The Power of the Therapeutic Alliance in the Treatment of Complex Trauma

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Objectives

- Understand the key components of the therapeutic alliance.
- Recognize the barriers in therapy faced by clients with complex PTSD and attachment trauma
- Understand the role of the therapeutic alliance in healing complex trauma
- Apply the therapeutic alliance to the treatment of your clients with complex PTSD and Attachment Trauma
- Analyze the importance of adequate self-compassion in creating and maintaining a strong therapeutic alliance

Section 1: Key Components of the Therapeutic Alliance

“When a person realizes he has been deeply heard, his eyes moisten. I think in some real sense he is weeping for joy. It is as though he were saying, “Thank God, somebody heard me. Someone knows what it’s like to be me.”

Carl Rogers

Therapeutic Alliance

A therapeutic alliance is defined as the collaborative, trusting relationship between a therapist and a client. It is sometimes referred to as the “working alliance." The therapeutic alliance provides an essential foundation for successful therapy; without it, therapeutic progress would be difficult, if not impossible.

Four Key Elements of The Therapeutic Alliance

Positive Rapport: Therapists should strive to create a non-judgmental, supportive environment for clients.[1] This includes setting clear boundaries, providing feedback in an empathetic manner, and actively listening to what the client has to say.

Mutual Agreement on Goals: The therapist and client must agree on the goals of therapy in order for it to be successful.[2]The therapeutic alliance is reinforced when both parties can openly discuss and explore different possibilities together.

Realistic Expectations: During the course of treatment, therapists and clients should remain realistic about what can be achieved within the given timeframe and resources available.[3] Setting expectations too high may lead to feelings of disappointment or frustration if they are not met.

Sharing Responsibility: Both the therapist and client must share responsibility for progress towards the therapy goals.[4] The therapist should provide guidance and support while allowing the client to take an active role in his or her own healing process. Ultimately, it is up to the client to make use of their therapeutic experience and apply it in daily life.

The active components in the therapeutic relationship according to Carl Rogers

- **Empathy**
- **Congruence**
- **Unconditional Positive Regard**

Empathy

“The state of empathy, or being empathic, is to perceive the internal frame of reference of another with accuracy, and with the emotional components and meanings which pertain thereto, as if one were the other person, but without ever losing the 'as if' condition.”

Congruence

Carl Rogers believed that for a person to achieve self-actualization, they must be in a state of congruence. This means that self-actualization occurs when a person's “ideal self” (i.e., who they would like to be) is congruent with their actual behavior (self-image)

Unconditional Positive Regard

According to Rogers, unconditional positive regard involves showing complete support and acceptance of a person no matter what that person says or does.

The therapist accepts and supports the client, no matter what they say or do, placing no conditions on this acceptance. That means the therapist supports the client, whether they are expressing "good" behaviors and emotions or "bad" ones.

Section 2:

Understanding the barriers in therapy caused by complex PTSD and Interpersonal trauma

“Trauma is perhaps the most avoided,ignored, belittled, denied, misunderstood, and untreated cause of human suffering.”

Peter Levine

Trauma

A traumatic experience is one that overwhelms our capacity to cope and function in our everyday lives. It may come from repeated experiences such as childhood abuse, neglect, intimate partner violence or sexual abuse. It is important to note, however, that it is not the event itself which creates the trauma; rather, it is how wounded we are by the event.

Trauma comes from the Greek word meaning “wound”. Trauma may also arise from single incidents such as an accident, a crime, the death of a loved one or a natural disaster.

The Impact of childhood trauma on interpersonal relationships

If we have not experienced secure attachment in childhood, or have had our sense of security ruptured by adverse childhood experiences such as sexual or emotional abuse, our ability to self-regulate is compromised and we are likely to go on to develop dysfunctional attachment styles. These can significantly negatively impact our adult interpersonal relationships.

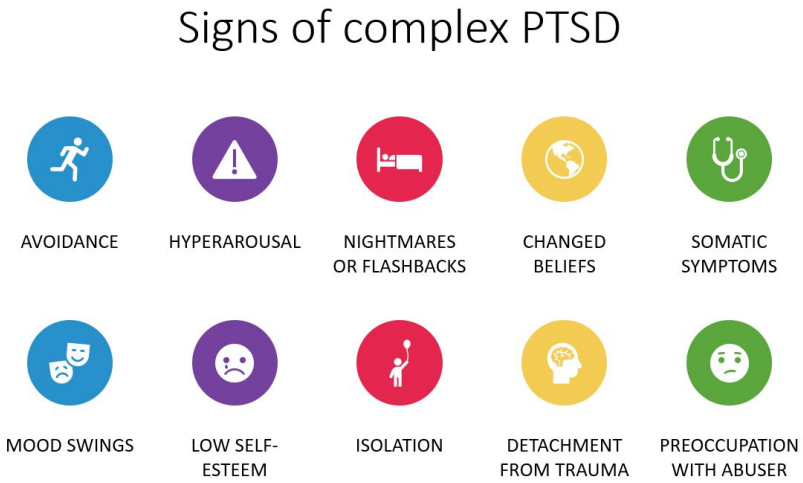
- Secure Attachment
- Avoidant Attachment
- Ambivalent Attachment
- Disorganised Attachment

Avoidant attachment is characterized by having discomfort with emotional intimacy, a strong desire for independence, and difficulty wholly trusting others as a result of our needs not being met by our primary caregivers, so we choose – consciously or unconsciously – to ignore them or try to get them met by ourselves. As we develop into adulthood, this typically manifests as social avoidance and emotionally distant interpersonal relationships.

Ambivalent attachment style usually forms if the perpetrator of abuse was responsive at times and neglectful at others. Interpersonal relationships are impacted by ambivalent attachment styles as the person is likely to experience deep insecurity and will easily become frustrated, even resentful, if they feel vulnerable or misunderstood.

Disorganised attachment is likely to be fearful of relationships, while at the same time feeling a deep desire for emotional connection. Intimacy and being alone are scary thoughts, yet displaying affection for others is difficult. As a result, the ability to form healthy interpersonal relationships is compromised. Those with disorganised attachment styles as a result of childhood trauma often have poor emotional regulation, a poor understanding of social cues, and a distrust of other people.

Signs of Complex Trauma:



Section 3: Understanding the role of the therapeutic alliance in healing complex trauma

Five types of therapeutic alliances commonly used in therapy:

Directive Alliance: This type of alliance is focused on the therapist taking an active role by providing instructions and feedback to facilitate changes in behavior or thought patterns.

Nondirective Alliance: In this type of alliance, the therapist takes a passive role and does not give direct advice or instructions, instead allowing the client to explore their own solutions to problems through self-reflection and discussion.

Facilitative Alliance: This type of alliance is focused on exploring the client's feelings, thoughts, and emotions in order to facilitate personal growth

Supportive Alliance: In this type of alliance, the therapist offers emotional support and comfort to the client while providing guidance as needed.

Task-Oriented Alliance: This type of alliance is focused on helping clients attain specific goals or acquire new skills through practical activities or assignments given by the therapist

Clinical Vignette

Mr. Terrence Jones is a 26-year-old man who is employed in the construction industry. He has been experiencing sleep difficulties, lack of energy and motivation, lack of patience, and less productivity at his job. His boss encouraged him to see a doctor about these symptoms. His primary care physician referred him to a Psychiatrist, Dr. Kurtz, after a normal medical workup.

Mr. Jones appeared uncomfortable when Dr. Kurtz met him in the waiting room. Dr. Kurtz smiled encouragingly when they sat in his office.

“Your primary care doctor referred you to me, thinking you might be depressed. Have you seen a mental health professional before?” Dr. Kurtz queried.

“No,” Mr. Jones replied curtly.

“Hmm. Well, if I am the first psychiatrist you’ve seen, I guess I’d better make a good impression,” Dr. Kurtz quipped humorously, in an obvious attempt to help Mr. Jones feel more comfortable.

Mr. Jones donned a wry smile and replied frankly, “Doc, let me be honest with you. I don’t want to sit and talk about my problems. I have enough on my plate without having to spill out my guts about everything that is bothering me. I just want to be able to sleep and get my energy back. I’m afraid I am going to get fired from my job.”

Clinical Vignette Cont.

Dr. Kurtz gazed empathically at Mr. Jones. “Wow. It must have been really hard to come here. I’m sorry life has been so hard. How do you think I can be helpful?”

“Honestly, I don’t think you can help me. Maybe give me a medicine that I don’t really want to take and robs me of my sex drive. I don’t know,” Mr. Jones replied sarcastically, with a hint of defeat in his tone.

Dr. Kurtz pursed his lips thoughtfully, still gazing at Mr. Jones. “Thank you for being honest, Mr. Jones. And I’m glad you came here. You know what you want and what you don’t want. I admire that. I think we can work together, if you agree.”

Dr. Kurtz went on to ask more diagnostic questions and to learn of Mr. Jones’s fears and hopes about mental health treatment. They reviewed safety concerns, stressors, and supports. Mr. Jones even admitted that he didn’t think a Jewish doctor could understand or “really ‘get’ a black working man.”

Dr. Kurtz smiled. “I really do love your honesty. Some people never are aware enough and brave enough to say what they feel. I’ll really try to listen and understand you. I hope you will let me know if you feel I am or am not ‘getting’ you.”

They discussed an antidepressant medication and chose bupropion because it has fewer sexual side effects. They also made a plan to increase Mr. Jones’s socialization with friends and family, add sleep hygiene and melatonin as needed to improve his sleep patterns, and include psychotherapy with the medication treatment when he returned in one week.

“Hey, doc, you’re not so bad,” Mr. Jones said with a broad, relieved smile as he was leaving. He firmly shook Dr. Kurtz’s hand and stated, “See you next week.”

Break into small groups of 8-10 and discuss which of the five therapeutic alliances Dr. kurtz used in the vignette.
(7 Minutes)


We heal interpersonal trauma
through interpersonal healing

Section 4:
Compassion Fatigue:
The price we pay for change!

Compassion Fatigue

Also called “vicarious traumatization” or secondary traumatization (Figley, 1995). The emotional residue or strain of exposure to working with those suffering from the consequences of traumatic events. It differs from burnout, but can co-exist. Compassion Fatigue can occur due to exposure on one case or can be due to a “cumulative” level of trauma.

Dr. Charles Figley on Compassion Fatigue

“We have not been directly exposed to the trauma scene, but we hear the story told with such intensity, or we hear similar stories so often, or we have the gift and curse of extreme empathyand we suffer. We feel the feelings of our clients. We experience their fears. We dream their dreams. Eventually, we lose a certain spark of optimism, humor and hope. We tire. We aren’t sick, but we aren’t ourselves.”

C. Figley, 1995

Symptoms of Compassion Fatigue

- **Negative emotions, including anger, annoyance, intolerance, irritability, skepticism, cynicism, embitterment, and resentfulness**
- **Interpersonal problems, including difficulties getting along with others and problems with intimacy, resulting in hurt feelings, disappointments, and disconnection.**
- **There may be mood swings, tearfulness, anxiety, irrational fears, melancholy, sadness, and despair**
- **There may be lapses in memory or forgetfulness**

Compassion fatigue disturbs the ability to think clearly, modulate emotions, feel effective, and maintain hopetion

Professional Symptoms of Compassion Fatigue

•Compassion fatigue can cause a sense of dread working with certain patients and clients, and in certain situations

•Some people with compassion fatigue may eventually find professional life unfulfilling. No longer enjoying work, and disappointed, disheartened, and disillusioned, they may turn to alcohol or drugs to ease the discomfort

•They may engage in premature job changes, believing the problem to be specific to the place, or type, of employment.

•Becoming less productive and effective professionally

Self-Care Tips

•Declutter and redecorate your workspace
•Unplug for an hour. Switch everything to airplane mode and free yourself from the constant bings of social media and email
•Join a supervision/peer support group
•Attend workshops/professional training
•Ask for help—big or small, but reach out
•Reflect on three good things that happen every day
•Cut yourself a break
•Say no to strenuous demands more, and yes to more self-care

What Do We Know Now??

- The key components of the therapeutic alliance
- The barriers in therapy due to PTSD and Attachment issues
- The importance of self care and compassion in creating and maintaining a strong therapeutic alliance with clients.

Questions & Answers

Thank you!!

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