CHAPTER 1

Component-Based Psychotherapy with Adult Survivors of Emotional Abuse and Neglect

with Hilary B. Hodgdon

At least three million children are victims of abuse or neglect each year in the United States. The vast majority of this maltreatment is perpetrated by the same adults these children rely upon for nurturance, protection, and, quite often, their very survival: parents and other primary adult caregivers or their romantic partners (Sedlak et al., 2010). Among maltreated children, more than half endure *psychological maltreatment,* characterized by repeated or ongoing exposure to severe *emotional abuse* or *emotional neglect* (Spinazzola et al., 2014). The American Professional Society on the Abuse of Children (APSAC) defines psychological maltreatment as "a repeated pattern of

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caregiver behavior or a serious incident that transmits to the child that s/he is worthless, flawed, unloved, unwanted, endangered, or only of value in meeting another's needs" (Myers et al., 2002, p. 81). It may also involve the terrorizing, rejecting, spurning, or exploiting of children (Kairys, Johnson, & Committee on Child Abuse, 2002), as well as the "persistent or extreme thwarting of the child's basic emotional needs" (Barnett, Manly, & Cicchetti, 1993, p. 67).

While the term "psychological maltreatment" is sometimes referred to interchangeably as psychological abuse, in this book and elsewhere, the former term is primarily used because it more intuitively subsumes emotional neglect in addition to verbal or emotional abuse as an integral component of this form of maltreatment.

Relational in nature, psychological maltreatment represents a fundamental disruption in the attachment bond through both a lack of attunement or responsiveness and overt acts of verbal and emotional abuse. These "attachment injuries" harm children by (1) undermining their development of an internal sense of psychological safety and security and (2) impeding their cultivation of capacities essential to successful life functioning, including emotion regulation, self-esteem, interpersonal skills, and self-sufficiency (Wolfe & McIsaac, 2011). In Table 1.1, we inventory various forms of emotional abuse and emotional neglect, along with some of the contextual factors that influence variability in the expression and effects of psychological maltreatment.

UNSEEN WOUNDS

Overlooked, underreported, and unsubstantiated in comparison to more overt or tangible forms of childhood maltreatment such as sexual or physical abuse, psychological maltreatment has historically constituted a "blind spot" for families, providers, researchers, and government agencies (Rosenberg, 1987). For example, one study examining child protective service case records revealed that while 50% of maltreated children had experienced psychological maltreatment, this abuse was officially noted in only 9% of cases (Trickett, Mennen, Kim, & Sang, 2009). In contrast to state and federal reports on the prevalence of psychological maltreatment, research studies on the prevalence of emotional abuse and emotional neglect in clinical and community samples most always reveal much higher rates of exposure, with community estimates ranging as high as 80% of children surveyed (Chamberland et al., 2005). An important study of over 11,000 trauma-exposed children and adolescents receiving treatment services across the United States through the National Child Traumatic Stress Network (NCTSN) found that impaired caregiving (impacting 40% of all youth assessed), psychological maltreatment (38%), and gross neglect (31%) were the third, fourth, and fifth most prevalent of 20 types of trauma assessed (Briggs et al., 2012).

TABLE 1.1. Variability of Emotional Abuse and Emotional Neglect Based on Type, Context, and Individual Factors

Variability in emotional abuse and emotional neglect
• Inflicted by part or all of caregiving system
• With or without co-occurring abuse or other trauma
• With associated affection (unintentional, inconsistent, or reactive psychological abuse or neglect) or negativity (intentional or malicious abuse or neglect)
• Caregiver's capacity, resources, presence, and impairments

Types of emotional neglect (absence of warmth, support, nurturance)	Types of emotional abuse

• Caregiver is not physically present
  ▫ Forced to be physically absent due to work, military service, hospitalization, or incarceration
  ▫ Choosing to be absent due to substance or alcohol abuse or prioritizing another family
	• Caregiver calls the child derogatory names or ridicules or belittles the child

• Caregiver is emotionally absent due to dissociation, severe depression, chronic mental illness, or developmental delays	• Caregiver blames the child for family problems or abuse of the child
• Extreme family stress due to poverty, lack of social supports, or dangerous neighborhood interferes with caregiver's emotional availability	• Caregiver displays an ongoing pattern of negativity or hostility toward the child
• Caregiver ignores child's bids for attention or shuns child	• Caregiver makes excessive and/or inappropriate demands of the child
• Caregiver abandons the child for periods of time with no indication of when he or she will return or imposes extended periods of isolation from others	• Child is exposed to extreme or unpredictable caregiver behaviors due to the caregiver's mental illness, substance or alcohol abuse, and/or violent/aggressive behavior
	• Caregiver uses fear, intimidation, humiliation, threats, or bullying to discipline the child or pressures the child to keep secrets
	• Caregiver demonstrates a pattern of boundary violations, excessive monitoring, or overcontrol that is inappropriate considering the child's age
	• Child is expected to assume an inappropriate level of responsibility or is placed in a role reversal, such as frequently taking care of younger siblings or attending to the emotional needs of the caregiver
	• Caregiver undermines child's significant relationships
	• Caregiver does not allow the child to engage in age-appropriate socialization
	• Child is exposed to relationship conflict between caregivers

Historically, emotional abuse and neglect have been understudied compared to other forms of trauma and interpersonal victimization. And yet, whenever empirical research has shined light on these unseen wounds, "sepsis" has been uncovered. For example, one of the first studies comparing the longitudinal effects of physical abuse, neglect, and psychological maltreatment found maternal verbal abuse and emotional unresponsiveness to be equally or more detrimental than physical abuse to attachment, learning, and mental health (Erickson, Egeland, & Pianta, 1989). Another early study found verbal, not physical, aggression by parents to be most predictive of adolescent physical aggression, delinquency, and interpersonal problems (Vissing, Strauss, Gelles, & Harrop, 1991).

Despite the proliferation of nearly 100 evidence-based or promising treatment models tailored to survivors of other forms of trauma designed to target particular posttraumatic symptoms or disorders, until now none have been specifically developed to treat adult or even child survivors of psychological maltreatment. In fact, many well-established, evidence-based, and widely disseminated treatments of adult traumatic stress omit assessment of exposure to childhood emotional abuse or emotional neglect entirely when conducting otherwise comprehensive trauma histories to identify clinical targets for intervention. Presumably, this is because these forms of trauma continue to be left out of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013) as adverse life experiences that "qualify" as causal (or "Criterion A") stressors for posttraumatic stress disorder (PTSD), the prevailing psychological trauma-related diagnosis in the United States since the establishment of this guide in 1980.

The lesser attention paid to psychological maltreatment is likely due to a confluence of societal and cultural factors. Notwithstanding compelling research from our Center revealing that psychological maltreatment typically serves as a "driver" of subsequent familial physical abuse and assault (Hodgdon, Suvak, et al., in press), in and of itself psychological maltreatment is less likely to result in harm to the child that leaves overt physical "evidence." In contemporary Western societies, child sexual abuse and, increasingly, physical abuse have finally attained the status of consensus social taboo, motivating adults to intercede. Conversely, psychological maltreatment perpetrated by parents or other adult caregivers still largely remains in a gray area of (mis)perception regarding familial and cultural differences in parenting practices, or at worse as the unintentional consequence of ineffective or "stressed" parenting. Thus, it often fails to generate the larger systemic response from schools, pediatricians, child welfare, or law enforcement that is often necessary to result in intervention. Interestingly, as a society, we have a much easier time recognizing psychological abuse for what it is—and refusing to tolerate it—when it occurs outside the home, be it in our children's schools or communities perpetrated by peers (where we have renamed it "bullying") or when perpetrated against adults in the workplace (where we are quickest

to condemn it as "harassment"). In contrast, valid assertions of the psychological maltreatment of children are often met with resistance, minimization, and even outright dismissal.

This societal "astigmatism" against recognizing psychological maltreatment clearly for what it is enables emotional abuse, and especially emotional neglect, to remain unseen or at least avoided by therapists, case workers, and other adults within a child's broader caregiving system. Perhaps more than for any other form of childhood maltreatment, providers can become complicit in "looking the other way" rather than defining emotionally aversive parenting behavior as psychologically abusive or neglectful and risk immersing themselves in a contentious and potentially ambiguous situation. Tragically, these patterns of familial and societal denial of the reality and consequences of psychological maltreatment heighten risk trajectories and exacerbate mental health disparities for this highly vulnerable subpopulation of trauma survivors. They contribute to the perpetuation of emotional abuse and neglect, with reduced likelihood of prevention, detection, and protective response, accurate understanding, or adequate intervention prior to adulthood.

A TURNING OF THE TIDE

Psychological maltreatment is finally beginning to receive greater recognition as a widespread and dangerous form of trauma in its own right and an important target of health disparities research and policy. Neuroscientific research has convincingly demonstrated specific and deleterious effects of emotional abuse and neglect perpetrated in childhood on brain development (for a seminal review, see Teicher & Sampson, 2016). The foremost leader in this research, Teicher has found parental verbal abuse to be an especially potent form of maltreatment, associated with large negative effects comparable to or greater than those observed in other forms of familial abuse on a range of outcomes including dissociation, depression, limbic irritability, anger, and hostility (Teicher, Sampson, Polcari, & McGreenery, 2006). Notably, when coupled with witnessing domestic violence, parental verbal abuse was found in that study to be associated with more severe dissociative symptoms than those observed in any other form of familial trauma or their combination, including sexual abuse. In 2012, the American Academy of Pediatrics released a special report identifying psychological maltreatment as the most challenging and prevalent form of child abuse and neglect (Hibbard, Barlow, MacMillan, & Committee on Child Abuse, 2012). Statements such as these echo emerging research findings from our Center documenting equivalent or greater immediate and long-term negative effects of childhood psychological maltreatment as compared to other forms of child victimization.

In our research using the Core Dataset (CDS) of the NCTSN, a large national sample of trauma-exposed children and adolescents, we found that

psychological maltreatment was not only the most prevalent and earliest onset form of maltreatment, but also the most chronic form of trauma exposure out of 20 types of trauma assessed in the CDS (Spinazzola et al., 2014). Compared to physical and sexual abuse, psychological abuse, despite rarely being the focus of treatment, was the strongest predictor of symptomatic internalizing behaviors, attachment problems, anxiety, depression, and substance abuse and was equally predictive of externalizing behaviors and PTSD. In addition, psychological abuse was associated with equal or greater frequency than both physical and sexual abuse on over 80% of risk indicators assessed, and it was never associated with the lowest degree of risk across these three forms of maltreatment. Strikingly, experiences of emotional abuse or emotional neglect were found to carry greater "weight" or "toxicity" than other egregious forms of childhood abuse. Specifically, children and adolescents with histories of only psychological maltreatment typically exhibited equal or worse clinical outcome profiles than youth with combined physical and sexual abuse. In contrast, the co-occurrence of psychological abuse significantly potentiated the outcomes associated with either of those forms of maltreatment.

ADULT TRAUMA TREATMENT: CAN ONE SIZE REALLY FIT ALL?

The developmental disruptions that result from psychological maltreatment place children on a trajectory of continued difficulty over time. Interruption of one developmental step undermines mastery of subsequent developmental tasks, leading to an unfolding of impact that manifests over the course of the lifespan. In our clinical work, we have long regarded this form of childhood maltreatment as also having some of the most pervasive, complicated, and enduring effects on individuals across all aspects of identity and functioning. Accordingly, our approach to psychotherapy with adult clients contending with the aftermath of profound childhood psychological maltreatment differs in many important ways from traditional treatments for PTSD.

A large number of intervention models have been recognized as evidence-based treatments for PTSD based on carefully controlled clinical efficacy research (Foa, Keane, Friedman, & Cohen, 2010). However, much of the data on which these designations are based have been demonstrated to be constrained by conclusions derived from highly exclusionary study designs with adult survivors of acute traumatic events or those presenting with less complex clinical profiles and fewer risk indicators than is typically observed in clinical practice settings (Spinazzola, Blaustein, & van der Kolk, 2005). This raises fundamental questions about the generalizability of this body of research and the actual effectiveness of those treatments with real-life people who are seeking treatment for trauma, especially those suffering from more complex or treatment-resistant adaptations to trauma. This concern has led prominent trauma theorists and clinical researchers alike to challenge the

adequacy of one-size-fits-all approaches to trauma treatment (e.g., Cloitre, 2015; Stein, Wilmot, & Solomon, 2016; Sykes, 2004).

In our experience working across the range of treatment settings with adult survivors of childhood emotional abuse and neglect—from community mental health centers and general outpatient clinics to trauma-specialty treatment centers and private practices, to inpatient, residential, and day-treatment settings—PTSD is the tip of the iceberg, if present at all. Through the accumulation of a substantial body of clinical wisdom, research, and scholarship over the past four decades, we have come to understand the legacy of chronic and severe childhood interpersonal violence, exploitation, attachment disruption, and neglect as a problem of *complex trauma*.

COMPLEX TRAUMA: THE MANY-NAMED FIEND

The quintessential unifying feature observed in our adult therapy clients with histories of chronic childhood trauma is this: their current difficulties are not merely linked to early life adversities; rather, the essence of these struggles, along with the core of their current identities and life narratives, cannot be meaningfully understood outside of the context of these formative experiences. For many of our clients, past experiences and present existence can appear to be hopelessly, inextricably entangled. Courtois (2004) articulated the first formal definition of *complex trauma* as a *recurrent* and *escalating* form of trauma occurring primarily within familial or intimate relationships. More recently, she elaborated on this definition in her excellent treatment book with Julian Ford:

> traumatic attachment that is life- or self-threatening, sexually violating, or otherwise emotionally overwhelming, abandoning, or personally castigating or negative, and involves events and experiences that alter the development of self by requiring survival to take precedence over normal psychobiological development. (Courtois & Ford, 2013, p. 25)

The Complex Trauma Workgroup of the NCTSN (Cook et al., 2007; Spinazzola, Ford, et al., 2005; Spinazzola et al., 2013) has a similarly developmentally anchored definition of complex trauma as—a *dualistic,* pernicious, and *progressive relationship between exposure and adaptation,* concepts that have guided our thinking about the treatment of adult complex trauma.

Nearly as many other names and clinical conceptualizations have been offered in an effort to describe and define the problem of complex trauma as there are clinical experts, researchers, and scholars in the realms of traumatic stress, victimology, and public health. First among these was Terr's (1991) highly influential differentiation of *Type I* (exposure to *single, shocking, intense* traumatic events associated with more focal intrusive symptoms and cognitive

misperceptions) and *Type II* (exposure to *multiple, long-standing, or repeated extreme* traumatic events associated with broader psychological consequences and coping deficits, including numbing, dissociation, aggression, self-hatred, and personality/character impairment) trauma. While Terr did not use the term *complex trauma* per se, her conceptualization of Type II trauma has subsequently been attributed by some to be the origin of the complex trauma construct (e.g., Ford & Courtois, 2009). Even a largely overlooked conceptualization of complex trauma as constituting *Type III trauma* has been offered in the criminology literature (Solomon & Heide, 1999).

Foremost among conceptualizations of complex trauma is Herman's (1992a, 1992b) articulation of a diagnostic construct of the complexity of adaptation to trauma: *complex posttraumatic stress disorder* (*CPTSD*). For some time, this diagnostic construct was also described as *disorders of extreme stress not otherwise specified* (*DESNOS*; Pelcovitz et al., 1997; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005) in an effort to differentiate it from PTSD during and for some time following the DSM-IV field trials. An impressive body of empirical research on CPTSD has been amassed over the past two decades to bolster the widespread clinical support for and international recognition of this diagnostic construct (Cloitre et al., 2009, 2011; Cloitre, Garvert, Brewin, Bryant, & Maercker, 2013; de Jong, Komproe, Spinazzola, van der Kolk, & van Ommeren, 2005; Ford & Kidd, 1998; Ford & Smith, 2008; Ford, Stockton, Kaltman, & Green, 2006; Karatzias et al., 2017; Zucker, Spinazzola, Blaustein, & van der Kolk, 2006), despite lingering debate that the symptoms captured by CPTSD may more accurately be conceptualized as clinical correlates of a more severe form of PTSD (Wolf et al., 2015). More recently, a parallel stream of research and advocacy has been directed toward delineating and pursuing official nosological classification of *developmental trauma disorder* (*DTD*; D'Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012; van der Kolk, 2005), a diagnosis designed to capture the negative consequences of childhood complex trauma exposure on core regulatory capacities, domains of functioning, and risk trajectories (Ford et al., 2013).

Other complex trauma experts, most notably John Briere, have resisted establishment of a unitary diagnostic construct for complex trauma, emphasizing instead the variable expression of impairment across clusters of symptoms and domains of functioning influenced by the nature, number, and timing of trauma exposure in conjunction with individual differences in physiology, personality, temperament, and social context (Briere & Scott, 2015). Such researchers have focused instead on the effects of complex trauma exposure on phenomenological constructs such as *symptom complexity* (e.g., Briere, Kaltman, & Green, 2008; Hodges et al., 2013) and *complex posttraumatic states* (e.g., Briere & Spinazzola, 2005). Still other trauma and victimology researchers have created clinical constructs emphasizing the number of different types of trauma exposures in general (e.g., *cumulative trauma*; Agorastos et al., 2014; Karam et al., 2013) or else the number of different types of

particular victimization experiences (*polyvictimization*; e.g., Finkelhor, Ormrod, & Turner, 2007) on the breadth and severity of clinical outcomes and risk trajectories. In turn, Ford and Courtois (2009) provide a useful differentiation of *complex psychological trauma, complex posttraumatic sequelae,* and *complex traumatic stress disorders*.

Finally, preventive medicine and public health researchers have independently generated constructs that overlap with facets of complex trauma exposure and adaptation. Paradigms such as *early life stress (ELS), toxic stress,* and *adverse childhood experiences* (*ACEs*) emphasize medical outcomes related to compounded experiences of maltreatment, neglect, or absence of a protective adult figure during childhood. Research on ELS (e.g., Garner et al., 2012) and toxic stress (e.g., Pechtel & Pizzagalli, 2011) has primarily focused on the effects of living with chronically activated bodily stress response systems on brain architecture, organ systems, and cognition. In a similar vein, the ACE framework has produced groundbreaking studies documenting the explicit link between an exponentially predictive risk of exposure to 10 different forms of familial trauma during childhood and a startlingly wide range of serious health conditions, diseases, and premature mortality in adulthood (e.g., Felitti et al., 1998).

ON THE SHOULDERS OF GIANTS

This book is intended primarily for clinicians as an applied guide to practice. Attempting an exhaustive review of the now rather extensive literature on adult complex trauma intervention would detract from this aim (for this purpose, we recommend Courtois & Ford, 2009). Nevertheless, this book would not exist without the foundation of four decades of complex trauma treatment theory, model development, and empirical validation that preceded it, and without the numerous luminaries in the field whose formative insights and essential groundwork guided our thinking and set the stage for the model introduced here. Prominent among these influences are Putnam's (1989) seminal book on the diagnosis and treatment of dissociation and the groundbreaking early writings on treatment of complex trauma by Herman (1992b) and van der Kolk, McFarlane, and Weisaeth (1996b). Chu (2011) offered an early practical guide for the treatment of CPTSD and dissociative disorders. Brown (Brown & Fromm, 1986) paved the way for modern understanding of the intersection between childhood trauma and altered states of consciousness in adulthood and provided innumerable strategies for working with dissociative self-states. Courtois (2010) and Roth (Roth & Batson, 1997) greatly expanded understanding of treatment of adult survivors of childhood incest. Pearlman and Saakvitne (1995a) and Perlman (1998) produced lasting works exploring the effects of trauma treatment on the practicing therapist. In addition to being developers of major complex trauma treatment models in their

own right (Cloitre et al., 2006; Ford, 2015), Cloitre and Ford have spearheaded vital clinical research advancing the empirical basis for complex trauma intervention paradigms and diagnostic constructs (e.g., Cloitre et al., 2010; Ford et al., 2013). Most recently, Courtois and Ford (2013) have published the most sophisticated book to date on the nuance and sequencing of relational treatment of complex trauma.

Childhood emotional abuse and neglect leave behind a powerful residue. These experiences can shape survivors' attributions of self and perceptions of others, undermine their establishment of healthy attachment relationships, and obstruct their capacity to tolerate the receipt and expression of emotional intimacy. These effects can lead some survivors of psychological maltreatment to internalize an innate sense of failure or shame to a more global extent than that observed in response to nearly any other form of trauma. We find that adult survivors of severe and prolonged childhood emotional abuse and neglect present with clinical profiles and therapeutic needs that overlap with (but that are in important and nuanced ways distinct from) those observed in adults with other complex childhood traumatic experiences. As a result, it is our experience that adult survivors of childhood emotional abuse and neglect typically require therapeutic approaches that not only diverge from those offered by traditional PTSD-focused intervention models, but that also vary in focus and degree from those offered by existing complex trauma intervention paradigms. Accordingly, whereas the new framework we describe in this book has been designed for use in treatment with adult survivors of all forms of complex trauma, we pay particular attention to adults with pronounced histories of childhood emotional abuse and neglect.

MODELS AND MYTHS

> Essentially, all models are wrong, but some are useful.
> —GEORGE P. BOX

The question of how to facilitate psychic healing in adults suffering from the legacy of familial maltreatment has drifted in and (often been driven) out of the forefront of psychotherapeutic theory and practice, since the advent of psychology as a science in the late 19th century. In that time, many specific treatment models have been developed or adapted to address posttraumatic sequelae. Most of these interventions fall to a greater or lesser extent within one of what we loosely conceptualize as three predominant paradigms that emerged over more than a century of traumatic stress inquiry and research, acknowledgment and denial, remembering and forgetting. Each of these paradigms has made pivotal—and to our mind, essential—contributions to the evolution of our field.

The first and most enduring of these paradigms has concentrated on the intentional activation and processing of traumatic memories as the primary

mechanism of intervention. This paradigm spanned and survived the major political and ideological regime shift from psychoanalysis to behaviorism that took place in psychology in the middle of the 20th century. From Janet and Freud to Foa, disclosure and catharsis became repackaged and abridged as exposure and desensitization with surprisingly little actual change in the focus, targets, and desired end result of the work (e.g., see Foa, Chrestman, & Gilboa-Schectman, 2009; Freud, 1896; van der Hart, Brown, & van der Kolk, 1989). In fact, the first formal treatment outcome study for PTSD in adults compared the relative efficacy of three very distinct approaches to engaging traumatic memories and sequelae—psychodynamic group psychotherapy, hypnotherapy, and flooding—and found all three approaches to achieve equivalent outcomes (Brom, Kleber, & Defares, 1989).

In its position then and now as the dominant paradigm of trauma treatment, traumatic memory processing is often maligned as an approach by competing paradigms: its merits are questioned, its limitations emphasized, its contraindications inventoried, and its demise is repeatedly portended (Wylie, 2004). Nevertheless, the great contribution of this paradigm to the lives of those impacted by traumatic experiences cannot be questioned. Exposure-based interventions and their proponents, beyond providing viable means of relief from suffering for many survivors of some forms of trauma, will ultimately be most remembered for their importance to victim advocacy, policy, and public awareness. In response to a century characterized by cyclical periods of societal minimization and denial of the prevalent reality of maltreatment and its devastating effects, this paradigm's champions—and none more authoritatively than Foa—have played a critical role in amassing an extensive body of empirical research that proves once and for all that violence and abuse constitute undeniable, tangible, and serious sources of human affliction that directly cause psychiatric distress and impairment of life functioning.

The birth announcement of the second paradigm arrived swaddled within the covers of Judith Herman's seminal book, *Trauma and Recovery* (1992b). This book was the first to emerge from the members of the Boston Trauma Study Group. This fecund think tank of clinicians and researchers had come together to examine and stretch the parameters of the nascent traumatic stress field. They were driven by their collective challenges to safely and successfully utilize the various emerging trauma exposure and memory processing treatment models for adults with more chronic and severe histories of childhood abuse or neglect. The three-phase model succinctly and eloquently proffered by Herman resonated deeply with clinicians for over a generation. It provided an organizing, guiding framework for what was otherwise routinely experienced by clinicians as a challenging, confusing, and chaotic treatment process. Her model restored the primacy of the therapeutic relationship to trauma treatment and illuminated the importance of establishing an internal sense of safety before engaging clients in processing traumatic memories. Shortly thereafter, van der Kolk and colleagues (van der Kolk, McFarlane, & van der Hart, 1996a) elaborated a five-phase version of treatment for complex

PTSD that emphasized the importance of fostering affective and somatic regulation capacity as a critical precursor to deconditioning traumatic memories and restructuring meaning-making.

Although complex trauma treatment in routine practice often does not smoothly progress through such clear, linear stages, these phase-oriented paradigms provided something that is sorely needed: more hopeful, better tolerated, and more affirming approaches to trauma treatment for this large subgroup of trauma survivors—the growing numbers of adult women and men bravely coming forward with disclosure—and acknowledgment of chronic childhood victimization and intrafamilial trauma. Moreover, these models recognized that the clinical needs of complex traumas change and evolve over the course of treatment, and thus so must the focus of therapeutic intervention. Initially relegated by the academic community to a status subordinate to that ascribed to the exposure-based paradigm, two decades later, the phase-oriented trauma intervention paradigm has finally attained sufficient empirical validation to receive formal endorsement as the best-practice approach to treatment of CPTSD in adults (Cloitre et al., 2011, 2012).

More recently, contemporary vanguards in the field have heralded what we regard collectively as an innovative and exciting third paradigm for recovery from traumatic stress. This emerging third paradigm is physiologically and neurobiologically driven, focusing on the critical importance of mind–body approaches to trauma recovery. Recognizing the limits of traditional forms of psychotherapy, proponents of this mind–body paradigm have pursued nonconventional approaches that target the somatosensory imprint of trauma, particularly with the sizable subset of psychotherapy-resistant adults living with chronic, complex traumatic stress and related conditions and disorders (Levine, 1997; Ogden, Minton, & Pain, 2006; van der Kolk, 2014). Intervention models falling within this paradigm revive, retool, and blend ancient, largely eastern, physical arts such as yoga, meditation, and acupuncture with advanced new technologies, including clinical biofeedback and neurofeedback, in an effort to build regulatory capacity and "retrain" brains "wired" by chronic early trauma exposure to exist in fixed or oscillating states of hyper- and hypoarousal.

While the model we introduce in this book, component-based psychotherapy (CBP), has been informed by and draws heavily from all three of these paradigms, it ultimately does not fit neatly within nor subscribe fully to any of them. In our view, successful complex trauma intervention in real-life practice—particularly when conducted with adult survivors of the kind of pervasive and profound deprivation and debasement that comes from living through chronic and severe emotional abuse and neglect in childhood—can almost never be accomplished through adoption of a singular clinical target, follow a consistently linear process, or result from adherence to one specific clinical technique. In contrast, it is tangled, precarious work, work that is predictable in its unpredictability, that inevitably requires the therapists'

extensive use of themselves in the treatment process, and that simultaneously demands attention to the body and all that usually goes unspoken in trauma and in psychotherapy. Out of necessity, then, CBP has been designed as a multi-tiered, multitargeted, component-based approach to complex trauma treatment (Grossman, Spinazzola, Zucker, & Hopper, 2017).

To be clear, with the introduction of CBP, we do not profess to be forging a new paradigm for traumatic stress intervention. Our work has most accurately evolved from a long-standing, potent, but often overlooked paradigm or "undercurrent" in mental health treatment that is hardly new at all, but rather is in line with a long-standing recognition of *common factors* or *core components* in psychotherapy dating back to the 1930s (Rosenzweig, 1936) and bolstered by decades of empirical research (e.g., Barth et al., 2012; Duncan, Miller, Wampold, & Hubble, 2010). In this vein, with the publication of their book *Psychological Trauma and the Adult Survivor*, McCann and Pearlman (1990a) quietly introduced the first theory of change and a model for treatment of relational trauma in the contemporary era: constructivist self-development theory. While their book was well respected, their delineation in it of a complex, relationally driven, component-based model of change received limited overt attention. Perhaps their important contribution to the traumatic stress field was inadvertently eclipsed by the ascendance shortly thereafter of Herman's book, with the irrefutable definitiveness of its title and the brilliant clarity of its intuitively resonant three-phase course of recovery.

Nevertheless, many of the advances made in the traumatic stress field toward understanding the intervention process have been influenced, directly or indirectly, by McCann and Pearlman's articulation of their approach to treatment with adults impacted by interpersonal trauma. Over the past decade, a resurgence of interest in applying core components-based principles of psychotherapy has been witnessed in the child traumatic stress field, spearheaded by the NCTSN (Layne et al., 2011). Inspired by this movement, colleagues at our Center developed the ARC (attachment, regulation, competency) model, a components-based approach to complex trauma treatment in children for which this book serves as a complementary companion (Blaustein & Kinniburgh, 2010; Kinniburgh, Blaustein, Spinazzola, & van der Kolk, 2005).

We wish to claim several additional companions, whose important work we seek to build on by using what we casually refer to as a "fourth paradigm" of "messy, relational" complex trauma treatment. CBP has been significantly influenced by Davies and Frawley's (1994) and Pearlman and Saakvitne's (1995a) efforts to integrate psychoanalytic models with traumatology and their strong emphasis on the therapeutic relationship in trauma therapies. Moreover, the relational psychoanalytic school, best represented by Bromberg (2001), has enriched our understanding of the complex relationships and enactments that occur in the treatment of traumatized adults, especially those with histories of complex childhood emotional abuse and neglect.

CBP intentionally delves deeply into certain problem areas and intervention components, particularly in the realm of dissociation; these components were barely understood at the time of publication of some of the formative trauma treatment models mentioned earlier. In contrast, CBP offers less extensive consideration of certain intervention components than other previous trauma treatment models, particularly in the realm of cognitive processing. Nevertheless, in its emphasis on the pivotal role of the therapeutic relationship in complex trauma treatment, its concurrent implementation of a multi-tiered set of core components, and its unwillingness to downplay the inherent idiosyncrasies and lack of "neatness" of this work, we hope that the intervention model introduced in this book helps to inspire the next generation of trauma treatment innovation.

COMPONENT-BASED PSYCHOTHERAPY: NEW MODEL, NEW MYTH?

Psychological trauma is seemingly ubiquitous to the human condition, and the prototypical adult who presents for psychotherapeutic services comes with a history of exposure to trauma. For a minority of clients, trauma occurred in the form of a single, impersonal incident: a terrible accident, an unexpected injury, or a natural disaster. For most, trauma was chronic or recurrent, began in childhood, and involved episodic or chronic exposure to often-interconnected experiences of maltreatment, exploitation, or neglect. The impact of these experiences on neurobiology, emotional development, and identity is profound and requires complex adaptations that routinely result in enduring psychological disturbance and associated social and functional impairment. Moreover, when childhood emotional abuse and/or emotional neglect constitutes the primary form or "organizing thread" of an adult survivors' trauma history, the consequences tend to be most global, the infiltration into self-appraisal and meaning systems most insidious, and the response to traditional psychotherapy most recalcitrant.

CBP is an evidence-informed framework designed to guide clinical intervention with adult survivors of complex interpersonal trauma, especially adult survivors whose trauma histories include prominent exposure to childhood emotional abuse or neglect. Conceived by senior faculty of the long-standing Trauma Center in Brookline, Massachusetts, founded by Bessel van der Kolk, CBP represents the outgrowth of four decades of extensive clinical practice, supervision, training, and research. Development of CBP was predicated on integration of perspectives and strategies from virtually all of the Center's current and alumni senior clinicians and supervisory staff members through intensive focus groups, editorial review, and multiauthored contributions to this book.

CBP is a relational intervention that offers what we regard as the next juncture in sequential approaches to complex trauma intervention. A

core-components treatment model, it provides intervention targets, strategies, and techniques designed to address what we consider to be the four primary components of this work: relationship, regulation, dissociative parts, and narrative. CBP bridges trauma-focused, psychoanalytic, feminist-relational, humanistic, and mind–body theories of therapeutic action to a greater extent than any other trauma treatment model. Notable among contemporary approaches to psychotherapy—and certainly unique among evidence-based, trauma-focused interventions—is the extent of CBP's emphasis on the therapists' internal experience, relational challenges, and movement and growth within and across the four primary components of the model as work unfolds and evolves between client and therapist. Accordingly, much emphasis is placed on the role of supervision in CBP, as well as on constructively working with and through the frequent enactments that inevitably emerge in the context of this work.

CBP reflects an attempt to describe what *actually happens* in the room with our complex trauma clients, guided by our own and our colleagues' extensive collective practice at the Trauma Center over the past four decades and informed by the empirical literature on treatment outcome and evolving best-practice guidelines for intervention with adults affected by complex posttraumatic stress (Cloitre et al., 2012). We endeavored to develop CBP in accordance with contemporary perspectives on the evidence-based practice of psychotherapy (Kendall & Beidas, 2007). Nevertheless, as readers will frequently encounter throughout this book, we find this therapy to entail a complex, fluid, evolving, and at times convoluted process—one that can be hard to capture and sometimes not even within our conscious awareness. CBP is a framework designed to provide a sufficiently containing structure to support and tolerate this inevitably challenging undertaking.

As noted earlier, the CBP model incorporates four core, intertwined components within both the client and therapist: *relationship* (working within a relational frame), *regulation* (increasing self-regulatory capacity), *parts* (working with dissociative parts), and *narrative* (identity development, integration, and meaning-making of traumatic and other life experiences through narrative work as both therapist and client come to construct a shared understanding of the client's story). As we underscore repeatedly throughout the chapters that follow, clinicians' own competencies and struggles in regard to their personal relationships, emotion regulation, integration of self-states and narrative, and identity development invariably affect this work. These therapist-specific factors can advance or impede therapeutic progress through their influence on therapeutic attunement and rupture, healthy connection, detachment, and enmeshment. Moreover, CBP considers how each of these components is embedded within the unique and shared cultures and contexts of client and therapist. Above all, CBP attends to the interactive nature of each of these elements within and between the therapist and client (see Figure 1.1).

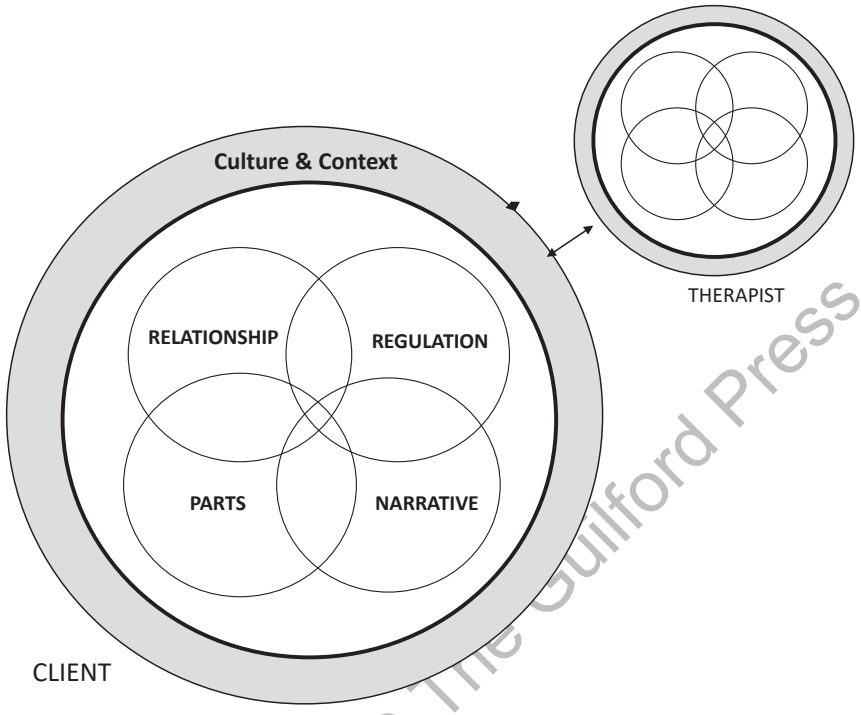

FIGURE 1.1. CBP components and context within both client and therapist.

Relationship

As we have said, the therapeutic relationship is the cornerstone of this work, and that fact is reflected throughout this book. Relational trauma requires, and seeks, relational healing; thus, complex trauma treatment should happen within a relational frame. The healing of relationally inflicted wounds occurs within the context of a holding environment, with another person to witness the client's suffering and to provide support and validation. Adults who have experienced chronic emotional abuse, neglect, and other forms of trauma have generally been deprived of this type of holding relationship. Therapy provides a partial surrogate—a parallel frame or container within which to develop self-knowledge and self-regulatory capacity.

We believe effective treatment of the relational traumas of emotional abuse and neglect involves a collaborative process between the client and therapist. The therapist guides the client in being able to go to and sit in dark places. To do so, the therapist needs to have the ability to create internal quiet and to sit in his or her own dark places. CBP is interactive and collaborative, as the therapist's and client's inner processes drive them to connect, move

apart, and come back together, codeveloping the therapeutic process over time. In our view, much of what happens in this relationship is nonverbal, and much of it occurs outside the conscious awareness of the client and therapist.

Because early neglect and abuse often disrupt people's capacity for attachment, the therapeutic relationship provides a context in which the client can build relational capacity. The repair of disruptions in attunement and attachment are as important as the development of a trusting therapeutic relationship. In addition to Pearlman and Bromberg's guiding contributions noted earlier, CBP has been heavily influenced by Fosha's (2000; Fosha & Slowiaczek, 1997) delineation of specific dyadic attunement techniques and strategies for therapeutic use of self to build the relational and regulatory capacities of adult trauma clients.

Regulation

If the research of our Center and that of our colleagues over the past two decades has established anything, it is that a complexly traumatized client is a dysregulated client. Be it disturbance in regulation of affect, impulses, cognition, physiology, self- and relational attributions, or, most often, the cascading confluence of dysregulation across many or all of these domains, disrupted capacity of self-regulation has come to be heralded as the sine qua non of complex trauma. Practitioners tend to recognize dysregulation most readily when it is "loudest": in clients with pronounced bursts of hyperarousal—such as explosive and often fragmented states of rage, terror, or panic—activated by perceived threat and traumatic reminders, and perhaps followed by states of extreme hypoarousal such as social withdrawal and isolation, emotional numbness, or amnesia.

While these are undoubtedly hallmark manifestations of dysregulation, to some extent they belie the ubiquity of dysregulation in its more "quiet" expressions: the chronic unease, the hair-trigger irritability and surges of shame and loathing of self and others, and, above all, the baseline inability to self-soothe or restore equilibrium in response to internally or externally generated shifts in arousal. Particularly for adults whose adaptation to trauma has been shaped by the neurobiological sequelae of impaired caregiving, emotional abuse, and neglect in infancy and early childhood, it is often these less dramatic, more perfidious forms of dysregulation that underlie their lasting difficulties and demand primary focus in treatment (Schore, 1996).

Therapy with relationally traumatized adults almost invariably begins in a place of relational dysregulation. Given repeated past experiences of relational betrayal, abandonment, violence, or rejection, these clients are primed to distrust their trauma-specialty therapists and to discount or feel threatened by engagement in whatever new trauma-focused strategies or techniques these well-meaning practitioners introduce to help their clients learn to identify, tolerate, and modulate their distressing emotions, reactive behaviors, and

troubling states of arousal. Moreover, the process of developing self-regulatory capacity with such clients takes place within this challenging relational context and is unavoidably influenced by the therapist's ability to monitor and effectively modulate his or her own regulatory systems in general, and particularly in response to his or her interactions with the client.

Important influences on CBP within this component of treatment include Linehan's (1993) and Cloitre's (Cloitre et al., 2006) approaches to emotion regulation, distress tolerance, and interpersonal skill building; Ford's (2015) integration of mindfulness and present-focused approaches to regulation; Ogden's (Ogden et al., 2006) strategies for promotion of somatic regulation; and Korn and Leeds's (2002) use of guided imagery–based techniques to cultivate internal resources for self-regulation and facilitate client readiness to access fragmented parts of self and undertake trauma processing and narrative construction.

Parts

Therapy with survivors of early childhood neglect and abuse involves bringing to awareness that which has been discounted and bringing together that which has been fragmented. Therapy with adults exposed to early deprivation and abuse is not just interrelational but also intrarelational. Dissociation and fragmentation of aspects of experience and aspects of self are common coping mechanisms for children facing violence and interpersonal deprivation. In recent years, increasing numbers of trauma therapists and theorists (e.g., Chefetz & Bromberg, 2004; van der Hart, Nijenhuis, & Steele, 2006) have come to understand that full healing of individuals suffering physical and sexual abuse requires working with dissociative "parts"—aspects of self that are to some degree disconnected from conscious awareness. We have found that working with parts is at least as essential in working with clients with histories of chronic neglect and emotional abuse as with victims of physical and sexual abuse, whether or not their histories include sexual and/or physical abuse as well.

We view parts work to be an almost universal component of intervention with adults struggling with the aftereffects of these complex forms of childhood trauma. This is a unique feature of our model and a clear departure from traditional treatment approaches for psychological trauma, which either entirely omit consideration of the presence of and response to dissociative experience or else regard this as a distinct, "comorbid condition" present in only a subset of trauma clients and needing to be addressed separately from other forms of treatment. In contrast, in our work, we have come to understand the fragmentation of traumatic experiences and posttraumatic accommodations as integral to the prototypical adult survivor of chronic and severe childhood emotional abuse and neglect. By necessity, then, CBP considers parts work to be an essential ingredient in routine clinical intervention with

this complex subset of trauma survivors. Consistent with CBP's relational approach, the therapeutic process often involves interactions between parts of the therapist and parts of the client. Successful navigation of this complex process requires that the therapist be willing to explore aspects of self routinely held outside of conscious awareness. It also requires that the therapist examine his or her own overt and implicit identities and self-narratives, as both a person and a therapist, and their influence on the treatment process.

Narrative

Treatment models for adult complex trauma vary considerably in their position on when, whether, and how to integrate a memory processing or narrative component of intervention. These questions have become the nexus of a lively and long-standing debate in the traumatic stress field. A small but important body of empirical literature has documented (1) poor tolerance of exposure to traumatic memory processing interventions in emotionally dysregulated, highly avoidant, or dissociative adults; (2) better tolerance and modest gains associated with stabilization-focused treatment; and (3) enhanced outcomes associated with adherence to a phasic approach to treatment comprising the sequential combination of emotion regulation–based intervention followed by traumatic memory processing (Cloitre et al., 2010; Cloitre, Koenen, Cohen, & Han, 2002; McDonagh et al., 2005).

We view narrative work as an integral component of treatment for the majority of adult complex trauma survivors. It is our viewpoint, however, that narrative work with complex trauma clients in general, and adult survivors of childhood emotional abuse and neglect in particular, involves much more than the processing of or desensitization to discrete traumatic memories. Much of our narrative work in CBP is directed toward helping clients come to understand how their chronic difficulties stem from survival-based adaptations that they developed in response to early life adversity, and to then organize these experiences into a cohesive, meaningful, and forward-looking life narrative that transcends trauma and instills a sense of purpose and hope.

As such, the focus and end goal of narrative work in CBP goes beyond the telling of one's trauma story (or, more commonly, stories) toward constructing a comprehensive life narrative that integrates, nurtures, and helps to mature previously fragmented, underdeveloped, or compartmentalized aspects of self and identity. Another facet of CBP that is relatively unique among adult complex trauma interventions is its recognition of the implicit omnipresence of the narrative process throughout all stages of treatment, as well as its prioritization of pursuing some explicit form of trauma experience integration and life narrative work with even the most complexly traumatized adult survivors of emotional abuse and neglect. In this vein, CBP departs from a tendency of some complex trauma practitioners who display in their approach

to practice a strong tendency to restrict intervention, sometimes indefinitely, to the stabilization phase of treatment

Similarly, therapists possess their own personal and professional identities and life narratives. Often implicit, these narratives and identities inevitably enter the treatment room, for better or worse, interacting with and becoming influenced by the therapeutic relationship. As with those of their clients, clinician narratives and identities change and evolve over time, affecting what they attend to and overlook in the work, how they respond to their clients, and what biases, motivations, and needs of their own seep into and complicate the treatment process. CBP places great importance on ongoing examination of these therapist-specific factors as the critical focus of the supervisory process; emphasizes recognition of the influence of the clinicians' personal experience on the treatment process; and grapples with strategies for constructive use of these experiences in working through therapeutic reenactments.

CULTURE AND CONTEXT

CBP teaches therapists to listen for gaps and omissions in the stories they are told, to attend carefully to the cultural and social contexts within which trauma and life narratives are constructed by clients, and to increase their awareness of the shared and disparate contexts from which they hear and interpret this information. There has been an increasing call to action regarding therapists' responsibility to be culturally sensitive and to cultivate awareness of institutional barriers that may prevent people from receiving and benefiting from mental health care (La Roche, Davis, & D'Angelo, 2015; Pedersen, Crethar, & Carlson, 2008). In an effort to capture in an inclusive manner the range and complexity of cultural influences and identities of potential salience in psychotherapy, Hays (2001) delineated the ADDRESSING framework: *A*ge and generational influences, *D*evelopmental or acquired *D*isabilities, *R*eligion and spiritual orientation, *E*thnicity, *S*ocioeconomic status, *S*exual orientation, *I*ndigenous heritage, *N*ational origin, Gender. CBP elaborates on and expands Hays's framework to include consideration of additional contexts that are important to the treatment of complex trauma: gender identity (Singh & Dickey, 2016) and trauma exposure group membership. Recent scholarship on cultural influences on the psychotherapy process counterbalances early efforts in the mental health field regarding culture-specific knowledge accumulation (e.g., see Sue, 1998), with emphasis on the importance of respect for subcultural diversity and of the therapist's recognition that personal identity and group membership is highly individualized even for clients sharing cultural contexts (Nezu, 2010).

CBP prioritizes adoption of an *intersectional* understanding of cultural context, namely, that these categorizations are heavily interconnected social constructs put in place by systems of power and enforced, explicitly and

implicitly, to impart and maintain privilege and advantage to members of dominant cultural groups while serving to enforce and justify discrimination and oppression of others (Crenshaw, 1989). Of central importance to all mental health practice, intersectionality is critically relevant in the treatment of victims of interpersonal trauma and maltreatment. Racism, discrimination, and poverty are fundamentally experienced in and of themselves as forms of trauma (e.g., see Smith, 2009). Likewise, the history of exposure to interpersonal trauma itself functions as a societally engendered layer of oppression, serving to further subordinate, isolate, or condemn impacted individuals existing within often already marginalized cultural contexts. We believe that the historical minimization, denial, and, at times, outright mockery of childhood emotional abuse and neglect and reframing of associated difficulties as innate defects in character are part of the deepest and most treacherous layers of social ostracism.

In this book, we devote considerable attention to the ways in which perceived and actual commonalities and differences in cultural context between CBP therapists and their clients can have a significant impact on the therapeutic relationship and the course of treatment, often serving as drivers of misattunement, enactments, and therapeutic ruptures. Critiquing the status of academic multicultural training in psychology and social work and its failure to demonstrate empirical benefit for the psychotherapy outcome, Holmes (2012) identifies therapist self-awareness of implicit cultural biases as the true goal of cultural competence in therapy. CBP seeks to illuminate the early-installed, often deeply buried, prejudices and emotional misconceptions of therapists and clients alike. These underlying biases may be particularly hard for therapists to recognize because of our tendency to consciously value egalitarianism and our typical need to regard ourselves as empathic, compassionate, and generally unselfish. To avoid making inaccurate assumptions about our clients and to gain some understanding of their cultural identities and the contexts informing their exposure and adaptation to traumatic life experiences, we need to begin by striving to identify our own explicit and especially implicit prejudices, biases, and assumptions about culture (Hays, 2001). As we highlight throughout this book, this type of self-examination can engender considerable avoidance, fear, discomfort, and ultimately growth on the part of the therapist. Finding ways to manage and endure the anxiety that can ensue from engaging issues of bias and prejudice is an essential part of successful treatment in CBP, especially as effective intervention typically involves bringing conversations about issues of racism, discrimination, and other forms of oppression and marginalization to the surface with our clients. The capacity to engage these challenging topics in an authentic way with clients has been found to be beneficial not only to the therapeutic alliance but also to treatment retention and outcome (Cardemil & Battle, 2003).

Likewise, in CBP we endeavor to attend to the ways in which trauma survivors' experiences have been shaped by and viewed from the vantage point of

the immediate and larger ecological contexts within which they occur (Bronfenbrenner, 1989). These contexts are layered and change over time. For adult survivors of childhood maltreatment and neglect, this entails consideration of pivotal childhood, adolescent, and current adult ecological contexts. Most often, these contexts prominently include the client's past and present immediate environments or *microsystems* (e.g., family of origin; current adult family living situation); expanded personal environments or *mesosystems* (e.g., school and peer relationships; adult work relationships); external factors relevant to their broader communities or *exosystems* (e.g., youth drug culture; geographically linked adult political climate); and larger factors at play at the time of the trauma and currently in the society at large or the *macrosystem* (e.g., prevailing social beliefs about child development; current mental health policies and health care practices). Accordingly, CBP is predicated on a belief that effective intervention requires awareness of and ongoing exploration of the intersection of these ecological contexts and the challenges faced by clients. Building on the work of Harney (2007), CBP places particular emphasis on "the first context": the enduring gravitational pull of formative attachment relationships in the lives of adult survivors of complex childhood trauma.

INTO THE ABYSS

In his seminal book on complex trauma, our colleague Bessel van der Kolk introduced the metaphor of the *black hole of trauma* (van der Kolk et al., 1996b). For van der Kolk, the black hole represented survivors' consuming fixation on traumatic memories and their associated physiological and affect sequelae. Unable to sustain meaningful engagement in present-focused and future-oriented experience because of the continual triggering of trauma-related memory networks, survivors were recognized by van der Kolk to be caught in time, lost in the gulfs and crevasses of their past.

Since that time, we have come to recognize in our complex trauma clients, especially in adult survivors of chronic childhood emotional abuse and neglect, other poignant intrapsychic and interpersonal dimensions of this phenomenon. Through the metaphor of *the abyss,* CBP revisits the black hole of trauma as the predominant state of being experienced by adult survivors of childhood emotional abuse and neglect and thus, too, as the primary nexus of treatment. This book explores the shifting meaning and mutable protean expressions of the abyss in each component of CBP. From the simultaneous longing for and dread of closeness in *relationships* to the roller coaster of annihilating eruptions of intense affect states and utter eradication of emotional experience in *regulation,* the abyss is the central motif of this book. In *parts,* CBP invokes the abyss metaphor in the form of zones of the ocean to reframe and refine clinical understanding of awareness and integration of fragmented aspects of self. In *narrative,* CBP's rendering of the abyss motif echoes Courtois

and Ford's (2013) "void of self" as the embodiment of the most desolate state of identity development: the complete absence of self. Strategies for recognizing manifestations of the abyss and for effectively engaging treatment on its precipice and in its chasm are the primary concern of CBP.

WHAT WE SEE, WHAT WE DO: CONCEPTUALIZATION AND INTERVENTION

The CBP framework is not a one-size-fits-all approach, and we try to attune to the nuanced differences among individuals as we approach case conceptualization and intervention. We view each component as being comprised of numerous dimensions, with each individual falling at a different place along these dimensions at different points in time. The first chapter on each component (Chapters 3, 5, 7, and 9) includes a table that identifies several dimensions for that component; we provide examples of how different clients might be conceptualized using these dimensions, establishing the groundwork for treatment planning. Therapeutic change can be assessed by reconsidering where a client falls along these dimensions of each component over time. Similarly, we are well aware that there are many paths to a common goal. Because CBP has emerged from a rich history of various intervention modalities, many of the intervention strategies or tools might be familiar to clinicians. To help place these strategies within the context of CBP, the second chapter on each component (Chapters 4, 6, 8, and 10) includes a table that provides examples of intervention techniques that target that component or interactions between that component and others. Chapter 11 includes a final integrative table that describes intervention strategies addressing all of the components in CBP. These tables can be used to assist clinicians in considering *why* they are doing *what* they are doing in the room, supporting meta-awareness of the therapeutic process over time.

THE STORIES WE TELL: A NOVEL APPROACH TO TEACHING COMPLEX TRAUMA TREATMENT

Introduction to the CBP approach to complex trauma treatment revolves around the stories of two adult trauma clients: David and Nicole. These cases, together with our collective struggles in understanding and treating them, are the heart of this book and serve as its organizing thread. Both vignettes are case composites reflecting core themes, histories, and challenges encountered in the many complexly traumatized adult survivors of childhood emotional abuse and neglect whose treatment we have conducted or supervised. Also featured throughout are Nicole and David's therapists; these therapists represent facets of ourselves at various stages of our professional development,

as well as aspects of the many novice and experienced clinicians we have supervised. The crafting and function of these vignettes intentionally deviate from those of traditional case illustrations. They are not composed of typical categories of information of relevance to conceptualization and treatment planning, and they are delivered in a more or less sequential, orderly fashion. No attempt is made to provide comprehensive information, exhaustive history, or "objective" rendering of the clients' experiences. Instead, clients are revealed in vivo, in glimpses and fragments representing discrete moments at various stages of treatment, from vantage points that alternate between client and therapist. Written in literary form, the chapter introducing these characters tells stories: about this approach to treatment, about the clients immersed in it, and about the therapists struggling to provide it. In this book, we have set out not only to elucidate the fundamental elements of the CBP model but also to absorb the reader in an in-depth exploration of the complexities of this work.

Like ourselves and our colleagues, the therapists depicted in these vignettes at times demonstrate deep compassion or attain moments of great insight or attunement; in other instances, they miss the mark entirely. Like all of us, they are as intrinsically flawed in their capacity to understand themselves and others as they are filled with profound potential for growth and connection. CBP is equally concerned with the clinician's internal processes of relationship, regulation, parts, and narrative. At times these are strikingly parallel to those of their clients and at other times markedly divergent. Invariably, the therapists' internal systems and schemas become activated and challenged by engagement in this complex relational work. Accordingly, these vignettes are as much about the clinicians as about the clients they are struggling to treat.

The vignettes are taken up in each ensuing chapter, intermingled with brief consideration of other cases, to illustrate key aspects of CBP. Each chapter offers observations of false starts, missed opportunities, pivotal interactions, and alternate approaches in response to particular exchanges between therapist and client and highlights and builds on interactions and interpretations perceived to bear promise. In the final chapter, we revisit David and Nicole and offer an integrative consideration of their treatment using the CBP framework. Our aim is for the reader to arrive, in a manner as close as possible to actual supervised treatment itself, at successively deeper understandings of the CBP approach to complex trauma intervention. If this book's somewhat unorthodox narrative device sufficiently intrigues you to sustain the openness and curiosity necessary to remain "experience-near" to this rich but often opaque subject matter, then we will have succeeded in our intent.

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