. In this early stage, Samantha seemed quite skeptical that a relationship that was truly supportive could ever exist, although she was beginning to see small parts of it in the therapy relationship. Samantha readily dismissed my caring because I was paid to do it. It was clear that Samantha had never had a relationship that was mutual and respectful. A relational inventory (a clinical strategy utilized by this author and colleague Judith Jordan) revealed that the few people in her life needed her more than she needed them. Friends and family were constantly telling her their problems. For the first time, being the confidante felt stifling.

Samantha’s second year in therapy coincided with changes in the focus of the work. Samantha had established a relationship with me in therapy that seemed safe enough. She had stopped her self-destructive behavior and was beginning to focus on the relationships in her life that felt more mutual. A few months after the anniversary of the rape, Samantha began talking about the details of the assault. This was different from the first few times in my office. She wept as she described her feelings of betrayal and helplessness when she knew the assault was inevitable. The story was recalled with affect and memory together. The retelling was slow and painful for both of us. At one point we were both in tears as she described how the assault brought back a virtual video

clip of her father's rages—The feeling of terror and hopelessness as this powerful man lost control, and how alone she felt in the midst of the violence. Though my tears surprised her, she was also able to say that it made her feel as if I understood her experience. It was one of the more connected and healing moments in the therapy and was referred to often by both Samantha and myself throughout the rest of our work together.

Many times when Samantha was telling her story she could not remember details, but could feel the experience in her body. I explained to her that trauma can be stored differently in a person's brain and body, that sometimes traumatic experiences are remembered in many different ways and that it is essential to honor and believe all of the ways she is getting information. This often seemed like a stretch for her.

The most impressive aspect of the second stage of therapy was how connected Samantha had become when discussing painful life experiences. Earlier in the therapy it was often clear to me that she was acting out some assumed role in the therapy relationship, doing and saying what she thought she "should" do and say. In this second stage of therapy, Samantha grew more comfortable in her skin; she felt more accepted and loved as who she was even with the abuse history. Because she was more herself, she was able to bring much more of her experience into the therapy relationship. She had a wonderful sense of humor which no longer came out as biting comments about others or severe self deprecation. She used humor to connect rather than disconnect.

Samantha's healing was not linear. There were periods of time, particularly around anniversaries, when Samantha returned to work on safety in order to control urges to cut. She would retreat back into isolation as the only sure way to survive. However, even though she could drift off during these times, she could more readily see the disconnection and make a more informed decision about whether this was how she wanted to be handling her pain. Often, when I would point out the pattern she could rely on the therapy or other relationships to help ground her and to feel safe.

As the third stage of healing emerged Samantha talked less of the abuse in her life and more about her current struggles. She had finished a master's program in psychology and was anxious about applying to a PhD program. She was in love for the first time and realizing she would not be alone for the rest of her life. Her father was now 2 years sober and though not fully recovered, more reasonable. Samantha confronted him about the impact his drinking and abusive behavior had had on her childhood. Though he minimized the violence, Samantha herself felt proud and empowered by the confrontation.

Samantha still meets with me once a month for a “tune up.” She has learned many basic skills needed for interacting with people. She now recognizes the ways in which the abuse as a child and as an adult stripped her of the desire to reach out to people for comfort and she understands that her brain chemistry stills pulls her into many of those same patterns. On a daily basis, she stills needs to fight her protective instincts to stay in connection. The therapy relationship helps her to do this.

The first stage of therapy, safety, can be the most difficult and frustrating phase of treatment. Relationally, the trauma survivors are in a bind. Even though they are asking for help, they may not know how to be in a healthy relationship. Any movement within the relationship can be frightening and trigger the reactive brain chemistry. The therapist and the therapy relationship are then seen as dangerous. Even if the client does have a history of some positive relationships the traumatic relational images can be overwhelming. Traumatic memories or relational images are also commonly recalled with much more affect and intensity than a non-traumatic memory or relational image (Southwick et al., 1997). When a traumatized person is trying to move out into relationship, the traumatic relational images may flood her experience drowning out any memory of the past healthy relational experiences. In those moments of triggering, there is only abuse, and no knowledge of caring, safe connection.

As described in this case example, Stage one treatment involves a survivor establishing a safe relationship with her or himself and with her or his therapist. Trauma survivors may be profoundly disconnected from their own experiences. They may have been talked out of their experience as children or their reality may have been denied by others. At times, abuse that is too overwhelming to integrate can lead to dissociation, which can range from frequently “spacing out” to Dissociative Identity Disorder.

A person must be present in her own experience in order to move into healthy, mutual relationships. Helping a survivor build a relationship with herself or himself begins by simply identifying the many ways in which a survivor is disconnected from herself. If the disconnection takes the form of dissociation or flashbacks, the survivor must learn grounding techniques to stay present. Identifying the patterns of disconnection from self means developing an awareness of how intense affects (shame, terror, rage, grief) are a prelude to dissociation. When Samantha realized that she cut herself when she felt scared or angry, she could more easily think of other ways to comfort herself. When survivors are better able to tolerate affects, they have a better chance of staying present with themselves and of sharing these feelings within the therapy relationship.

In the first stage of work, the therapist is as much teacher as co-explorer. Teaching basic information about the impact of trauma on a person's brain, body and relationships is an essential first step in de-pathologizing the survivor's experience. Together the therapist and client must strategize ways to shift the dysregulated body and brain chemistry. For some this mean seeking a psychopharmacological evaluation, for others a DBT group, acupuncture, exercise, or other somatic interventions may help to reregulate. While there are many ways to impact the dysregulated chemistry, it is essential that a direct, intense effort is made to understand the power of these chemical changes and to understand the futility of trying to connect in safe relationships when the PTSD symptoms are sending off chronic danger signals.

Since many trauma survivors do not find relationships comforting, they must find other ways to cope with the dysregulated brain chemistry. Self-destructive behaviors like cutting or burning oneself, eating disorders, substance abuse or extreme work schedules are all ways that people try to manage the chemistry of trauma. Although each may work in the moment to shift chemistry, in the long run, each strategy leaves the person full of shame and more disconnected from themselves and others. Work on safety must focus on naming self-destructive behaviors and finding healthy ways to reconnect the mind and body. Self defense, exercise, dance or meditation can be helpful. There is not one right way for anyone person. The task for the therapist to be able to explore alternatives with survivors and assist in consideration of strategies that shift away from the isolating self-destructive patterns which once were life saving.

Most individuals diagnosed with PTSD have at least one other co-morbid diagnosis (Kessler et al., 1995). Beginning in the early stages of therapy and continuing for the duration of therapy, the therapist and client should explore the full range of symptoms and experiences the client has and to consider additional diagnosis. Frequently, conditions and diagnosis change over time. For example, Samantha found herself drinking more on the weekends when she stopped cutting herself. There is a constant attempt in the early stages to try to shift the painful chemistry any way possible. This can make the clinical work even more complicated. A therapist may feel she is constantly one or two chemical shifts behind the client, with little clarity about what is happening. When a therapist feels uncertain about the therapy connection he or she may feel more vulnerable and turn to his or her own strategies of disconnecting to manage. Remembering the erratic brain chemistry seen in PTSD and how the client will attempt to control this chemistry can help the therapist stay present.

Many people who have been abused as children have not learned basic relational skills. The therapist may have to educate and identify feelings for a client much in the way a parent of a toddler would do. Not only is it essential to explore what feelings are and where they are felt in the body but also to educate about the role feelings play in relationships. Without access to feelings, it is impossible for a person to clarify her or his relational experience to her or himself or to others.

Distorted thinking and a need to control things can cause survivors to feel that the abuse or trauma was their fault, that they deserved it, or that they could have stopped it "if only." Trauma survivors at this stage of healing have little ability to be empathic towards themselves. A therapist should introduce the concept of self empathy (Jordan et al., 1991), with an awareness that in the early stages of treatment, a cognitive understanding may long precede a real change in attitude towards oneself. A trauma group can be particularly useful in developing self empathy. Samantha started a safety and stabilization group after the first few months of our working together and found that hearing the stories of other women touched her. Over time she could see that her story was not different and she began to feel some compassion for herself as a young girl. For Samantha, this was the beginning of self empathy.

Safety and stabilization also includes establishing a relationship with the therapist. This can be quite difficult. Particularly for someone who was abused by a caretaker, the distrust and betrayal extends into all "helping" relationships. Therapists need to be aware of the intense "relational paradox" (Miller & Stiver, 1997) that exists for the survivor entering into therapy. Clients are likely to be terrified of entering into this relationship at the same time that they feel an intense longing to have someone help them. In more severe abuse, the desire for connection can be quite small and the therapist must be attentive to pulls for distance.

Given how difficult it is for a survivor to trust, it is essential that the therapist find ways to help the relationship feel as "safe as possible." Jordan and colleagues (1991) have talked about relational therapy being more about a change in attitude than any specific technique. It is a change in attitude away from therapist as a "blank slate" and toward therapist as a mutual, responsive partner in the exploration of relationship. Therapists must be authentic in their responses to the client. Authenticity within the therapy relationship does not mean total honesty or spontaneous expression, but rather a "real" response that is based on an understanding of the client, consideration for the impact of the response on the client and careful consideration as to what would be therapeutic for the client at that moment (Jordan, 2001).

Authentic responsiveness by the therapist is essential to the healing powers of mutual empathy. Mutual empathy refers to the therapist being impacted by the client and clients seeing that they have impacted the therapist (Jordan, 2001). As I had mentioned, one of the most profound experiences in my work with Samantha was when she saw me tear up with her as she was describing a painful memory. In that moment of affective and cognitive joining, Samantha was not alone. With trauma survivors it is important to let the client see the impact but also to describe and discuss the impact when possible. One of the hallmarks of an abusive relationship is that the abused do not feel as if they have any power in the relationship. In the moment of abuse, the then-victim has no knowable impact on the perpetrator. While the abused clients may not readily see that they are having an impact on the therapist, many therapists have been trained to not let clients know that they are making an impact. When clients are unable to see that they have made an impact on the therapist they are yet again deprived, of an empathic response to her experience. The potential of the healing moment is lost when the therapist retreats into unknowability.

The therapist should be aware that many survivors are not comforted by a “larger than life” persona. Big does not equal safe. The therapist’s role of should be demystified as much as possible. Describing how the therapy process works can help a client feel empowered. Many models of therapy have encouraged the therapist to sit back and listen patiently to the client’s free associations. The role of the therapist in these models is to listen for underlying conflict which may be “interpreted” for the client. These models argue that when the unconscious, internal conflict is brought into consciousness, the distress will melt away.

The relational-cultural model argues that this strategy does not work with trauma. A relational therapist dealing with a traumatized individual must be more interactive, at times even directive in the work. I will often “think out loud” or share my thought process with the client so that it is not a mystery. It allows clients to correct my mistakes and to correct their own misconceptions about how a person “in power” is thinking about them.

Many traumatized individuals who enter treatment are unaware of what their needs are or how to represent them in a relationship. Many clients with histories of abuse have spent time in the mental health system being told what their needs “should be.” Needs that fall outside of the “should” range are pathologized. The therapist should encourage and work with clients to negotiate their needs within the therapy relationship. Jordan (1996) has emphasized the need for therapists to “state

their limits” rather than “setting limits” on the client. A therapist setting limits can be experienced by the client as a “power over” maneuver which is ultimately disempowering to the client. When a therapist states her own limits within the relationship, it provides the client with a real life opportunity to negotiate needs.

An example of this would be a therapist who is struggling with frequent emergency phone calls from a client in the late evening. Rather than saying, “you should not be trying to reach me that late in the evening or even, I am not available after 7 pm” the therapist could say, “I am not able to return phone calls after 10 pm, however, this clearly is a time that you need contact with someone you trust. Let’s try to work out a plan to help you with a crisis in the middle of the night.” In this approach, the client is able to see that the therapist respects her needs, whatever they are and wants to help her work this out. It provides respect for the client’s experience without providing the unrealistic expectation that the therapist will “always be there.” The client can experience a mutual relationship where needs are negotiated.

The therapist may have to be quite direct about ways that the relationship will be non-violating. This could range from the expectation around returning phone calls to a clear statement that there will be no sexual contact within the relationship. Most traumatized clients, particularly if they were abused at home, do not understand or know what is involved in a healthy relationship. They might enter into the relationship hoping for the best but expecting a betrayal. For those individuals with PTSD, their brains are literally programmed to expect the betrayal.

Before the relational therapist can explore clients’ patterns of connecting and disconnecting, the therapist may have to provide concrete education about connection and disconnection. Educating about the neurobiology of PTSD is essential. The therapist should be able to provide a general description of the chemical changes seen in PTSD in a way that helps the client begin to understand the physiological imperative to disconnect. Clients can thus come to understand that the reactive chemistry literally pulls them out of relationship and back into connection with the old trauma. The therapist must also hold onto this understanding during the entire course of therapy. Miller and Stiver (1997) have talked about “honoring the strategies of disconnection.” This does not simply mean the therapist understanding the disconnection. Rather, this honoring is a deeper fuller appreciation of the role played by disconnection in keeping the client safe (alone, yes, but safe).

In many more traditional therapies, “strategies of disconnection” are seen as resistance which should be pushed through gently. When a per-

son has PTSD, pushing against a real “resistance” is likely going to trigger the person further. The process of honoring the disconnection, not pushing the client or getting into a control struggle, can greatly facilitate the movement back into connection.

When there is a disconnection within the therapy relationship, the therapist should first check to see if she or he has disconnected for some reason. Therapists, regardless of theoretical perspective, are all taught to analyze the clients’ movement in the relationship. Some therapists even feel a pressure to be “fully analyzed” so that their issues are minimally present within the relationship. Relational therapy would argue that this idea is unrealistic and leads to much confusion between client and therapist when there are ruptures in the relationship. A colleague of mine reports a story of her own therapist falling asleep in the session—when caught, he responded by asking why she thought he was asleep? This sort of response would be profoundly retraumatizing for the trauma survivor who has repeatedly faced denial of the realities of her or his perceptions.

When there is a “traumatic disconnection” and by this, I mean a severe disconnection where the client is clearly triggered into the reactive, PTSD brain chemistry, the therapist should not explore for the meaning of what has happened. Meaning will not be available because the brain will be operating without the capacity for meaning-making in those moments. Neuroimaging studies on clients with PTSD show that during traumatic recall, the medial prefrontal cortex of the brain, an area which should be helping to modulate the fear response from the amygdala, is not working (Bremner et al., 1997; Bremner, Narayan et al., 1999b; Bremner, Staib et al., 1999a). Therefore, when triggered by a deep traumatic disconnection, the client is not able to engage in a sophisticated cognitive way until the brain chemistry settles down. In the moments of the trigger, the therapist should focus on and on grounding the client in the present.

Most survivors need basic education about relationships both in and out of therapy. The “five good things” of a “growth fostering relationship” (Miller & Stiver, 1997) is a good, simple template for healthy relationship. The five good things include (1) an increased sense of energy or “zest” within the relationship; (2) each person within the relationship feels an increased ability to act and does act; (3) each person within the relationship has a greater sense of worth; (4) each person in the relationship has a greater clarity about herself, the other and the relationship; and finally (5) each person within the relationship has an increased desire for more connections outside of the relationship. This template may make it easier for them to identify the feelings of a healthy relationship or even the opposite feelings that happen in an abusive relationship.

For survivors, most relational images are contaminated by the “abuse triangle.” The abuse triangle is composed of the perpetrator, the victim and the ignoring “mother” or caretaker. The traumatic relational images become constricted by these three roles. For example, the relational image may be one of victim and perpetrator, it could be one of perpetrator and ignoring caretaker, or even one of ignoring caretaker and victim. Because these dynamics were so influential, in early childhood from the trauma and because the neurobiology of trauma may make them “louder” than normal relational images, it is very hard for people with PTSD to develop relationships or to take information and not have it filtered through this distorted lens. It can be very helpful to educate about the abuse triangle and begin to watch with the client the ways that relationships in her life tend to fall into these patterns. It may also be important to watch as new relationships develop and how they end up being experienced as a repetition of one of these old relational images.

Throughout relational therapy with trauma survivors, the therapist and client may want to develop a relational inventory. As their awareness of relationships becomes more complex, survivors may have more ability to differentiate relationships along the range of abusive to “growth fostering.” In stage one treatment, the therapist may have to walk clients through the process and point out ways that relationships in their lives are either healthy or not. Because survivors have experienced being an object within relationships, it is often hard for them to act with any agency and feel that they can be the one to evaluate relationships and make choices about who they would like in their lives.

Herman (1992) has labeled the second stage of trauma therapy “remembrance and mourning” (p. 175). She describes the need to develop a narrative of the abuse in depth and in detail starting before the relational violation and ending after it. This happens when the client feels “safe enough” within the therapy relationship and within herself to uncover or discuss the affective and cognitive details of the abuse. For most abuse survivors, the experiences of abuse are appraised with great vulnerability and shame. These feelings make the experiences difficult to bring to any relationship. However, if they are not brought into the therapy, then the traumatized person will continue to leave large parts of experience out of human connection. Survivors risk remaining in a state of condemned isolation. The goal of the retelling is not a narrative catharsis, but rather a chance to integrate all of the survivor’s experience and to represent it safely and authentically within a safe relationship. When discussed too early in the treatment, the abuse story may come out in a fragmented way or with affect and cognition disconnected.

Therapists may notice a lack of feeling in their own response when hearing a premature disclosure; this can be unsettling to the therapist.

Trauma material may be recalled through body memories (e.g., strong physical associations), dreams, or disconnected affective surges. A client may talk of having no memories of the trauma, but then relate periods of intense body memories or extreme overwhelming affect, not attached to any obvious trigger. The therapist can educate the client that memories may be stored throughout our bodies and that all information coming forth must be listened to in the healing process, and that not all trauma memories will be recalled in the usual verbal manner. A client must learn to trust other sources of memory as “real” memory. In fact, when abuse is chronic and severe, when the client has dissociated at the time of the abuse or if the abuse was preverbal, it may be unusual for a client to have verbally mediated recall. The survivor develops basic trust in her experience when the therapist listens, believes and validates that the material being expressed is an accurate representation of clients’ experiences of their abuse.

As more details about the trauma or abuse are revealed and connected with affective experience, the work may deepen from global relational patterns seen with abuse (i.e., fear of closeness, fear of abandonment) to specific relational patterns which are idiosyncratic to the individuals abuse experience. For example, Pam, who had a history of severe childhood abuse, used to come late for appointments. She and I struggled to understand her ambivalence about being in therapy, about not really wanting to work on the abuse because it was so difficult. As the details of her abuse were revealed, it became clear that her tardiness for the therapy sessions was specifically related to the fact that when she was a child she was forced to sit and wait as her sister was being abused in the next room. The waiting process in and of itself created enormous, overwhelming anxiety for her. Once this was revealed, she had an easier time coming on time. We were both able to see her lateness as a healthy survival strategy rather than evidence of some sort of pathology or ambivalence.

The hallmark of stage two, recovery work, is the ability to reconnect affect with the memories of the abuse or trauma and to be able to bring a more integrated picture of the relational violation into the therapy relationship. The therapy relationship is asked to hold intense affect. It is essential that the relational therapist has an understanding of the level of feeling that she or he can tolerate. Relational pacing of the work involves a clear recognition of how much affect both the therapist and the client can hold together. If the therapist is getting overwhelmed by the work, she or he will disconnect from the client and repeat the pattern of

leaving the client alone with the abuse. If the therapist has an awareness that the pace of the work is going too quickly for her or him and she or he is feeling out of control, it is necessary for the therapist to discuss this with the client. There is a risk in this situation that the therapist may put the struggle back on the client, saying that the therapist is not able to manage the affect being stirred up. However, when therapists are able to admit their own limitations and to try to negotiate them within the relationship, it provides a concrete example for the client to follow. It allows the client to observe that something concrete (i.e., slowing down the pace) can be shifted to hold onto a connection. The therapist models the ability to be in respectful of her or his own limitations or needs in the relationship, and demonstrates that attention to needs and limits create the possibility for continued relationship.

The third stage of recovery according to Herman (1992) is termed “reconnection” and happens when clients have reconnected in a safe, integrated, respectful way with both themselves and the therapist and has been able to bring together the affects of their lives with the cognitive knowledge of what has happened in that life. The client now has the freedom and desire to expand her or his relational world. The old, traumatic relational images are now attached to past abusive relationships, and are not as readily generalized to all relationships. The survivor has broken out of the “abuse triangle.” Certainly, she or he can still be triggered back to these difficult, scared places, but she or he is more quickly able to clarify what is going on and to reach out to healthy relationships for help.

The client finally has the skills to choose relationships based on mutual respect and the “five good things” of a healthy relationship (Miller & Stiver, 1997). With the new found clarity of this experience, the client may become able to confront an abuser, as Samantha did. This needs to happen when a survivor is able to trust her or own experience as being her or his truth, and is not dependent on the perpetrator to acknowledge the truth of that experience.

Finally, some people who have been traumatized may choose to empower others (Herman, 1992) and to try to bring other survivors into the world of respectful relationships. This is perhaps the ultimate, more global healing that is possible when individuals move out of isolation and back into reliance on the human community.

Though I believe relational therapy, with its focus on decreasing isolation through empathic connection, is the best model for treating survivors of trauma; I also believe that it may be one of the hardest for a therapist to use. The model encourages the therapist to be open and vulnerable in the face of severe traumatic disconnections within the rela-

tionship; it also encourages the therapist to empathetically know the client's abuse experience in order to help decrease her isolation. In fact, many therapists who work closely with trauma survivors describe a secondary traumatization, a "vicarious traumatization" from the work. This is more likely to happen when the therapist is working in isolation, without input from and contact with colleagues. In order for this work to be done effectively and safely, both therapist and clients need to break the patterns of isolation and develop a community of mutual support to help. Say more, please. Perhaps refer here to vicarious traumatization, and how a therapist must do the same things as the client—stay relational, not disconnect, etc.

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