

Treating Adult Survivors of Childhood Emotional Abuse and Neglect: A New Framework

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Over the past four decades, we have seen major advances in mental health intervention for adults and more recently children affected by exposure to traumatic events and experiences. An impressive body of clinical research now supports the empirical evidence base for a number of psychotherapeutic treatment models for use with victims of traumatic stress. However, despite the great proliferation of approaches to the treatment of psychological trauma, the majority of these models and the research that supports their effectiveness have been principally designed to address symptoms of one specific psychiatric diagnosis, posttraumatic stress disorder (PTSD). Although undoubtedly a pernicious and pervasive condition, epidemiological research in adult and child populations has clearly established that PTSD is neither the sole nor even most common condition experienced by survivors in the aftermath of trauma. In fact, our own research has demonstrated that much of the extant clinical research supporting the evidence base of traditional psychotherapy models for treatment of PTSD and related disorders in adults has been predicated upon recruitment

of study participants with less complicated co-occurring clinical disorders, behavioral issues, and functional impairments than those typically encountered in real-life clinical community practice settings.

This historic partial reliance upon unrepresentative samples to validate traditional treatment models raises important questions about the generalizability of these findings toward meeting the needs of adult trauma survivors suffering from more complex adaptation to trauma. This concern has led prominent scholars and clinical researchers such as Marylene Cloitre to challenge the adequacy of one-size-fits-all approaches to trauma treatment, particularly when attempting to aid the recovery of adult clients with chronic, multilayered, and treatment-resistant psychological and psychiatric conditions.

Perhaps least represented in existing treatment outcome research are the needs of adult survivors of childhood maltreatment experienced primarily in the form of severe emotional abuse and neglect during childhood. Frequently overlooked, minimized, or misunderstood is *psychological maltreatment*, defined as children's exposure to recurrent and severe forms of emotional abuse and emotional neglect including insults, shaming, degradation, threats, shunning of affection, forced isolation, exploitation and imposition of excessive and unrealistic demands. Psychological maltreatment has long been identified in large-scale research—including the Centers for Disease Control's seminal Adverse Childhood Experiences studies—as a major public health problem. Only recently, however, has it been recognized as a major target of health disparities research and policy. In fact, in 2012 the

American Academy of Pediatrics produced a policy report naming psychological maltreatment as “the most challenging and prevalent form of child abuse and neglect.”

At our outpatient trauma-specialty clinic in Brookline, MA, we have grappled for decades with how to best serve adult (and child) survivors of *complex trauma*, namely, prolonged and recurrent exposure to maltreatment, neglect, violence, and exploitation and the ensuing complex effects these experiences have on mental health and physical wellbeing, maladaptive coping, engagement in risk behaviors, and the derailment of normative life trajectories leading to long-term health and educational, relational, and occupational success. At the forefront of this struggle has been the challenge of adequately treating the clients most often “in the shadows:” adult survivors of severe childhood emotional abuse and neglect. Despite nearly a half-century of attention directed in psychiatry, psychology, social work, and allied professions to the development of treatment models for victims of psychological trauma, resulting in the establishment of nearly 100 distinct evidence-based or promising practices, to date not a single one of these models has been specifically designed to target the effects of childhood emotional abuse and neglect in adult or (for that matter) child survivors. Moreover, the vast majority of these models neglect to include even a single page of specific guidelines or considerations for working with this population.

In our research and that of our colleagues, we have amassed considerable evidence verifying that victims of childhood emotional abuse and neglect exhibit equal or worse immediate and long-term effects than survivors of other forms of maltreatment and violence that have been much more the fo-

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cus of clinical and research attention over the past four decades (e.g., physical abuse, sexual abuse, community and domestic violence). Moreover, through this research we have been able to demonstrate empirically

central mission. In this spirit, we endeavored to articulate a clinical framework for complex trauma treatment intentionally designed to address longstanding disparities in the mental health field by emphasizing the needs of this

of multidisciplinary psychotherapists and allied professionals locally and nationally. CBP is an evidence-informed model that bridges, synthesizes, and expands upon several existing schools, or theories, of treatment for adult survivors of traumatic stress. These include approaches to therapy that stem from more classic traditions in psychology, such as psychoanalysis, to more modern approaches including those informed by feminist thought. Moreover, CBP places particular emphasis on integration of key concepts from evidence-based treatment models developed in the past few decades predicated upon thinking and research on the effects of traumatic stress and processes of recovery for survivors.

To date, no treatment model has been specifically designed to target the effects of childhood emotional abuse and neglect

what we had long observed anecdotally in our clinic work, namely that these survivors exhibit overlapping but distinct outcomes, or *clinical profiles*, compared with other survivors of childhood trauma. For example, we found that victims of emotional abuse and neglect tend to have more widespread or global effects across domains of self and identity, behavior and functioning, and clinical psychopathology. Specifically, these trauma survivors tend to show greater impairment in the capacity to establish and maintain safe, healthy, and loving relationships; to possess more negative self-image, worth, or esteem; to be more likely to internalize their distress, leading to more frequent difficulties with depression, anxiety, social withdrawal, and isolation; and to engage in more maladaptive forms of coping, including greater prevalence of self-injury, alcohol and substance abuse, and other risk-taking behaviors including sexual acting out.

Accordingly, whereas the new framework for adult psychotherapy we describe in this article has been designed for use with all adult survivors of complex childhood interpersonal trauma, we pay particular attention to adults with histories that include pronounced childhood emotional abuse and neglect. Much of the therapy with such clients at our trauma center revolves around building their capacities for trust, attachment and relationships, sense of self, and tolerance of intense emotions. These capacities were either not acquired in early childhood or were built in distorted ways because of the lack of adequately responsive and consistent emotional support in childhood. This attention to the kinds of traumatic wounds that often remain unseen is directly informed not only by our clinical experience, but also by the guiding tenets of our nonprofit organization, which upholds the promotion of social justice in mental health service delivery as its

chronically marginalized and misunderstood subpopulation of trauma survivors.

We regard this emphasis upon social justice to be of particular importance for two reasons. First, we have come to view the heretofore often overlooked or minimized backdrop of pronounced childhood emotional abuse and emotional neglect as an invisible web that binds and drives many of our clients toward lifelong trajectories of failure, revictimization, and self-loathing. Second, we believe that authentic engagement in trauma-informed services necessitates that therapists educate and collaborate with multidisciplinary professionals not only to recognize and appreciate the pervasive reality and deleterious effects of childhood emotional abuse and neglect, but also to identify and challenge mental health practices and societal structures that obfuscate or impede recognition of and adequate response to these issues. Such intersectionality is essential to challenge and overcome chronic stigma and injustice surrounding these survivors. Specifically, in the absence of more overt or “tangible” traumatic events or adverse experiences, their difficulties have historically often been objectified, dismissed, or responded to with aversion by coworkers, family members, significant others, and providers alike as indications of innate defects in personality or character, and not as the inevitable consequences of (at worse) malicious wrongdoing or (at best) chronically impaired caregiving.

Component-Based Psychotherapy (CBP)

CBP is an outgrowth of several decades of work as clinicians and supervisors at The Trauma Center at Justice Resource Institute in Brookline and our clinical practices and extensive consultation supporting the work

The Empirical Base for CBP

The overall structure and four components of CBP intentionally build directly upon four empirical bases of evidence: (a) the extensive clinical and research evidence base on the importance of processing traumatic memories and constructing a trauma narrative as an essential component of treatment of traumatic stress; (b) the evolving awareness across disciplines of psychology and psychiatry that the quality of engagement, empathic rapport, and authenticity in the client–therapeutic relationship is integral to the treatment process; (c) the expert guidelines of the International Society of Traumatic Stress Studies highlighting the importance of phase-based approaches to trauma treatment that foster emotion regulation prior to traumatic memory processing through specific efforts to increase the client’s capacity to identify, tolerate, safely manage or “modulate,” and appropriately express emotions as an essential component of complex trauma intervention; and (d) the forthcoming expert consensus guidelines from the International Society for the Study of Trauma and Dissociation that maintain that the treatment of clinical dissociation is a core element of intervention with virtually all adult survivors of childhood complex trauma.

CBP intentionally attends to and builds upon these four paradigms in the traumatic stress field. It represents an evolution of earlier paradigms of phase-oriented, complex trauma intervention through reliance upon a more comprehensive, intensively relational, and concurrent component-based approach. In our articulation of the CBP

framework, we have sought to distill and disseminate our center's innovation in the arena of complex trauma treatment through our careful integration and advancement of each of these four prevailing and emerging

paradigms. First, in CBP we recognize that particularly for adult complex trauma survivors whose childhood was characterized by identity-defining emotional deprivation, debasement, and neglect, the entire story of their lives has been impacted. Therefore, the trauma treatment component traditionally focused upon construction of a life narrative must be expanded to address the effects of trauma on our clients' entire life narratives, including their development of a sense of self and social identity. This stance is inherently and explicitly strength-based, with irrefutable social justice implications. Namely, we are ultimately more interested in enhancing the personhood of the trauma survivor than merely reducing their psychopathology and symptoms of posttraumatic stress. It is not just about helping our clients to stop "living in the past," "haunted by their trauma" but to cultivate and embrace a past, present, and future narrative of self that is greater than the sum of their traumatic experiences.

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paradigms.

Second, in CBP we acknowledge that the personhood of the therapist, or their professional and personal identity, inevitably has a profound influence (for better or worse) upon the treatment process. Therefore, we believe that incorporation of a more relational approach to treatment, such as has been increasingly recommended for psychotherapy in general and complex trauma intervention in particular, will likely be best served by taking this a step further. We recommend adoption of a social justice-informed focus (primarily achieved through intensive ongoing supervision) on the personhood of the therapist and its influence upon, responsibility to, and vulnerability/fallibility in the treatment process. Accordingly, numerous specific strategies and techniques for ongoing self-examination, self-management, and self-care of the therapist have been incorporated into the CBP model.

Third, in CBP we realize that in real-life clinical practice, gains around emotion regulation are best achieved via more comprehensive attention to and focus on all the intertwined systems of self-regulation (behavioral, physiological, cognitive) that fuel, drive, suppress, and mediate processes of emotion regulation. Moreover, CBP emphasizes the heightened challenge in working with adult complex trauma survivors in general, and those with histories of profound rejection, shaming, and abandonment by formative attachment figures in particular, around the delivery of emotion regulation skills and techniques in the context of the therapeutic relationship. Namely, for many of our clients, the therapeutic relationship, or the personhood of the therapist, often precisely because of their efforts to exude warmth and compassion, is frequently experienced as a primary source of emotional dysregulation that undermines the effectiveness of whatever specific coping technique the therapist may be attempting to deliver. Accordingly, in contrast with most other trauma treatment models that focus on the content of the many emotion regulation and coping skills being taught to clients, the CBP model places just as much emphasis on the *relational context and process* of skills administration.

Fourth and finally, CBP devotes particular attention to integration of treatment strategies that address the pervasive presence of *clinical dissociation* in adult survivors of complex trauma. These include manifold expressions of *dissociative coping*, including spacing out, mentally shutting down, and retreating to internal fantasy worlds to escape emotional pain, relational conflict, or perceived threat. Far more complex is the not infrequent *dissociative fragmentation of identity or consciousness* encountered in working with these clients. These involve the splitting off of strong emotions or personality attributes (e.g., intense rage, aggression, sexual urges, childlike yearnings to be loved and protected) associated with memories of enduring or escaping overwhelming traumatic experiences to parts of self. These strong emotional states are often tied to specific visual, olfactory, auditory, or somatic fragments of traumatic memory. Although typically suppressed or existing partially or fully outside of conscious awareness, these components of self have the propensity to emerge suddenly in the form of high-risk and acting-out behaviors, particularly when the adult complex trauma survivor becomes triggered by reminders of their past, feels threatened by present circumstances, or becomes overwhelmed by the activation of intense emotional states including emptiness, loneliness, hopelessness, and shame. CBP is the first treatment model to attempt to integrate highly specialized approaches to the treatment of clinical dissociation into a general model of trauma-focused therapy intended to be widely disseminated and effectively and safely delivered by new, in-training, and experienced general psychotherapists alike and not just psychoanalysts or highly specialized experts in the small subfield of clinical dissociation.

In sum, CBP integrates several prevailing theories and models of trauma treatment into a comprehensive, relational, strength-based, and social justice-informed approach to working with adult survivors of complex trauma, with particular emphasis on the legacy of chronic childhood emotional abuse and neglect. In a full description of this model, described in the forthcoming book *Treating Adult Survivors of Childhood Emotional Abuse and Neglect: Reaching Across the Abyss*, we present ways to conceptualize and carry out this work in its real-life messiness and complexity. In this article, we briefly describe the four components of the CBP model and highlight some key elements of this approach.

The Four Components of CBP

CBP integrates four components: relationship, regulation, working with dissociated aspects of the self, and narrative. In this approach, we pay particular attention to the internal experience of the therapist and that of the client and view the therapeutic relationship as a primary medium for healing. In our descriptions, we try to illustrate the real-life complexity of the sequencing and lay-

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ering of intervention components. This model also focuses on addressing dissociative processes and integrating approaches to the treatment of dissociation.

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Relationship component. We, as others, have learned much from several pioneers in the field of trauma therapy, including *Psychological Trauma and the Adult Survivor* by Lisa McCann and Laurie Anne Pearlman, *Trauma and the Therapist* by psychologists Laurie Anne Pearlman and Karen Saakvitne, and psychiatrist Philip Bromberg's book, *Standing in the Spaces: Essays on Clinical Process, Trauma, and Dissociation*. Beyond that, research on psychotherapy has shown repeatedly that it is the client's feeling about the quality of their relationship with their therapist that determines how much they benefit from the therapy.

In CBP, as in some other approaches, the most important early tasks in therapy are seen as building a relationship and establishing safety. Here is a brief sampling of what we have learned about building and maintaining good relationships with these clients. Clients who have experienced complex trauma often develop problematic attachment models because of their early histories of emotional neglect and abuse. Thus, they may come to therapy mistrustful or overly trustful, often angry and frightened or desperately needy, and lacking the skills to engage comfortably with a therapist or anyone else. Some are clingy, some avoidant, and some both. Some present with a disorganized attachment style and are very unpredictable or variable in their approaches to their therapists. These often problematic styles then interact with the therapist's attachment style, making it harder for the therapist to maintain a steady, empathic, accepting, warm, appropriately boundaried, and authentic approach. In our view, therapists of these clients need to be open to intimacy but not needy of closeness with their clients. Almost all therapists have to do their own therapeutic work, particularly but not only

when their attachment styles or other issues interfere with the therapies they do, and all of us continue to need trauma-informed supervision.

The relationships we work to build with clients need to be much more responsive to contextual factors than therapists are usually trained to be or do. These include all the subtle nuances of therapists' and clients' upbringings and locations in the social world, including but not limited to social class, sexual orientation, ethnicity, and religion, some of which may be similar and many of which are often different. In her 2012 article in the *National Register of Health Psychologists*, psychologist Dorothy E. Holmes articulated that in order to deal meaningfully with differences between themselves and their clients, therapists need to learn *not* the details about the particular cultures of the clients, but rather how to find and explore in themselves all of the biases about others that they learned growing up, including such difficult issues as racism, sexism, homophobia, and class biases.

CBP also supports therapists being as fully as possible in the present moment and noticing the relational ebbs and flows reflected in clients' body language, tone, eye contact, and so forth, while also being aware of the often subtle shifts in themselves. Our model encourages therapists to maintain this present-moment awareness while also bearing in mind the broader framework of the therapy and the treatment. Although no therapists can be totally mindful of all of these aspects of the encounter all of the time, the more we can do it, the more able we are to hold the client, the relationship, and the therapeutic frame.

In CBP, we encourage therapists to work together with clients to figure out what they want and/or need from us, and our capacities to meet their needs. We often help them find additional supports (e.g., a trauma therapy group, yoga class) and work with them from the beginning to develop relationships outside of the therapy that can be supportive

and nurturing to them and activities and interests that are energy-giving.

Regulation component. Many clients with histories of childhood emotional neglect and abuse come to therapy deeply dysregulated, in part as a result of dissociation. They can be volatile and reactive and can manifest an extreme range and intensity of emotions in their lives and in their therapies. It is often the intensity of their reactions that frightens nontrauma-trained therapists. As Judith Herman described in her groundbreaking book, *Trauma and Recovery*, helping clients regulate their emotional states is a key aspect of therapy for clients with histories of sexual abuse (whom we now know mostly also have histories of emotional abuse and neglect). Inadequate brain development from faulty attachment relationships—and insufficient early support for and modeling of regulation—can lead these adult clients to come into therapy with limited capacities to identify, accept, modulate, and appropriately regulate their emotions, physiological states, behavior, thoughts, and attention. In CBP, eating disorders, addictions, problems with sexuality, self-harming behaviors, avoiding closeness, depression, and anxiety are all seen as ways of attempting to manage dysregulation.

Furthermore, in our attempts to help our clients regulate, therapists at The Trauma Center at Justice Resource Institute often experience the profound sense of emptiness that preoccupies many of these clients, along with their deep yearnings, extreme sensitivity, and difficulties allowing connection and nurturance. These clients often come to us not knowing who they are, what they need, or what they feel. How therapists make use of themselves in the midst of their clients' intense affective and physiological states is at the core of CBP.

In CBP the relationship is seen as a way of *holding*, or containing, these clients' experiences so that they can begin to develop the capacity for self-regulation. Because of the extreme sensitivities and vulnerabilities clients may bring to therapy, nuanced aspects of the therapeutic relationship are required, such as the development of gently and empathically humorous rituals, careful use of confrontation, response to shifts in state, and thoughtful use of self-disclosure. How therapists are in the room is more important than what regulation techniques they use. These clients need their therapists'

patient, even presence over long periods of time to begin to feel safe, and ultimately, to heal. Therapists need to be able to understand themselves well, to know how their vulnerabilities and strengths are engaged in

sodically present in treatment at much younger levels of development and functioning. In these instances we often find that clients experience our use of regulation tools and techniques initially developed for chil-

ing totally dissociated from other components of the psychological system. In our view, the key element in creating extreme dissociation is inadequate bonding, particularly in early infancy and the ensuing first 3 years of life, leaving the infant and young child at the mercy of intense and intolerable physiological and emotional dysregulation. (Cults who practice mind control have found deliberate ways to fracture infants' systems.)

In CBP, dissociated parts or states are often built on aspects of early attachments, and sometimes on specific aspects of abuse, terror, and neglect. We, like Richard Chefetz and Phillip Bromberg and others, emphasize the interpersonal aspect of dissociation. That is, when a dissociative part of a client reacts to something that part sees in the therapist, often, if not usually, that part is seeing something real—and dissociated—in the therapist. For example, a client became enraged because she thought her therapist was putting her down for a comment she made, and only after the session was the therapist able to see that in fact some part of her did indeed feel critical of the client for a comment that seemed hurtful to a part of the therapist.

Further, we, like others in the field, see a similar organization of parts in all dissociative clients, with most having very young parts that carry intense unmet needs (e.g., for nurturance), feelings that were unacceptable to the family (e.g., rage), or memories of traumatic experiences (e.g., being rejected by Mom when she was in an alcoholic stupor). When therapists engage with them, these parts seem to be developmentally the age they were when they first came into being, with the cognitive, language, and emotional abilities they likely had then. Many parts pretend to be older, as they also had to pretend in the original circumstance in an effort to survive overwhelming experiences and navigate treacherous relationships with dangerous and unpredictable adult caregivers, authority figures, older siblings, and other youth.

Built upon this young layer of parts, referred to in CBP as *child parts*, another layer develops to silence, destroy, or otherwise manage the young parts who carry the trauma. A troubled mom gets enraged by her toddler leaving a mess, so when that child is a little older, he in turn may develop a part who makes very sure he never leaves a mess and who becomes angry, either at himself when he makes a mess accidentally or at

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any given therapy, and to believe in the power of sitting together mindfully for clients to heal.

Window of engagement is a new clinical construct we introduce in CBP to characterize and guide the complex trauma therapists' role as a *coregulator* for adult complex trauma survivors contending with overwhelming and often oscillating states of extreme dysregulation. Here we challenge therapists not only to increase their awareness or attunement to their clients' momentary level of hypo- or hyperarousal, but also to endeavor to stretch the limits of their own comfort to inhabit extremes of dysregulation in order to meet their clients where the work needs to be engaged.

A number of regulation techniques have been developed, including grounding techniques and relaxation and breath control. CBP emphasizes skill-building in many areas, including developing an increased tolerance for and a growing ability to identify emotional states, learning to communicate to safe others about these internal states, and making links between aspects of internal states and past and present experiences. CBP uses imagery, sensory and emotion-focused techniques, movement, various breathing techniques, biofeedback, progressive muscle relaxation, and other body-focused techniques. Learning these skills can ultimately transform these internal states and our clients' capacities to live their lives fully and richly.

Finally, CBP emphasizes that in treatment with adult survivors of complex trauma and especially chronic childhood emotional abuse and neglect, the processes of engaging and cultivating a client's regulatory capacity are often of equal or greater importance to successful skill acquisition than the particular regulation techniques utilized. For example, many of these clients routinely or epi-

dren or adolescents as more safe, resonant, or effective than those designed for adults. Moreover, many of our clients encounter profound challenges in their efforts to attain, tolerate, and sustain meaningful attachments and intimate connections given their often treacherous early histories of relational betrayal, victimization, belittlement, or abandonment. Consequently, we recognize in CBP that the empathic presence of the therapist itself often inadvertently functions as a primary and direct (i.e., nontransferential) source of dysregulation to these clients that can undermine or derail the effectiveness of whatever specific regulation technique or tool the clinician is endeavoring to deliver. For some such clients, the internalized pressure to please or comply with their well-intentioned therapist conflicts with their hyperattuned detection of even subtle nonverbal expressions of uncertainty or frustration by the clinician. It collides against their own recurrent feelings of hopelessness or nagging fears about the futility of any coping skill to ever be sufficient to fill the seemingly immense emotional void in their lives. Accordingly, a critical aspect of our approach to regulation in CBP is our embedding of this work within the relational context and tailoring strategies to address fragmented, dissociative, and developmental younger aspects of self.

Dissociative parts component.

We view working with dissociative parts as central to treatment of survivors of emotional abuse and neglect. In CBP, we understand dissociation as a process that keeps different mental states and body experiences disconnected from one another. Parts are viewed as an aspect of normal development, existing on a continuum from normal to pathological, with the most problematic be-

others who make a mess. Many of these parts develop in adolescence and present in therapy as adolescents. Over time, these protector or defensive parts become part of the personality, and that individual may become

with some level of problematic dissociation, is to describe and illustrate our model of dissociative parts. We often begin this psycho-educational approach in the first session. A few clients initially do not accept it

her up to be so triggered by her daughter's behavior. It is important to note that this is all cognitive; at this point we are not exploring feelings, although we are talking about a feeling of anger.

The final step, which allows CBP to go deeper into the work with dissociative parts than many models do, is to invite the client to bring herself and sometimes her conception of the therapist into imagery of the part and begin to reeducate and heal that part. This method, described in detail in our book, very much involves feelings and can only be done with clients who have sufficient resources and therapists who have the supervisory resources and foundational knowledge to ensure that this advanced feature of the model is implemented cautiously and judiciously. It is a technique that is meant to connect the affective, cognitive, physiological, sensory, and behavioral aspects of the client's fragmented experience, and thus can generate a strong emotional response.

Even with the most centered, relational, and skilled therapists, interpersonal difficulties occur with regularity in this work. What used to be called *transference* and *countertransference* we have come to think of as *enactments*. Enactments occur when something in some part of either the client or the therapist gets activated, or triggered, by something in the relational environment. This process often occurs outside of either participant's conscious awareness. The individual having the reaction in some way signals the other, often nonverbally but sometimes by tone or language, and a usually nonconscious part of the other reacts. These predictable disturbances between therapist and client are described in a 2001 article by psychiatrists Richard Chefetz and Phillip Bromberg in *Trauma, Dissociation and Multiplicity: Working on Identify and Selves*. Enactments exist *between* the therapist and client rather than residing separately in the therapist and/or in the client, as is often understood to be the case with transference and countertransference. In CBP, we see the successful recognition and repair of these events as key moments of healing in therapy with clients with histories of emotional neglect and abuse.

The conscious experience of therapist and/or client might be that they suddenly do not know what is happening between them, or that they feel frozen, that something is wrong. Less experienced trauma therapists are likely to leap into action, for example suggesting a topic or a regulation technique,

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activated or dysregulated when his spouse or child leaves a mess. There can be many protectors or few, depending on how many child parts there are and how fragmented the individual has had to become.

Finally in CBP, we view *many* individuals as having an adult self—or at least an underdeveloped or fragmented adult component of self—which may or may not have developed outside of trauma. The particular capabilities of this adult self that are critical to healing are the capacity to learn compassion for the whole self, including young parts, to be curious, and to have a bigger picture of the world. One easy test of whether a client has some adult self functions is, when they are struggling with a question like “What should I do about my neglectful and sometimes abusive boyfriend,” to ask them how they would advise a friend who came to them with that same question about herself. The clients who can say “I would tell her she should think about whether this relationship makes sense for her and consider breaking up with him,” are speaking from a coherent adult self. For clients who do not appear to have a functioning adult self but may have some fragmented capacities of this self, they might be able occasionally to take a larger perspective on their children's difficulties or why they themselves are struggling so much in their lives, but that clarity is only accessible occasionally or about a few topics. How to continue to develop, integrate, and strengthen the adult self is crucial in CBP, because the adult self needs to help heal dissociated parts. When clients do not appear to have anything approximating an adult self, it makes the work slower and the ultimate prognosis less positive.

In CBP, we have developed a model for working with parts that has three levels. The first, which is useful for virtually all clients

because it makes them feel they are very disturbed, like having schizophrenia or dissociative identity disorder. Normalizing the idea of parts as something inherent in everyone, to greater or lesser degrees of dissociation, often helps. In fact, most clients are receptive to it and may be greatly relieved that they are not “crazy” or schizophrenic because they have parts. It is important to note that the existence of dissociated parts does not imply a psychiatric diagnosis of dissociative identity disorder; it can also include complex or classic PTSD. Often the language matters to clients: parts may resonate with some, but others prefer the therapist to use feeling language or some other unique way of describing the idea of parts. For example, one client referred to her various “planets” and another to his “brothers.” It is never useful to force a perspective on clients if it does not resonate, but therapists often reraise the idea of parts as the therapy continues.

The second level of parts work involves focusing on parts cognitively but not affectively. When a client comes in ashamed and regretful because she yelled at her adolescent daughter, the therapist might say something like, “Some part of you gets triggered by your daughter.” This kind of comment helps the client develop a frame for understanding her mystifying behavior. It indicates that the therapist does not think she, as a total person, gets that angry with her daughter, but rather that this is a part of her. It continues to educate the client about parts and what therapists mean by parts. It paves the way for the next step in the intervention, which may be to say, “Do you know what things your daughter does that particularly get to that part of you?” This question may then lead to further discussion of the daughter's specific behavior and eventually to the events in the client's family of origin that set

or becoming overtly reactive to the client. CBP advocates for therapists to first learn the signals that an enactment is occurring. When noticing these signals, therapists need to stop doing and start thinking and feeling about what is occurring. It is then appropriate to say to most clients—the ones who can tolerate a process comment, which is most clients at some point in the therapy—that something seems to have happened between them, or that they noticed a different feelings in themselves, and ask if the client noticed anything. Often they have. It might then be appropriate to say to the client, if it is the first time this process has occurred in the therapy, “I could tell you what I experienced or you could go first; which do you prefer?” The therapist and client each take a few moments together to try to discern what was going on between them when the enactment began, and then each describe as honestly as possible their internal experiences during the period of the disturbance. A client who is experienced at these processing moments might say, “It felt to me from your tone that you disapproved of what I said to my partner, and then part of me got mad at you.” The therapist might then say:

A part of me appreciated that you were standing up for yourself in that interaction and another kid part of me, the part that likes everyone to be “nice,” was a little distressed by it. I am sorry that the disapproving part of me came out in my tone. I think you have done a good job describing it.

In further discussion, it may become clear that some young part of the client also disapproved of what the client had said because it was not “nice,” and the therapist was either carrying that emotion for the client or joining with it because of their own young part.

These process discussions of enactments are reparative and sometimes the first time in the client’s life that such direct and explicit emotional repairs have occurred. When the therapist routinely and comfortably takes responsibility for his own missteps and misattunements, it models a kind of relationship the client has likely never experienced. When it is not recognized and acknowledged by the therapist, either because of the therapist’s lack of self-knowledge or comfort with acknowledging their mistakes, therapies can and do become stuck. There are also clients who are not able to do this kind of work, sometimes for many years of therapy, and in those cases we have

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Suggested Websites

The Trauma Center at Justice Resource Institute, www.traumacenter.org

Centers for Disease Control, Adverse Childhood Experiences Study, www.cdc.gov/violenceprevention/acestudy

found that the therapist has to hold the awareness of what is occurring until the client can tolerate these discussions.

Narrative component. These clients, as described by several contemporary trauma theorists and in our book in a special contribution by psychologist Jodie Wigren, struggle with meaning making. This process requires knowing their larger stories, which is often challenging both because their stories are so difficult and because of dissociation and fragmentation among the parts of the self who hold aspects of the story. Helping these clients build a coherent narrative about large and small aspects of themselves is key to recovery and occurs in almost all aspects of the work. Typically, as they struggle to share pieces of their narrative—in dreams, enactments, body language, and recollections—the therapist and adult self of the

client struggle to understand. This process helps to clarify the story and build both of their attachments to the characters in the story, which are the client at different stages of life. As this work progresses, clients begin to explore what happened inside themselves to cope with their experiences and to learn more about their inner space and how it has been shaped by their early trauma. The therapist also assists in helping connect different parts of the story, for example how being subjected to endless angry tirades by his father in childhood has led the client now to shut down and withdraw whenever he perceives even a small conflict or tension in a current personal or professional interaction.

In CBP, therapists are taught to notice the gaps in the stories they begin to hear and to attend to the various cultural contexts within which the narrative is constructed, which provides a wider perspec-

tive and helps to make the stories more complete. The development of clients' narratives occurs in every aspect of the work, from the way clients approach therapy, to the side comments they make and the enactments in which they participate. All are ways of "telling" their narrative and the ways we encourage therapists to listen. Some stories have not been shared because they are too horrible and because telling them and insisting on their truth may lead the client to be cut off by or to have to cut off from their family. CBP emphasizes the importance of making these possible outcomes clear, and therapists help to create a safe space for the client to weigh the possibilities for and against telling. Often clients cannot tell because they have forgotten, or more likely, dissociated parts hold the information that the adult self cannot yet access. Marked emotional dysregulation often accompanies the beginning of telling these dark stories, and the therapist must both continue to help clients build stronger and less problematic methods of self-regulation and also guide the pacing of the telling.

With this particular group of clients, much of their stories are about what didn't happen—the lack of adequate emotional support, of mirroring, of being taught about emotions and regulation—and these are typically the parts of the story they cannot tell. Instead they show their therapists in what they expect and do not expect from them and from others in their lives, and in the enactments therapists experience with them. In this way, therapists come to understand how what didn't happen, and the clients' resulting relational styles, have shaped their identities over time.

Therapists, of course, also have their narratives, professional and personal, and these also change over the course of their work, although generally less dramatically than those of clients. Therapists' narratives affect what they can see and what they fail to see, what they can respond to and what they avoid, and what needs of their own they bring to their work.

Developing a narrative is a way of making meaning, which is central to the task of healing for these clients. Coming to terms with questions like "Why did this happen to me?" or "Why did they abandon me?" are important aspects of these therapies, even if sometimes they are ultimately answered by

the clients' understanding of "I may never know." In two studies of resilient male and female survivors of childhood trauma by psychologists Frances Grossman, Lynn Sorsoli, and Maryam Kia-Keating, survivors found a commitment to helping others, sometimes using what they had learned in healing from their traumas, to be greatly satisfying. Furthermore, engaging in helping others seemed equally helpful whether or not survivors associated it with their traumatic histories.

Finally, we have observed that clients impacted by complex childhood trauma seem to evolve in a five-stage process of identity development. The first is *no self*, emphasizing the emptiness and disconnection. The second is *damaged self*, during which shame about being so damaged is a key emotion, as well as a sense of being bad or evil, and/or being irrevocably damaged. The third stage is *victim*, in which the client focuses on the harm done to them. The fourth is *survivor*, which has historically often been regarded as the appropriate end of trauma therapy, in which the client's identity is still focused around the abusive history but the individual has grown significantly and is living life much more fully. Some individuals arrive at a fifth stage: that of *person*, in which their traumatic history becomes one aspect of the many life experiences and influences that have brought them to become the person they are.

In CBP, movement across these stages is seen as fluid. This therapeutic work often involves helping clients envision, glimpse, or come to believe in the possibility of higher stages of identity, and when possible, to hold onto and sustain experiences of self at higher levels of identity in the present moment. Notably, different parts of self often carry different stages of identity development, and not all clients go through all stages. CBP also proposes various facets and stages of the trauma therapist's professional identity that variously inform, limit, enhance, become challenged by, and have opportunity to evolve in the context of this work.

Conclusion

In this brief introduction to CBP, we describe how the model integrates recent work in the trauma field with classic ap-

proaches to psychotherapy to advance four 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).

The CBP model awaits empirical validation through carefully controlled outcome research, but to date we have amassed considerable *practice-based evidence* of its utility. At our trauma-specialty clinic and private practices in Greater Boston, we have a long history of implementation of this model with a mix of urban adults of color living in poverty amid high crime neighborhoods in Boston and upper-middle class to economically privileged adults living, working and quietly suffering lives of self-degradation, emotional constriction and isolation across Metropolitan Boston. In addition, over the past several years we have conducted extensive training and ongoing clinical supervision in CBP for therapists working with diverse clinical populations of complex trauma survivors in a rich variety of settings. These include Caucasian and Black adults receiving Christian and pastoral counseling at a community-based general outpatient clinic in Tennessee and an exclusively Medicaid-insured, adult population of Caucasian, Black, and Alaskan Native adults with extensive trauma histories and comorbid substance abuse/dependence and/or severe and persistent mental illness receiving outpatient services at a large community-based mental health system in Anchorage, Alaska. Ultimately, the value of CBP, as should be the case for any model of psychotherapy, will hopefully rest at least as much upon its demonstrated capacity in replicable, real-life practice to help many adult survivors of childhood trauma transcend suffering and live meaningful lives, as on the validation that comes from the test of its efficacy in a carefully designed, randomized controlled trial (see Appendix for suggestions of further reading and web sites).

Keywords: emotional abuse; emotional neglect; complex trauma; Component-Based Psychotherapy