

Volume 1 | Issue 1

Frontiers in the Psychotherapy of Trauma & Dissociation

*The Official Clinical Journal of
the International Society for the
Study of Trauma and Dissociation*

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Frontiers in the Psychotherapy of Trauma & Dissociation

The Official Clinical Journal of the ISSTD

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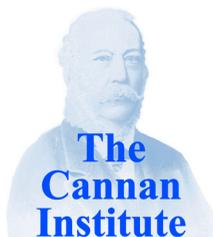
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EDITORIAL

Sources for Psychotherapy's Improvement and Criteria for Psychotherapy's Efficacy

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The publication of the first issue of Frontiers is a happy occasion. In this editorial, I take the opportunity to share my vision of it becoming the forum for clinicians to test their insights and interventions with colleagues of various theoretical views, by means of thoughtful articles and follow-up commentaries. I also share how I use the principles of the journal's mission statement in my clinical practice and writings. Among other expectations and suggestions, that statement encourages authors to (a) demonstrate how related disciplines help us improve psychotherapy for persons with complex trauma-related disorders related disciplines; (b) report the psychological, behavioral and/or social outcomes that they use as criteria for success. Here, I share my gratification with using concepts and findings from social psychology and anthropology, how they helped me understand the interpersonal operations of power abuse. I learned about the function of intimacy in good caretaking. When a child fears reasons like selfishness or neglect for the caretaker's failure to fulfill the child's expectations, caretakers ordinarily relinquish their power to deceive the child. Instead, they disclose such reasons and promise to prove their intention to remedy them, as the child understands proof of that intention. I learned how untrustworthy caretakers abuse that principle of intimacy. That, in turn, helped me discern my patients' specific fixation from such childhood experience, a flawed working model about the interpersonal operations of intimacy. I have treated it as their fundamental impairment while they suffer disorder during crises of trust in later relationships. Therefore, I measure my psychotherapy's efficacy

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in degrees of correcting that impairment. I measure it in my patients' competence to cultivate intimacy for restoration of trust in their troubled relationships.

KEYWORDS *shared reasoning; power abuse; intimacy; fundamental shortcoming*

Welcome to the Inaugural issue of *Frontiers in the Psychotherapy of Trauma and Dissociation*.

Our inaugural issue guest authors:

Richard P. Kluft, M.D., Ph.D.

Joyanna L Silberg, Ph. D. and Chevy Schwartz Lapin, MA

Ellert R.S. Nijenhuis, Ph.D.

Writing this editorial is a happy occasion for me. Our new journal, *Frontiers in the Psychotherapy of Trauma and Dissociation*, is a great instrument for our Society's advancement and for fulfillment of its mission. I envision this journal as the medium for shared reasoning about defining good psychotherapy for patients with complex trauma-related and dissociative disorders. I look forward to working with everyone inspired to make that happen.

1. SHARED REASONING

The concept of "shared reasoning" sums up my understanding of how people grow knowledge (Kuhn, 1962). Clinicians often replicate one another's insights and improvisations that seem to end commonly encountered impasses in patients' objectives in psychotherapy. For example, clinicians routinely make hypotheses about patients' reasons to behave counter to insights they already embraced in therapy, mostly reasons latent to patients themselves. Then, they improvise interventions to address the postulated reasons, occasionally with good outcomes. Many creative clinicians do not have opportunities to test their insights and interventions with colleagues of the same or different theoretical views. That is one phase of shared reasoning in growing knowledge. Could *Frontiers* stage such opportunities, e.g., with thoughtful articles and commentaries or special issues? Steve Frankel and I believe that lessons shared collegially among front-line practitioners are indeed the seed for hypotheses to test in empirical research and for revision to existing theories. To set the stage for sharing lessons collegially, we will advise authors to explain how they tested alternative hypotheses and why they attribute the good outcome to the particular intervention, instead of other therapeutic and extratherapeutic developments that often coincide with it (Fonagy & Bateman, 2005; Paris, 2005).

Myself, as an author, I would look forward to being challenged to make such discriminations by reviewers and postpublication commentaries. In my view, a good critic is one who first presumes that my insight has merit and challenges me to test it in their clinical impasses; it is someone who joins me in looking at their objectives through my eyes, probably helping me to refine my vision in ways I could not pursue alone. Then, in my turn, I should join them in reasoning about the merit of competing insights and interventions. It is well understood that people become ready to explore a competing paradigm after they logically exhaust the heuristic power of their own (Kuhn, 1962).

I envision *Frontiers* becoming the medium for that kind of reasonable, collegial discussion among competing clinical paradigms, beyond merely showcasing each one's merit alone. To that end, the potential of an online clinical journal is far greater than discussing presentations in our Annual Conference or sharing the syllabus of our Professional Training Programs. I cherish the prospect of a wide readership of clinicians watching a few clinicians reasoning jointly about psychotherapy's stepwise maturation and criteria of its efficacy.

2. MY ADVENTURES AS A PSYCHOTHERAPIST

Learning and then improving my psychotherapy has been a laborious endeavor. My training as a psychiatrist at the Sheppard Pratt Hospital (in Maryland, USA) included providing five hours a week of individual psychodynamic psychotherapy for each patient, plus group and family therapy. In return, trainees got five hours per week of psychotherapy supervision. For decades afterward, I worked in public systems of care for patients with every diagnosis, learning from clinicians who used every modality of treatment. I have witnessed the evolution of many schools of psychotherapy. I sought firsthand experience with several of them in the spirit of becoming able to compare conceptual paradigms and techniques in my clinical practice.

I have been primarily a clinician, in the sense that I have spent virtually all of my professional career treating patients and supervising others' treatment. In another sense, in the way my mind works while I treat patients, I have always been a theoretician and a researcher. Whenever my engagement with a patient becomes unproductive, I make and test competing hypotheses about the patient's mental workings and why that happened. That is how I develop my conceptual insights and treatment techniques. In my academic teaching, I have always invited medical students and psychiatry residents to do the same.

I had my best opportunity to develop psychotherapy in collaboration with other clinicians during 15 years as Medical Director for the Cape Cod

and the Islands Community Mental Health Center (in Massachusetts, USA). There, my personal mission was to develop psychodynamic psychotherapy for patients with personality and trauma-related disorders who were in the care of government-sponsored services. My concepts and techniques have come together in a model of psychotherapy, the Role Reconstruction Therapy (RRT), formerly known as the Cape Cod Model (Laddis, 2010, 2011).

3. MY SOURCES FOR PSYCHOTHERAPY'S IMPROVEMENT

The mission statement for *Frontiers* includes paying due attention to disciplines pertinent for psychotherapy's development. I am a physician, but my heart is in psychotherapy and in learning from anthropology, social psychology, and cognitive psychology. I believe that such knowledge will provide bridges for integration among schools of psychotherapy. Here, I will illustrate its benefit for my practice.

Anthropology and social psychology (beyond Attachment Theory) helped me understand the interpersonal mechanisms of power use and abuse. I learned how people in authority manipulate dependents' expectations and intentions for benevolent, care-taking purposes as well as for self-serving ones (Boehm & Flack, 2010; Gluckman, 1965; Overbeck, 2010). Then, I learned about the interpersonal operations of intimacy, the social mechanism whereby people may create assurances for one another's trustworthiness in "familial" relationships. Social psychology and anthropology have illuminated the qualitative difference between "familial" and "exchange" relationships in regard to purpose and rules for the failing or the aggrieved partner's role in restoring trustworthiness (Clark & Mills, 2012; Fiske, 1991).

In familial relationships, partners commit jointly to long-term goals by means of taking care of each other's current needs, as relevant for fulfillment of their roles in various other relationships and into the future. Relationships that people commonly make familial are, for example, with their children, a brother, a lover, or a lifemate. Familial partners make their commitment without preconditions; they make it before they can know the magnitude of the other's future needs and who may become unable to contribute. As is typical for parent-child relationships, one partner may understand and prioritize the other's needs better than the person in need can. Then, the dependent may endure certain pains and sacrifices as the means to that end, merely with faith, pending proof of its benefit. Intimacy is the collaborative mode in which partners restore trust when one partner fails promises made and expectations fostered. To that end, the failing partner discloses shortcomings, like selfish motives and psychological immaturities, sometimes latent ones, outside one's immediate awareness. The aggrieved partner, in turn, accommodates failure and helps with correction

of such shortcomings, without exploitative trade-offs or punishment, pending proof of the failing partner's intent to correct those shortcomings. For both, the incentive is jointly valued, long-term goals for fulfillment of both partners' roles. Instead, partners in exchange relationships trade benefits, one deal at a time, without regard for each other's future. To the contrary, they often have incentives and the prerogative to misrepresent reasons for making the deal.

From social psychology, I learned how self-serving caretakers manipulate a child to serve their own needs and wants, seemingly for the child's future benefit (Boehm & Flack, 2010; Wolff, 1983). Self-serving caretakers require the child to endure certain pains and sacrifices, which they falsely justify as necessary for the child's own future benefit. Additionally, they create appearances that alternative caretakers are untrustworthy or that the child is unworthy of them. They then use their material advantages and social prerogatives to obstruct the child's access to experiences and judgments otherwise. Such manipulation perverts the caretakers' fundamental function: to inspire the child with faith and endurance for pains and sacrifices for the child's own benefit (Laddis, 2011, 2015)? Understanding all that helped me discern my patients' psychodynamics during crises of trust in later familial relationships—i.e., when they must ascertain the veracity of others' reasons to fail promises they made and expectations they fostered. What struck me as a fundamental shortcoming was how stunted our patients' imagination is about the potential for intimacy in social reality. They often yearn for it, for partners who disclose selfish motives and immaturities and who then promise to prove their intention to correct those shortcomings. They yearn for that kind of certainty, because many seem to attain it occasionally. However, with every new inkling of betrayal in a relationship, our patients can no longer imagine the particular partner to have reasons and the will to relinquish the power to manipulate and deceive them. The next thing that struck me, nonetheless, was how eager our patients remain to have that reflexive weariness proven wrong if we offer to coach them about managing the risks of intimacy in the troubled relationship (Laddis, 2010).

4. CRITERIA FOR PSYCHOTHERAPY'S EFFICACY: PATIENTS' COMPETENCE TO MANAGE THE RISKS OF INTIMACY

The prevailing model of sequential psychotherapy for patients with complex trauma-related disorders measures efficacy in terms of the patients' progression in three phases. It aims for a phase 3, when patients pursue fulfillment in long-term, familial relationships, e.g., with parents, siblings, bosom friends, and lifemates (Courtois, Ford, & Cloitre, 2009; Ford & Courtois, 2009). The two preceding phases are designed to help patients become

confident to discern and manage risks of betrayal in the laboratory of the therapeutic relationship. That happens in contrast with patients' memory of powerlessness to do so during recurrent traumatic betrayal in earlier relationships. It is fair to say that we have no empirical investigations of phase 3 outcomes, let alone that we have no instrument that measures patients' competence to manage the risks of intimacy. On the contrary, we have consistent research findings that patients remain apprehensive of making the transition to phase 3, *even after measurable success in phases 1 and 2.*

Long ago, two pioneers of psychotherapy for Borderline Personality Disorder (BPD), Lorna Benjamin (1997) and Marsha Linehan (1997), proposed a project for psychotherapy's development beyond successful mitigation of symptoms (phases 1 and 2). I have reasons to include BPD among the variants of complex posttraumatic disorders, along with DID and Complex PTSD and to extend Benjamin's and Linehan's proposal to psychotherapy for the latter (Laddis, 2011, 2015). Linehan lamented that psychotherapy had so far helped patients merely pass "from loud to quiet desperation." She heralded such progress as a necessary means to the patients' later fulfillment, not relief worth resigning to. Benjamin and Linehan proposed a project to investigate the comparative efficacy of psychotherapies that compete about discerning and remediating the disorder's "core dysfunction." They surmised that none among schools of sequential psychotherapy, including their own, had targeted the true core dysfunction of BPD, or, otherwise, had not remedied it enough for patients to confidently expose themselves to threat of grave betrayal outside therapy (phase 3). They implied that: (a) The stepwise measure for psychotherapy's efficacy should be increments of the core dysfunction's remediation, and (b) the true test of such remediation would be patients' exposure to threat of grave betrayal in their "real-world" relationships.

In my view, analyzing patients' reasoning during crises of trust in the therapeutic relationship indeed pertains to remediating their core or fundamental dysfunction. I believe that analysis of the transference is sequential psychotherapy's great advantage over treatment with prolonged exposure², which aims merely for the patients' desensitization to reminders of traumatic betrayal. Analysis of patients' transference is an exercise in "mentalizing," i.e., discerning the therapist's reasons and intentions. Patients begin with assumptions they transfer from old relationships, including assumptions latent to themselves, not immediately evident. A surge of studies in

²Psychotherapy by "prolonged exposure" (PE) uses gradual desensitization to reminders of traumatic betrayal. Most studies of PE's efficacy properly measure only mitigation of hyperarousal, avoidance and flashbacks (Jayawickreme et al., 2013; Reger et al., 2016; van Minnen et al., 2016; Yehuda & Hoge, 2016). When some occasionally report also improvement in social or "global" functioning, the measuring instruments are too crude to allow inferences about patients having attained intimacy in familial relationships (Cloitre, 2015).

recent years showed seemingly paradoxical findings about the ability of persons with BPD to mentalize and correct such assumptions. Several studies showed that they have much trouble discerning others' intentions (Fonagy & Bateman, 2016; Preißler, Dziobek, Ritter, Heekeren, & Roepke, 2010; Sharp, 2014); however, others showed persons with BPD to have "superior mentalizing" ability (Fertuck et al., 2009). It is important to distinguish between patients' eagerness versus ability to mentalize. I think that patients with BPD doubt their ability to discern others' intentions for good reason. Therefore, they are more eager to attune to others' moods and spoken cues for those intentions than nonclinical subjects are. Worse yet, when it pertains to fear of mortal betrayal, they test the needed and feared person's trustworthiness (they mentalize) unstoppably. They test the veracity of the other's moods and words incessantly, despite awareness of their mentalizing ability's futility, which is the hallmark of mental disorder. I myself attribute that inability to find closure to errors in their mentalizing operations, errors born of manipulation by caretakers who wanted to make their own spoken reasons and intentions untestable (Laddis, 2010, 2011). Yet another finding from mentalization studies concurs with my explanation. That finding shows "*recursive* social-information processing. . . culminating in hypermentalizing in BPD" (Sharp, 2014; p. 211; italics added).

If analysis of the transference pertains to remediation of patients' core dysfunction, *more or less*, why do they remain apprehensive for phase 3? Two decades after Benjamin's and Linehan's manifestos, findings of such apprehension have been replicated by researchers of every theoretical orientation and motive (Bungert et al., 2015; Cloitre, 2016; Dorrepaal et al., 2014; Steenkamp, 2016; Zanarini et al., 2007). Despite unchanging statistics, we have many heartwarming exceptions, reports of patients who transitioned to phase 3 and became secure and fulfilled in familial relationships with psychotherapy's help. The authors of this inaugural issue have shared that kind of stories in their work. On the other hand, intriguingly, we also have occasional reports of similar outcomes without psychotherapy or for reasons unrelated to therapy's design (Fonagy & Bateman, 2005; Paris, 2005; Stone, 1993). What can we learn from success stories, whether with or without psychotherapy? What lessons can we draw to systematically adopt in our practice? I believe that we must ponder this question jointly with some urgency. To that end, I invited Chris Courtois, Kathy Steele and Bethany Brand to a panel discussion entitled "Is the gold standard of psychotherapy phases due for rethinking?" at the ISSTD Annual Conference in 2014.

For my part, the lesson I draw is that persons with complex posttraumatic disorder have no faith in restoring trustworthiness by the rules of intimacy. They cannot sustain faith in a social *reality* where people have reasons and the will to relinquish all power to manipulate and deceive their partners. They yearn for that kind of love, because many seem to attain it occasionally. However our patients quickly fall back on the futile way of

testing the truth of others' reasoning in troubled relationships without their partners' collaboration, even despite obstruction and punishment. Consequently, to end our patients' apprehension for phase 3 (making long-term, unconditional commitments of the familial kind), *it is necessary to remediate that fundamental shortcoming*. As we inaugurate *Frontiers*, I look forward to hosting articles that will grapple with how we measure progress in that regard.

5. OUR CLINICAL JOURNAL

How did my clinical adventures lead me to care so much for this journal's mission? Along the way, I discovered that: (a) I made progress by studying schools of psychotherapy and related disciplines systematically, also by staging occasions for shared reasoning with colleagues and trainees, and (b) many of my endeavors depended on luck and endurance. Often, I wished someone had compiled that curriculum and had staged those exchanges deliberately for me. I hope that we will make *Frontiers* just that kind of opportunity. A few years ago, I discovered that Steve Frankel shared that hope. We urged the Society's officers to study the feasibility of it. To our satisfaction, the Board of Directors approved the project last spring and took applications for the positions of coeditors. My pleasure was doubled when the Board matched me with Steve Frankel, a seasoned clinician and tireless ISSTD leader.

We intend *Frontiers* as a vehicle for the competition and maturation of concepts, skills and interventions for effective treatment of the posttraumatic and dissociative disorders seen among survivors of traumatic abuse and betrayal. In addition to articles about treatment of clients traumatized repeatedly in personal relationships, we encourage submission by authors who discern and treat the consequences of traumatic abuse and betrayal by the larger community. Such trauma pertains, for example, to (a) failure of institutions designated to correct abuse in personal relationships, and (b) suffering oppression and discrimination as a member of a group (racial, ethnic, religious, gender, etc.). I propose that it is necessary to understand the *social* dynamics of cultivating trust and the mechanisms of deception and exploitation. In Judith Herman's tradition of emphasizing "captivity" (1992), we should study the social dynamics of power abuse and victims' entrapment in greatly needed and feared relationships. Our patients' psychodynamics can be inferred as a reflection of possibilities of countering the powerlessness inflicted on them.

We expect our reviewers to base their recommendation mainly on the relevance and conceptual merit of an article. For this reason, we ask reviewers to offer advice and coaching for the improvement of an article that has such merit. To that end, authors may be asked to (a) amplify input from

related disciplines (e.g., neuroscience, cognitive psychology, social psychology) and (b) give operational, measurable definitions of terms that signify cause or mechanism of disorder and psychotherapeutic outcomes (e.g., stabilization, intimacy, betrayal, abuse, dissociation, integration, etc.)

6. OUR FIRST GUEST AUTHORS

In this inaugural issue, we proudly host three articles by senior clinicians: from our Society, Rick Kluft, Ellert Nijenhuis, and Joy Silberg (with her coauthor Chevy Schwartz Lapin.) All three articles are about clinical skills to discern the patient's meaning of being in a state of trauma-related dissociation, in the manner of dissociative alters/parts or dissociative shutdown.

On first look, the articles by Kluft and Nijenhuis appear to take opposite perspectives about how to discover clinical truth, i.e., what is the latent cause of disorder and how psychotherapy may remedy it. That requires making theory-informed hypotheses about that latent mechanism and how our modification of the patient's conscious, phenomenal experience might remedy it. Obviously, that requires meticulous observation of clinical phenomena, what experiences make disorder come and go, including experiences that we deliberately, experimentally devise. EN begins by saying "Ideally, trauma therapy is grounded on defensible basic philosophical premises and a coherent, cohesive, and useful theory of human experience, thought, and behavior. Such sound primary suppositions premises and a viable theory greatly empower therapists to comprehend the intricacies of trauma in general and of chronic interpersonal trauma in particular." RK, on the other hand, admonishes us, "Don't marry your hypotheses." His "approach to dealing with dissociative phenomena in therapy. . . . makes little use of models of dissociation that fail to address many or all of the core features of DID." He passionately advises us to proceed with the conviction that *clinical phenomena make sense, even if that is not apparent immediately*. RK shares his intuitive, pragmatic reasoning for his pioneering method of making sense of alters' function, a method that he calls "invitational inclusionism." EN, too, implicitly gives us similar advice for making sense of clinical phenomena at every other step of his article. EN's reasons for his method of making sense of dissociative parts' function, "enactive trauma therapy", consist of exacting definitions of human nature and psychological trauma. On second look, despite the contrast in rigorousness of theoretical foundations, I find RK's and EN's clinical methods strikingly similar. They both guide their interventions with explicit hypotheses, but they do not marry their hypotheses. That is what good clinicians do!

The article by Joy Silberg and Chevy Schwartz Lapin is similarly about technique to discern the latent psychodynamics of dissociative shutdown in children. It is, furthermore, about the excitement and satisfaction of

cross-fertilization between models of psychotherapy for the creation of that technique. With “shutdown”, JS means traumatized children’s passage to “a dazed, frozen, unresponsive state”. Traumatized children’s outward activity during dissociative shutdown resembles the stereotypical, reflexive activity of anxious, developmentally delayed and autistic children, whereas it manifests the intricate psychodynamics of traumatization in children able to self-reflect. JS speaks of her excitement to have learned the Development, Individual Differences and Relationships (DIR) with the help of CL, who is a speech language pathologist and psychotherapist. The DIR is an assessment procedure that “unravels how deficits in developmental functioning interact and affect primary relationships”. JS learned to “more carefully watch activation of the whole body, looking at affect, body carriage, developmental level, verbal skills and level of play with more sensitivity. . .” in order to discriminate between trauma-related and other developmental deficits and “discontinuities”. In turn, CL learned from JS to look for behavior that should cue her to infer the psychodynamics of traumatization in a boy who, so far, had been treated for autism. She narrates the heartwarming story of fulfillment as a therapist, how she engaged that boy to come out of dissociative shutdown to share his experience of entrapment in an abusive relationship.

Welcome to *Frontiers in the Psychotherapy of Trauma and Dissociation!*

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