

Treating Adults With Complex Trauma: An Evidence-Based Case Study

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This article presents an overview of complex trauma and a case study describing the evidence-informed treatment of a 25-year-old woman with chronic complex trauma symptoms resulting from childhood sexual, physical, and psychological abuse from a caregiver. Treatment followed a relationship-based, cognitive behavior therapy model across 3 treatment phases. Significant reductions in trauma and general distress symptoms occurred from pre- to posttreatment, although firm conclusions about cause cannot be drawn from case studies. Verbatim vignettes illustrate specific interactions.

Keywords: complex trauma, interpersonal trauma, relationship-based cognitive behavior therapy, child sexual abuse

Adults with histories of exposure to complex trauma (CT) present daunting challenges for counselors working with this population (Courtois & Ford, 2013). These clients may dramatically shift their opinion of the counselor from very positive (idealization) to negative (disillusionment) in a brief period of time; exhibit sudden, extreme swings in mood; and/or anxiously anticipate abandonment by significant others (Briere & Scott, 2013). The etiology of these behaviors is often linked to childhood abuse and forms the substrate for negative intrapersonal and interpersonal relationships, survival-based coping skills, and a general view of the world and others as unsafe and untrustworthy. The resulting symptoms continue in various forms into these individuals' current adult lives. The consequences associated with exposure to CT highlight the importance for counselors who work with these clients to be well grounded in the etiology, development, and treatment of CT. This article provides an overview of CT and a case study describing the evidence-informed treatment of a 25-year-old woman with chronic CT symptoms resulting from childhood sexual, physical, and psychological abuse from caregivers.

CT

Defining CT

The International Society for Traumatic Stress Studies (Cloitre et al., 2012) task force's definition of CT in adults includes the core symptoms of posttraumatic stress disorder (PTSD; reexperiencing, avoidance and numbing, alterations in cognitions and mood, and hyperarousal) and disruptions in self-regulatory capacities grouped into five domains: (a)

emotion regulation, (b) self/relational capacities, (c) alterations in attention and consciousness, (d) belief systems, and (e) somatic symptoms and/or medical problems. These symptoms most often result from prolonged exposure to multiple forms of interpersonal trauma, typically during childhood, by caregivers who are expected to provide a safe, predictable, and secure environment (Courtois & Ford, 2013). Typically, there is no escape from the abuse. This disruption in the caregiver-child bond compromises the development of a secure attachment and a coherent, stable sense of self (Courtois & Ford, 2013). As a result of early invalidating messages from caregivers and self-referent thinking, these individuals often develop personal schemas of self-blame for the abuse and view themselves as bad, deserving mistreatment, and undeserving of acceptance (Courtois & Ford, 2013). They may seek validation and yet anticipate and even facilitate their own rejection, or they may avoid relationships altogether.

It is more often the rule than the exception that adults exposed to CT experienced multiple types of interpersonal trauma (i.e., polyvictimization) beginning in childhood (Anda & Brown, 2010; Turner, Finkelhor, & Ormrod, 2010). For example, a study of a national sample of 4,053 children and adolescents (ages 2–17) noted that 66% had experienced more than one type of abuse, 30% experienced five or more types, and 10% experienced 11 or more types (e.g., sexual, physical, assault, community violence, bullying; Turner et al., 2010). In another study of 4,272 youth from the Illinois child welfare system, 34.5% had been exposed to multiple, chronic trauma by a caregiver (Kisiel, Fehrenbach, Small, & Lyons, 2009). In both studies, children who experienced multiple types of abuse by caregivers had more chronic psychological

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symptoms and fewer overall strengths than youth with single, noncaregiver trauma. Exposure to multiple childhood adversities increases the risk for health risk behaviors (smoking, obesity, alcoholism, drug abuse, exposure to sexually transmitted diseases, and suicide attempts) and health problems (heart disease, cancer, stroke, diabetes, and hepatitis) in adulthood (Anda & Brown, 2010).

In addition, research indicates that child victims of CT have a greater risk of interpersonal revictimization across their life span (Duckworth & Follette, 2011). Revictimization may be partially accounted for by the strong association between dissociation and revictimization (Banyard, Williams, & Siegel, 2002). Dissociation decreases awareness of one's surroundings and creates a sense of confusion, resulting in an individual's increased vulnerability to being a target for abuse (Cloitre, Scarvalone, & Difede, 1997). Research largely supports the hypothesis that exposure to traumatic experiences causes dissociation (Dalenberg & Carlson, 2012) and that dissociation is significantly related to disorganized attachment style (Cassidy & Mohr, 2001). Multiple and chronic exposure to CT in childhood disrupts the development of foundational self-regulation skills, secure attachment, and healthy interpersonal schemas (Ehring & Quack, 2010), resulting in the use of coping skills learned in a survival mode, such as dissociation, extreme avoidance, and over- or underreactivity to stressors (Briere & Scott, 2013), whether or not the situation reaches a level of objective threat that warrants such survival responses. Furthermore, these individuals may use tension-reduction activities such as substance abuse, criminal activity, indiscriminate sexual behavior, and reduced awareness to danger, which in turn increase the risk of revictimization and more maladaptive behavior (Anda & Brown, 2010; Bedi, Muller, & Classen, 2014).

The accumulation of traumatic stressors over the life span predicts both the range and severity of trauma-related symptoms such as depression, PTSD, anxiety, dissociation, sexual problems, guilt, shame, interpersonal problems, and anger (Duckworth & Follette, 2011; Hagenaars, Fisch, & van Minnen, 2011), especially when the onset of trauma stressors began in childhood (Cloitre et al., 2009). Revictimization often is associated with increasing severity of traumatic events as well as symptom complexity beyond the impact of multiple types of trauma exposures (Briere, Kaltman, & Green, 2008). Furthermore, the intergenerational transmission of abuse often is a key element in CT. For example, a mother's history of child sexual abuse (CSA) is the single strongest predictor of CSA in the next generation, with daughters being at a 3.6 times greater risk for CSA. Combined with drug use, the risk increases to 24 times (McCloskey & Bailey, 2000).

Early polyvictimization and revictimization have a negative effect on the neurobiological system, leading to a shift from a *learning brain* to a *survival brain*, resulting in greater activation of the primitive brain rather than cortical structures

dedicated to adjustments to the environment (Courtois & Ford, 2013). The survival brain leads to extreme responses to perceived threat, with an orientation of harm avoidance rather than openness to experience, limiting the ability to learn and implement coping skills based on the demands of a situation. Coping skills tend to be based on avoidance, isolation, and hypervigilance. Symptom severity in adulthood is related to age onset of CT exposure and a dose-response association, with earlier onset, polyvictimization, and higher frequency associated with greater impairment in adolescence and adulthood (Anda & Brown, 2010).

Incest

CSA perpetrated by a caregiver is associated with particularly severe symptoms throughout the victim's life span (Kluft, 2011). Nearly one in 20 families have experienced father-daughter CSA and one in seven families have experienced stepfather-daughter CSA (Russell, 1986). In a survey of 1,521 women, 15.8% reported CSA, with 7.9% reporting father-daughter incest (Stroebe et al., 2012). Browne and Finkelhor (1986) stated that 3% of the 16% of men who reported CSA reported mother-son incest. Incest is characterized by secrecy, betrayal, powerlessness, guilt, conflicted loyalty, fear of reprisal, and self-blame/shame, with only 30% of cases reported by victims (Collins, Griffiths, & Kumalo, 2005). Incest greatly affects a child's self-concept, creating a sense of self-loathing and being damaged and contaminated. It adversely affects a secure attachment with both parents, and later with a partner (Stroebe et al., 2012). Perhaps even more damaging are the dysfunctional family dynamics that accompany incest: parent conflict, contradicting messages, triangulation (e.g., parents aligned against a child), and improper parent-child alliances within an atmosphere of denial and secrecy (Courtois, 2010). More severe symptoms occur with early childhood onset, longer duration, violence and coercion, penetration, the parent blaming the child, and observed or reported incest that continues (Finkelhor, 1994). In severe cases, extreme avoidance of trauma memories and distortions in sense of self may result in the fragmentation of self, resulting in dissociative identity disorder (DID; Courtois & Ford, 2013). Dissociation is particularly "functional" when escape or avoidance is not possible. Chronic dissociation during incest initially solves a problem—conscious absence during the abuse—but creates a long-term problem—a fragmented sense of self (i.e., emptiness, absence, memory problems, and dissociative self-states) that, if not addressed, can continue into adulthood (van der Hart, Nijenhuis, & Steele, 2006).

Treating CT

With the multifaceted nature of CT, disruptions in normal child development, and the unique profile of each person, treatment also needs to be multifaceted and adapted to each person (Briere & Scott, 2013). Treatment focuses not only

on symptom reduction but also on the development of self-capacities in the areas of relatedness, identity, and affect regulation (Briere & Scott, 2013). Limited self-capacities exacerbate symptom severity and chronicity (Hobfoll, Mancini, Hall, Canetti, & Bonanno, 2011).

Most treatment models for CT are relationship-based, cognitive behavior therapy (CBT), and trauma focused (Courtois & Ford, 2013) with at least three major phases: (a) safety, stabilization, and alliance formation; (b) processing trauma memories; and (c) consolidation. Models may include couple and family counseling. Strength-based interventions (e.g., identifying solution behavior) are central in each phase. The three-phase format is similar in structure to treatment models for PTSD (e.g., trauma-focused CBT; Cohen, Mannarino, & Deblinger, 2006) but with longer phases and more time devoted to self-capacities. Treatment guidelines for adults with CT suggest treatment lengths between 14 months and 24 months, and even longer with severe cases (Cloitre et al., 2012).

Research

Few studies exist on treatment effectiveness for adults with CT. On the basis of the current literature and a review by Cloitre et al. (2012), there have been 10 published studies (randomized controlled trials) focused on models for treating adults with CT, as a result of childhood physical and/or sexual abuse. All studies were based on trauma-enhanced or phase-based trauma treatment models. Moderate to large effect sizes were noted in all 10 studies for treatment groups compared with control groups with respect to improved emotional regulation capacity and social and interpersonal skills. Five studies included stabilization/skill-building interventions with little or no trauma memory processing. Four studies used phase-based models with both trauma-focused components and stabilization/skill-building components. A final study used group treatment format, focusing on processing trauma material. Studies focusing on both stabilization/skill development and trauma memory processing were more effective than studies that emphasized either skill development or memory processing alone. Individual approaches were more effective than group approaches.

The following sections discuss the treatment model used with the case study presented later in the article. As noted earlier, it is a three-phase model that is trauma focused, is attachment/relationship based, and includes cognitive behavioral interventions (Courtois & Ford, 2013).

Phase 1: Safety, Stabilization, and Alliance Formation

CT clients often report feeling unsafe around others and being a danger to themselves (Courtois & Ford, 2013). Furthermore, they are prone to use unsafe and ineffective coping skills, such as alcohol/drugs, self-injury, and association with unsafe people

(Briere & Scott, 2013). Thus, safety plans that distinguish safe and unsafe places and people should be addressed. If clients have spent a large portion of their lives in a survival mode, achieving safety may be a slow process due to unfamiliarity with feeling safe, which itself may trigger survival reactions. Also, developing and maintaining a therapeutic alliance is critical as clients experience new, unfamiliar feelings, behaviors, and cognitions (Courtois & Ford, 2013). Clients also may test counselors' limits for acceptance, abandonment, and betrayal via reenactments of trauma-related defenses.

Psychoeducation can demystify trauma, its effects, the treatment process, and the counselor's role. Also, clients' adaptive survival strategies can be framed as strengths and used to enhance safety.

Client coping skills tend to revolve around nonreflective, survival-based avoidance responses; thus, self-regulation skills are necessary to replace avoidance responses. Interventions emphasize distress reduction and affect regulation skills for two types of trauma-related circumstances (Briere & Scott, 2013). The first type targets acute distress that occurs during treatment, such as grounding, focused breathing, and shifting to less emotionally intense topics. The second type emphasizes building general capacity to tolerate and resolve negative emotions, such as progressive muscle relaxation, guided imagery, and cognitive restructuring. Cognitive restructuring identifies and changes beliefs that mediate between an activated trauma memory (e.g., "Men are dangerous") and the subsequent negative emotions (e.g., anxiety). Related interventions include identifying and delineating emotions (e.g., "I feel anxious") and responding more effectively (e.g., breathing) to external and internal cues triggering trauma memories (e.g., "Men are dangerous") and maladaptive coping behaviors (e.g., avoiding men; Briere & Scott, 2013). These skills are used in all phases of treatment as new trauma material emerges. Although specific trauma memories likely will emerge, focus remains on enhancing self-capacity skills to better tolerate and manage negative emotions.

The technical aspects of treatment must be accompanied by ongoing attention to client-counselor interactions. Clients may feel unsafe as they attempt to focus on relaxation or experience thoughts or emotions associated with trauma experiences, which may trigger a defensive response based on a trauma relationship. It is important for the counselor and client to identify and process these dynamics. Counselors' awareness of their own reactions to clients' reactions is crucial for processing client experiences and maintaining an empathic, supportive role. Phase 2 is contingent on the clients' ability to reflect on trauma memories without feeling overwhelmed.

Phase 2: Processing Trauma Memories

Trauma survivors spend large portions of each day avoiding trauma-related thoughts, emotions, and physical sensations (Courtois & Ford, 2013). Avoidance has the opposite



effect than intended—it intensifies traumatic emotions and thoughts. Phase 2 works to increase self-reflective abilities, memory and emotional reconstruction, and continued development of conscious-based coping skills. Memory reconstruction reorganizes and integrates trauma and non-trauma experiences into an autobiographical memory (i.e., recalled episodes about one’s life) that is more optimistic, balanced, and coherent and that reflects a continuous, linear sense of self and relationships (Cloitre et al., 2012). Furthermore, maladaptive trauma-related beliefs are processed through belief reconstruction. A major goal is for survivors to increase awareness and choice of when and how to reflect on their abuse, not simply the absence of intrusive memories and reduction of fear.

Within a safe environment, clients are supported in recalling traumatic memories and themes, as well as body states, emotions, and perceptions at an optimal level of intensity. Remaining engaged within the *therapeutic window* of emotional activation (between under- and overwhelming emotional activation) increases tolerance for stressful memories and allows processing/integration of the traumatic memories (Briere & Scott, 2013). Subjective units of distress (SUD) ratings (from 0 to 10) help maintain an optimal level of activation. Thus, if the distress level goes beyond 8, clients shift to focused breathing until a rating of 4 is achieved. They then reengage processing the trauma memory.

Processing traumatic material is more than a recitation of facts. It is reexperiencing trauma material in a different context with a supportive counselor. The client makes a conscious decision to reengage trauma material while experiencing a tolerable, though high, degree of emotional activation (Briere & Scott, 2013). This process creates emotional disparity between anticipated consequences (e.g., overwhelming anxiety) and the actual, less intense reactions to trauma material. Clients with low levels of arousal may need to reengage trauma material at increasing levels of intensity until they reach the therapeutic window of activation (Briere & Scott, 2013). Clients who avoid trauma material may need more Phase 1 emotion regulation skill building before proceeding.

Emotional processing not only counterconditions the original trauma reactions but also reconstructs new meanings about the trauma. Memories are no longer viewed as uncontrollable. New meanings can emerge about previous interpretations as context material becomes more complete (e.g., from “It’s all my fault—if I just would’ve fought harder maybe they wouldn’t have raped me” to “Fighting harder could have made it worse for me”). Developing a detailed cause–effect and coherent trauma narrative that is processed repeatedly reduces trauma symptoms. A more balanced perspective of the trauma(s) emerges, reducing feelings of confusion and producing a more coherent sense of self and predictable world. Conversely, fragmented, noncausal memories lead to

more distress, confusion, and unprocessed emotions (Briere & Scott, 2013).

Clients begin processing by verbally describing a traumatic event in session and then writing about the event in more detail at home. It is read out loud in subsequent sessions, adding more detail and emotional processing. Counselors deepen the processing by using Socratic questioning to focus on feelings, thoughts, and physiological reactions to a traumatic event, for example, “What were you feeling when it happened?” Such questions engage self-reflection, which enhances integration and control of trauma memories (Briere & Scott, 2013). In many cases, clients have experienced hundreds, even thousands of abusive incidents, making it impossible to process each event. In such cases, helping clients identify and process trauma themes is advised (Cohen, Mannarino, Kliethermes, & Murray, 2012).

The intense emotional experiences likely will activate clients’ traumatic interpersonal schemas of danger. The counselor may be a target of the reactions. This is an opportunity to process danger schemas and provide the client with a corrective emotional experience via safety and support.

Phase 3: Integrating and Consolidating New Learnings

Phase 3 focuses on integration and generalization of self-regulation skills, positive affect, relationship network, problem-solving, and cognitive work. These new experiences need time, repetition, and support to become the norm. Moreover, the skills learned in Phase 1 are refined and generalized to different situations. Expanding relationships is particularly focal; however, they may trigger distorted beliefs and experiences not yet processed, thus necessitating a return to Phase 2 skills. Finally, clients refine problem-solving skills used in everyday life (Courtois & Ford, 2013).

Treatment phases are implemented in the form of a recursive spiral (Courtois & Ford, 2013), as themes from previous phases (e.g., shame) often reemerge in later phases. These themes are associated with clients’ earlier experiences of rejection, betrayal, and abandonment (Courtois & Ford, 2013). Thus, phases often overlap, such as acquiring new self-regulation skills in Phase 2 and emotional processing in Phase 3, as new reactions and trauma memories emerge.

CT clients present particular challenges for counselors. They struggle forming and maintaining a therapeutic relationship, which is curative of itself and a necessary precondition for processing trauma material (Cloitre, Stovall-McClough, Miranda, & Chemtob, 2004). Similarly, CT clients struggle with attachment, for to be attached often means to be abused. Also, they tend to avoid trauma-related issues due to shame, self-loathing, and fear of betrayal and abandonment. These issues create a failure identity, resulting in low expectations for change (Courtois & Ford, 2013).

Case Study

Susan (pseudonym), a 25-year-old married White woman, was referred to me by a counselor due to limited success in therapy. Susan reported being sexually, physically, and verbally abused by her birth father from ages 5 to 16. She disclosed the sexual abuse (SA) to her mother at age 8, but it continued. Because of her disclosure and outcry, her parents blamed her for disrupting the family. The SA occurred two to three times a week from ages 5 to 12. At 13, her parents divorced. The SA continued during weekend visits with her father. At 16, Susan moved in with her grandmother and the SA ceased.

During high school and college, Susan had problems regulating her emotions and flashbacks of the abuse. She also reported significant memory gaps, as well as fragmented and discontinuous memory. In college, she discovered that she had been involved in relationships she could not remember. Furthermore, friends and family members noted times she acted differently, “unlike her normal self” and being many “different Susans.” These revelations added stress to Susan’s marriage and to her fears of abandonment. She also reported hearing voices in her head since childhood. When questioned, she disclosed that she had not engaged in self-injurious behavior or had any thoughts of suicide.

Assessment

All clinical instruments except the Detailed Assessment of Posttraumatic Stress (DAPS; Briere, 2001) were administered at pre- and posttreatment and at 6-month follow-up. The Outcome Questionnaire–45 (OQ-45; Lambert, Lunnen, Umphress, Hansen, & Burlingame, 1994) assessed for client distress (symptom distress, interpersonal relationships, social role, and total score). The Trauma Symptom Checklist–40 (TSC-40; Elliott & Briere, 1992) assessed for trauma-related symptoms (anxiety, depression, dissociation, SA trauma index, sleep disturbance, and total score). The Multiscale Dissociation Inventory (MDI; Briere, 2002) assessed for dissociative symptoms (disengagement, emotional constriction, depersonalization, derealization, memory disturbance, and identity dissociation). The DAPS was administered at pretreatment only and examined trauma exposure and assessed for PTSD. At pretreatment, all instruments were in the clinical range (see Table 1). Higher scores indicate greater symptom severity. The Individual Therapy Alliance Scale (ITAS; Pinsof, 2005) assessed the therapeutic alliance with a combined score of goals, tasks, and bonds. The ITAS was administered three times across the first 6 months. All instruments were self-report measures.

Based on an interview and the various assessment instruments, it was determined that Susan had DID, PTSD, and sub-clinical levels of depression and anxiety. All PTSD measures

TABLE 1
Assessment Data

Instrument	Pre-Treatment	Post-Treatment	6-Month Follow-Up
OQ-45 total score ^a	108 ^b	76 ^b	68 ^b
TSC-40 total score ^c	60 ^b	47	47
MDI ^d			
Emotional Constriction	80 ^b	63	54
Memory Disturbance	134 ^b	58	52
Identity Dissociation	170 ^b	130 ^b	106 ^b
Disengagement	108 ^b	72	68
Depersonalization	126 ^b	74	74
Derealization	96 ^b	57	64

Note. OQ-45 = Outcome Questionnaire–45; TSC-40 = Trauma Symptom Checklist–40; MDI = Multiscale Dissociation Inventory.

^aOQ-45 scores 63 or above in clinical range. ^bAbove the clinical cutoff.

^cTSC-40 scores 48 or higher in clinical range. ^dMDI scores 80 or above in clinical range except for Identity Dissociation (95 and up).

on the DAPS (e.g., avoidance, reexperience, arousal) had *T* scores from 80 to 100 (65 > clinical range). She exceeded the eight criteria required for a diagnosis of PTSD according to the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013)*.

Treatment Course

Treatment extended over 52 weekly/biweekly sessions across 14 months. It followed the three-phase model, with some overlapping. Susan was cooperative and cordial, but guarded initially.

Work with self-states (distinct identities; International Society for the Study of Trauma and Dissociation [ISSTD], 2011) was interspersed throughout treatment. This included identifying triggers for dissociation, identifying self-states and their functions, and developing cooperative relationships with self-states (van der Hart et al., 2006). Other work focused on cooperation and compromises between self-states, client awareness of self-states, and co-consciousness of self-states. This method minimizes individual work with self-states, as this would reinforce independence rather than integration (ISSTD, 2011). Skill building and titrated trauma exposure strengthened presentness and tolerance, reducing the client’s susceptibility to dissociate.

Verbatim interchanges in the following sections were based on case notes and recorded sessions. The client’s name and identifying information were altered to protect her identity.

Phase 1: Safety, Stabilization, and Alliance Formation (Sessions 1–11)

Phase 1 addressed safety, stabilization, psychoeducation, attachment, self-regulation skills, and resources. The client’s coping strategies revolved around nonreflective, survival-based avoidance responses; thus, enhancing the client’s self-regulation skills and engagement was critical.

Susan related a long history of polyvictimization by her father and to a lesser degree by nonrelative adult males. She reported problems with long- and short-term memory, as well as memory gaps of up to 4 to 5 hours on some days. In the third session, she reported an awareness of four distinct self-states described as (a) needy and sexualized; (b) organized and in charge; (c) frightened little child; and (d) a dark, depressed self who experienced the abuse. Five other distinct self-states emerged over time.

Process goals were to provide a safe, collaborative, and adequately structured session in order to develop a therapeutic alliance and a predictable treatment process. At the end of the fourth session, the therapeutic alliance was moderately high (5.9 out of 7). However, I anticipated that it would fluctuate, especially as painful material emerged. I carefully monitored the alliance, repairing when needed. Information was provided on treatment phases, CT, and its impact on functioning. No medical or psychiatric services were a part of treatment.

At times, Susan experienced flashbacks without awareness of the triggering event. She slipped into a dissociative state such as feeling dizzy or shifting to another self-state. The following example occurred in the fifth session during an introduction to focused breathing and grounding. (My part of the dialogue is indicated by “Counselor.”)

Counselor: Susan, I noticed when you shifted to your dad, you seemed to get angry and pull back, and got quiet. (No response, looking down.) Susan, you’re in the office with me (initiated grounding to refocus in the present). You’re safe here. (Looking down; arms and legs crossed as if threatened.) Susan, could you look at me? (Looks up, her facial expression is a flat, expressionless, nonblinking stare.) Susan, you’re safe here. Susan, pick out something in the room, describe it for me? (Repeated her name to emphasize her core self-state in the present.)

Susan: Huh? (Long pause. Begins looking around the room.)

Counselor: A little more present? Can you look at me? (Pause.) OK. Looking at me, focus on something to describe, my clothes, the chair, pictures—your choice.

Susan: OK. (Long pause.) Your shirt. It’s blue, checked with white mixed in, and 1, 2, 3, 4, 5 buttons. (She continues to describe the shirt, then a lamp shade, and a picture.)

Counselor: How are you feeling now?

Susan: I was feeling like I was gonna pass out; tingling in my legs too. Didn’t hear you at first. I felt the presence of (self-state associated with the abuse). (Pause. She takes a “catch-up” deep breath; breathing becomes slower and more rhythmic.) I’m feeling better. I’m here now.

Counselor: That’s good, like we practiced. Continue breathing slowly for a few more minutes.

Susan: OK, I’m better now (stated in slow, relieved manner). Not hearing all the voices—everybody’s calmer (referring to voices of self-states).

Counselor: You did a good job catching yourself and refocusing in the present. It’s not easy. Take a moment and think back. Can you identify the point at which you started to dissociate?

We then identified the trigger leading to reduced consciousness and how Susan shifted out of a dissociative state with the prompts from me. We aimed to increase her awareness of this process, identify the least apparent markers signaling the onset of dissociation, and plan how to intervene before a loss of consciousness (e.g., breathing). Eventually, she concluded that anger at her father likely was the trigger. This was an opportunity to learn coping skills in vivo and strengthen trust for me, her counselor. Other triggers included unexpected changes, flashbacks, and feeling rejected or criticized. She also practiced shifting her thinking to nonabuse issues during flashbacks.

As Susan was often exploited by people during more vulnerable self-states, high-risk community settings and people were identified and largely avoided (safety plan). Other self-regulation components included exercise and cognitive restructuring (e.g., awareness that many sudden shifts in emotions were based on past and not present threats). Furthermore, we identified and reinforced several of her strengths, such as her completion of a college degree, her ability to maintain employment, support by several relatives and colleagues at work, and her commitment to treatment.

These skills were practiced in and outside sessions, including assessing distress level with SUDs. Susan also journaled, reflecting on feelings, thoughts, and experiences. These strategies promoted engaging rather than avoiding stressful issues and enhancing self-awareness, self-reflection, and self-regulation. We examined Susan’s progress in managing the dissociation during Session 11. She reported,

The breathing and grounding are really helping me. I’m not dissociating as much as before, but it still happens. But when it does, I don’t totally black out. I’m more aware of when it’s happening and I’m able to stop or slow it by breathing, grounding, or talking to myself. It’s much better.

At this point, treatment shifted to processing trauma memories. This decision was based on several changes: (a) Susan reported effectively using new coping skills; (b) she exhibited effective coping skills in session; (c) she was able to identify and express a range of positive and negative emotions; (d) she reported that symptoms had significantly decreased; and (e) she showed a fairly strong alliance with me, her counselor (scored 6.2 out of 7).

Phase 2: Processing Trauma Memories (Sessions 12–40)

The second phase focused on processing traumatic events and themes with sufficient detail to activate emotional trauma material (therapeutic window) while using self-regulation skills from Phase 1 to tolerate the emotional and physiological reactions. Susan began by writing about the impact the abuse had on her life (e.g., mistrust, family alienation), the duration of abuse (since age 5), a life narrative of abuse and nonabuse memories, and survival skills. Awareness and integration of nonabusive incidents into the narrative are vital because survivors often overuse avoidance strategies and overlook nonabusive incidents such as safe people. Noting these incidents provides a more balanced view of abuse and a foundation upon which survivors rebuild their lives. When prompted, Susan could recall “fun times” between abuse incidents, such as cooking with her grandmother. After completing the life narrative, she acknowledged the horrors of the abuse but also these fun times. Nonabuse incidents were revisited when processing beliefs such as “my whole life has been abuse,” not to minimize the abuse but to identify exceptions to counterbalance overly generalized negative beliefs.

The life narrative was the beginning of memory reconstruction and the integration of abuse incidents into a coherent, historical, autobiographical memory. Furthermore, it focused on enhanced tolerance for and desensitization of the trauma memories. Emotional regulation skills continued to be practiced in sessions, including assessing SUDs to gauge her level of awareness and distress.

Because Susan was abused hundreds of times over 12 years, we also focused on themes of abuse, such as incidents based on location. Another theme was punishment and revenge for her resistance to the abuse and her outcries to her mother. A nefarious theme was SA based on her father’s expression of “love” that created intense conflict, confusion, and self-blame.

Once themes were identified and elaborated, Susan would pick an example incident and address it in greater detail. For example, Susan chose two incidents of SA to process that eventually were connected. One involved SA as an “expression of love,” whereas the second involved SA with a punishment/revenge motive. She began by slowly and deliberately providing an overview of the expression-of-love incident without dissociating. She then rated her level of distress (SUD).

Susan: OK, I’d say it’s about a 7 or 8. I can feel a distance presence (self-state) and slight numbing but they’re not strong. I think I’m OK.

Counselor: Just for safety’s sake, look around, find something you can ground on and then once you feel you’re mostly present, take a few very slow breaths and exhalations.

The grounding and breathing reduced Susan’s distress and numbing. She then completed the first narration with adequate detail without dissociating. It triggered the following processing:

Susan: There were times when daddy treated me like his girlfriend. I mean I was 8, 9, 10 and I liked it, even though it would feel a little weird.

Counselor: OK, you felt close to him, but it felt weird. Can you talk about that?

Susan: Well, because I really loved my daddy then, maybe in a wrong way. I knew something was wrong about it even then. I felt bad for my mother sometimes, but other times I sided with my dad against her. Like she wasn’t being a wife, so I had to be. Confusing then. It still haunts me—confusing now. I can get into to the little girl part of me real easy as we talk about this.

This conflicted theme ran throughout Susan’s processing of the abuse. At times, it was more distressing for her than the abuse itself because of the overlapping and contradictory roles, secrecy, and triangles. She processed this incident over 3 weeks, continuing to add to the narrative. She processed a punishment/revenge incident in a similar manner. Each additional reading resulted in identifying more details and expressing a greater depth of emotion and accompanying distorted beliefs.

The conversation focused on the beliefs that emerged from processing both themes of SA.

Susan: I guess as I’m going back over all this stuff (pause), I feel dirty, damaged, defective. He told me that it was my fault I got abused. There must be a part of me that believes that ‘cause I feel that way. I guess hurt too, that my daddy would do this to me. It still bothers me now.

Counselor: The hurt makes sense. How could he do such a thing that made you feel so bad? Can you talk from that part of you that believes you’re defective—that the abuse was your fault?

Susan: Well, he’d tell me I deserved to be punished and then he’d abuse me. I guess I thought that for him to hurt me so bad I must’ve done something or be something bad.

Counselor: Like you deserved it—even though you were a child and he was the adult.

Susan: Yeah, I know what you’re saying. I was a child. I know that. It’s just easier to blame myself ‘cause I’m the one that lost the most; like everything.

Counselor: You did. I guess that’s a big part that keeps the self-blame strong—loss of childhood, parents, innocence. That leads to “What did I do to cause this?” A big gulf between facts and feelings, and a hard choice with strong, ingrained feelings.



Susan: (tearing up) Yep—a big dilemma. Feelings are stronger right now, but I know the facts.

Balancing empathy with examination of distorted beliefs is critical. The goal was not for Susan to entirely reject self-blame at this time, but to cast doubt, to offer an alternative view that diluted the self-blame, which over time was greatly reduced and neutralized to a large degree. The next week, she came back feeling less blameworthy and was able to articulate percentages of blame (equaling 100%) allotted to herself (15%), her father (70%), and her mother (15%). Initially, her self-blame was 40%. With time, her blame percentage decreased, although never to zero. It was important for her to take some responsibility for the abuse to salvage some redeemable part of her father.

The following theme emerged when processing the two aforementioned SA themes:

Susan: How could he say he loved me, followed by abusing me, and then another time he hated me and I deserved to be punished, followed by abuse? I grew up confused most of my childhood and teen years. The best times growing up were with my dad, but so were the worst.

Counselor: I can hear your confusion and frustration, and especially hurt. Your dad represented the best and the worst of your childhood. That's a lot for you to make sense of.

Susan: Yeah, it still hurts. It still haunts me. I love my dad but I'm angry with him, even hate sometimes. I'll never resolve it 'cause he won't have anything to do with me. I know that's why I don't trust men, or women sometimes.

Counselor: Not trusting men makes perfect sense given your experiences with *many* men. How is it sharing this with me? (An important process comment given her mistrust.)

Susan: Kinda uncomfortable, 'cause I don't talk about this with anyone. I'm embarrassed and ashamed. But I know it's safe in here. I know you've told me that and I feel it. It's taken time.

Counselor: Thank you for sharing that with me. I know it's hard talking about it, particularly with a male. You make perfect sense. You're honest with your thoughts, emotions, and me. That's important. How have you gotten to this point of risking to share your feelings?

Susan: I always feel uneasy at first talking about it, but it gets better. I feel better when I get home. I don't talk about it anywhere else. You're one of the few men I trust, and my brother.

Processing of the client–counselor relationship was critical to both strengthen the alliance and enhance the process of earning a secure attachment (Courtois & Ford, 2013).

Nevertheless, there were times when the client–counselor relationship activated a reactive response.

Counselor: I noticed as you talked about how you felt abandoned and abused by men you've been around, you seemed to pull back some, got quiet. I wonder what just happened for you?

Susan: Uh. I, I don't know for sure (looking away and physically closing off).

Counselor: How are you feeling right now?

Susan: Scared . . . like something's gonna happen but I don't know what. I think it's ____ (abused self-state). She always expects the worst about people, especially men.

Counselor: Like me?

Susan: No, don't think so, you're just a trigger I think, like we've talked about. There's lots of voices in my head. I think most know you're safe, but ____ (abused self-state) doesn't trust anyone.

Counselor: I wonder if it would help for you to talk about your experience with me—that part you know here in session, so that ____ (abused self-state) can listen? Invite her be a part of the conversation?

Susan: OK, 'cause I think she trusts you about as much as she can, but that's who she is.

Counselor: I want to be trusted but I've gotta earn it. I'll take the time for it to build as fast or slow as you like. Can you talk about how we're are working together for all self-states?

The goal was to provide counterconditioning (corrective emotional experience) to Susan's long-held fear of abandonment by men, within the context of a safe, validating, and caring relationship with a man. Thus, her fear of abandonment was followed by support and nonpossessive warmth, rather than demand, abandonment, or criticism. It was also important to encourage collaboration with self-states to enhance trust and to encourage direct dialogue between these states and between self-states and Susan. Homework revolved around writing about sessions, insights, feelings, and thoughts and then being more aware of each self-state reaction, empathizing with each one, and encouraging meetings with all self-states, which was often taxing for Susan. With greater awareness came more distress about previously unknown history. Thus, there was ongoing retooling of her self-regulation skills to build tolerance, especially for the unexpected, which previously led to dissociation. The therapeutic alliance continued to improve (6.5 out of 7). This may partially account for her continued improvement.

In addition to her father, Susan had been exploited by other men. Although much less traumatic than with her father, these experiences were in keeping with the theme that men will take advantage of her and then leave her. As her self-confidence

increased, she presented less as a vulnerable target and more as a self-assured person. She was less tentative and was appropriately assertive. This was an ongoing process, often three steps forward and two steps back. Her skill level for managing previously overpowering negative emotions had improved markedly. She was dissociating less, with shorter episodes and greater awareness during the dissociation. She continued to experience increasing co-self-state consciousness, suggesting increasing integration of self-states.

A concept introduced toward the end of Phase 2 was mindfulness. Of particular importance was nonjudgmental awareness and acceptance of self and others (Briere & Scott, 2013). Developing self-acceptance and self-appreciation was critical beyond acceptance by others alone. Mindfulness is the antithesis of the trauma adaptations of coping that largely are avoidance based. Yet, mindfulness as a state of mind had to be balanced with an accurate awareness of true danger.

Although Susan continued improving, old and new issues would arise, such as conflict with her mother or the emergence of new self-states. With these challenges came relationship repairs, backtracking, and adjusting to new conditions. These issues were an appropriate segue into Phase 3.

Phase 3: Integrating and Consolidating New Learning (Sessions 41–52)

Embedded themes related to abandonment, mistrust, and self-acceptance continued to resurface as Susan worked toward integrating and generalizing self-regulation skills to other settings. More than acquiring and practicing new skills, Susan learned experientially, in trusting relationships with her counselor and others to counter childhood experiences learned under traumatic and inescapable conditions. She was reacclimating from a “normal state” of self-dysregulation to one of self-regulation, self-efficacy, and self-trust. Although improving self-regulation was a logical linear goal, the adage “better a familiar devil than an unfamiliar angel” informed the change process, which in many respects involved not only grieving loss of a normal childhood but also relinquishing very effective and familiar coping strategies: dissociation and self-states. Replacing battle-tested survival skills, even when they are no longer necessary or effective, was a gradual process, interspersed with thankfulness and sadness. This phase also identified posttraumatic growth and resilience (Joseph, 2011), such as perseverance toward health despite limited family support. She continued self-reflective experiences such as journaling and daily mindfulness time.

Susan also examined her relationship with her mother. This involved rethinking her beliefs about needing her mother’s approval and in turn adjusting expectations for her mother. She was also learning self-validation. This was complicated, as she was raised to believe her perceptions either were not accurate or did not count. Additionally, she focused on responding to demands consistent with the

present context rather than her history. Mastery of these will require ongoing diligence.

A critical relationship was with her husband. He tended to be invalidating, often out of ignorance of what to say or do. Susan’s dissociation with self-states was confusing and mystifying to him, as it would be to most partners in such circumstances. He would not attend any sessions, but he encouraged her to attend. Couples therapy will be important for long-term stabilization.

In Session 45, Susan and I talked about termination and booster sessions based on several factors. Self-validation had become more a rule than an exception, reducing her dependence on others. Susan reported little to no dissociation, and when she did, she was aware of co-consciousness and partial integration of self-states. Likewise, her memory was more continuous. Furthermore, the relationship with her husband had improved, supporting a growing belief that some men could be trusted. The last four sessions were spaced 2 and 3 weeks apart, with a final session 6 weeks later. She attended three booster sessions following the 6-month follow-up. On an as-needed basis, Susan will benefit from occasional sessions to address any new issues that emerge.

Evaluating Outcome

The OQ-45, TSC-40, and the MDI provided cutoff scores in their respective manuals to distinguish clinical and nonclinical levels (see Table 1). With the exception of the total score for the OQ-45 and the MDI Identity Dissociation scale, all of Susan’s scores changed from clinical to nonclinical ranges pre- to posttreatment and were maintained or reduced at the 6-month follow-up. The moderate elevation of the OQ-45 reflects stress due to work and her extended family. Overall trauma symptoms (TSC-40) were greatly reduced in intensity. Flashbacks, avoidance, hyperarousal, and negative alterations in cognitions were significantly reduced, with flashbacks and hyperarousal nearly nonexistent, thus no longer meeting *DSM-5* criteria for PTSD. Although the MDI Identity Dissociation scale remained high, by comparison to no diagnosis of DID, it was not in the clinical range associated with a diagnosis of DID (*T* score of 141 and up). All other MDI scales were within the nonclinical range.

Discussion

This case study described an evidence-informed treatment of a 25-year-old woman with a history of CT. Treatment consisted of a relationship-based CBT approach that was stage based and flexibly implemented based on Susan’s unique needs. Pre- to posttreatment scores indicated significant reductions in symptoms and maintenance of the gains at follow-up. The MDI Identity Dissociation scale, though significantly reduced from pretreatment, was still elevated at a level beyond that of individuals not diagnosed with DID. Susan likely will have

occasions in which she will be susceptible to mild degrees of dissociation. At posttreatment, she continued to report distinct self-states—but without the dissociative amnesia that characterized her experiences at pretreatment—as well as increased co-consciousness of self-states, self-awareness, and present focus, indicating greater integration. She also reported greater awareness of early stages of dissociative phenomena. The process of integration likely will continue with increased unification of self-states a distinct probability in the future. The development of a secure relationship with a male counselor based on nonpossessive warmth, safety, and clear boundaries may have contributed to reconfiguring her sense of self as acceptable and worthy of love and respect, noncontingent on sexual favors. For clients with severe CT, it often is the case that the therapeutic relationship is the therapy (Courtois, 2010).

Several factors beyond specific interventions likely contributed to Susan's improvement that may not be present with all CT clients: (a) high level of motivation, (b) consistent practice of self-regulation skills, (c) support from her grandmother, (d) high level of intelligence, and (e) a strong therapeutic alliance. Absence or a lesser degree of these factors may have reduced her improvement.

Finally, counselors working with this population need to be aware of vicarious trauma and compassion fatigue. Repeated exposure to horrific stories of ongoing and severe child abuse by caregivers can overwhelm counselors' capacity to maintain a balanced relationship with clear boundaries. A client's transference can push the boundaries of an ethical and therapeutic client–counselor relationship. Thus, it is critical for counselors to engage in self-care, supervision as necessary, and support from trusted colleagues. That said, working with CT cases is a noble and worthy calling, although such cases may not be a therapeutic fit for all counselors.

Conclusion

Although it cannot be concluded that the treatment model described in this article produced the improvement reported by the client, the fact that Susan reported severe CT symptoms for 2 decades prior to treatment that were decreased posttreatment would appear to indicate some benefit from the treatment. Even so, several limitations and points of clarity merit notice. First, case studies are inherently limited as a basis for drawing conclusions about treatment effectiveness. No doubt other factors beyond those noted here could have influenced treatment outcome. Second, the goal here was not to demonstrate treatment effectiveness but to examine the finer details of working with a severe case of CT while using evidence-informed treatment. Third, treatment outcome likely would be more credible if additional CT cases were presented with similar outcomes using the approach noted in this article. Fourth, because of space limitations, the recursive nature of treatment and the intricate interactional process between the counselor and client may

appear more linear and less complex than in actuality. Difficult weeks and new self-states often resulted in relapses in the client that took weeks from which to recover.

Evidence-informed case studies provide unique perspectives that are necessary to identify change processes with CT cases, to confirm or disconfirm existing CT treatment principles, and to inform large-sample research designs. This article provided examples of this process and accompanying interventions consistent with the relationship-based CBT model.

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