# *Relational complications in current trauma therapy*

## *or: why trauma therapy often isn't working as it 'should'*

***by Morit Heitzler & Michael Soth © 2017***

## *Introduction: extending single-event into developmental trauma?*

Trauma therapy, aided by revolutionary neuroscientific understandings, has been very successful over the last 20 years or so, and has expanded enormously. New trauma therapies have proliferated, new tools, techniques and methodolgies have been developed, the reach and scope of treatable conditions has been extended and public and scientific acclaim (NICE guidelines) as well as financial success have followed (Ecker, 2012; Levine, 1997; Kalsched, 1996; Rothschild, 2000; Schore, 2003; van der Kolk, 1996).
Having extended their reach beyond the traditional focus on critical incident debriefing and single-event trauma, the modern trauma therapies, however, have reached a threshold. Increasingly, trauma therapists come into supervision distraught, frustrated and despirited because it is not working as it 'should'. Supervisees report that clients who initially present with circumscribed single-event trauma either cannot or do not respond well to standard trauma techniques like finding a safe place, body scans, mindfulness, or learning techniques for self-soothing. Many clients, although apparently desperate, fail to cooperate or exhibit active resistance. Some push and test the boundaries of therapy (e.g. demanding contact in between sessions), question or criticise the therapist, and generally create an atmosphere of suspicion and mistrust. Or they just fail to get better in terms of the reduction of trauma symptoms.
In response to these unexpected problems, therapists report confusion or incompetence, shock or frustration, or - when more intense - feeling powerless, used or worthless. Occasionally therapists make sense of their response in terms of vicarious traumatisation.

This paper is a collaboration between Morit Heitzler and Michael Soth from our shared vantage point as supervisors. Morit has been practising a variety of trauma therapies since the mid-1990s, integrating Babette Rothschild's Somatic Trauma Therapy, E.M.D.R, Sensorimotor Therapy, Somatic Experiencing, Trauma Constellations and various other trauma therapies. Michael is known for integrating humanistic and psychoanalytic traditions to bring a more comprehensive embodied understanding to the relational vicissitudes of therapy (Soth 2005a).

Increasingly we find that our supervisees need help addressing the relational complications of what on the surface appears as fairly straightforward trauma treatment. We have been trying to find accessible formulations for these relational complications in a way which makes sense to therapists from across the diverse modalities. In this article we intend to share these with you, revolving primarily around the notion of the 'trauma quadrangle'.

## *Do the same principles apply to <u>all</u> trauma and to <u>all</u> trauma therapy?*

For many years the field of trauma therapy was based on a fairly clear-cut consensual distinction between two types of trauma (Heitzler 2009):

1. Single-event trauma: an incident that occurs once, usually in adult life, typically involving unexpected, sudden shock, where unprocessed fear for life lingers and manifests as PTSD.
2. Developmental trauma: occurs repeatedly or systematically in childhood and usually carries elements of neglect, invasion or abuse by care givers. This has much deeper impact on the developing child's psycho-biological structure, as it impairs the capacity for self-regulation and affects the perception of self and other. This type of prolonged traumatic experience can lead to the development of complex PTSD (Herman 1992) or Disorder of Extreme Stress (van der Kolk et. al. 1996).

Over recent years, the new somatic, energy and other trauma therapies have been increasingly extending their reach beyond clearly defined single-event trauma to include early and developmental trauma. This extension has been driven forward on the assumption that the same principles apply to *all* trauma and to *all* trauma therapy.

To some extent this assumption is valid, because what is is indeed similar in all kinds of trauma is:

1. the neurobiology: similar areas of the brain are affected, i.e. the cortex shutting down in flight-fight-freeze, with the parasympathetic acting like a lid of ice on top of a hyper-aroused sympathetic volcano
2. some of the psychological trauma symptoms: i.e. the subjective experience of the traumatised person e.g. flash backs and panic attacks, dissociation, attempts at self-medicating, etc.

However, increasingly we find that the neat binary distinction between single-event versus developmental trauma is questionable, and in many clinical contexts is becoming more misleading than helpful.
The field of trauma therapy itself has proactively been blurring that distinction, claiming effectiveness for psychological issues that used to be the province of psychoanalysis or depth psychotherapy. As a result, clients are now seeking therapy with more complex presentations, so we often end up with significant overlap between developmental and single event issues. This is not just problematic in terms of the therapist's more complex perception and understanding of the case, and the resulting intervention.

As soon as developmental trauma is involved, **what really matters is the client's implicit and unconscious experience of the therapeutic relationship, regardless of the therapist's input**.

This hinges on the question whether the client brings with them a sufficiently healthy, non-traumatised personality structure that will allow them to form a trusting attachment to a therapist in the first place. Without that bond, we cannot assume the client's readiness and willingness to receive the therapist's interventions, however competent, helpful and effective these are in principle.

## *A spectrum: single-event to developmental trauma*

Starting from the variety of cases which therapists bring to supervision, we find a spectrum of scenarios, with pure single-event trauma at one end, clear and explicit developmental trauma being presented from the beginning of therapy at the other end, with a large and confusing swathe of the spectrum in between. So, with increasing severity of the developmental component, we can roughly distinguish the following categories[1]:

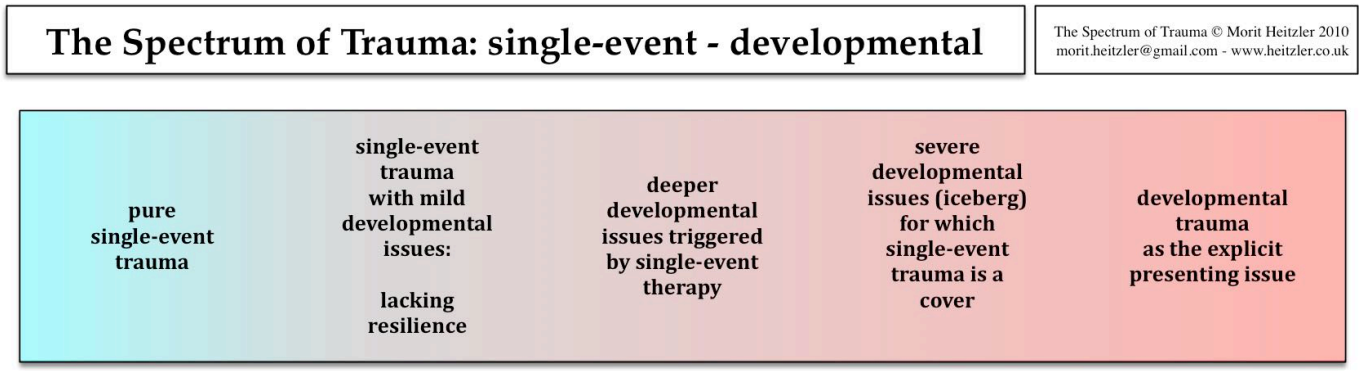


**Figure 1: The Spectrum of Trauma: single-event to developmental**

- pure single-event trauma
- single-event trauma with mild developmental issues: lacking resilience
- deeper developmental issues triggered by single-event therapy
- severe developmental issues (iceberg) for which single-event trauma is a cover (tip of iceberg)
- developmental trauma as *the* explicit presenting issue

[1] which are obviously not clear and distinct, either; it is precisely our point that these categories overlap and blur into one another

## *All developmental trauma complicates therapy*

Our experience and conclusion is that *any* manifestation of developmental trauma, whether as lacking resilience, surfaced during therapy, or already present as the primary underlying 'iceberg', complicates the therapy and takes it beyond the realms of straightforward one-person psychology treatment[2].
**Here we need to state unambiguously one of the central planks of our argument: in spite of some superficial and neuro-biological similarities, early developmental trauma constitutes a qualitative difference to single-event trauma. It calls for a qualitatively different therapy, in terms of its depth and complexity, and the demands it makes on the therapist as 'wounded healer', including their awareness, skill, understanding, their presence and involvement and especially their processing of relational dynamics, both internally and interpersonally**.

### *The necessity of authoritative treatment*

Responding to the client's helplessness and urgency in their traumatised state, most trauma therapies have veered towards 'one-person psychology', defining themselves as *treatments*, with clear protocols and procedures, administered by a knowledgeable expert; here the therapist is understood – by both parties – as an authoritative and directive 'doctor-like' figure, requiring the patient's cooperation.

Since the traumatised client feels helpless and unable to auto-regulate, they need the therapist to offer a safe, empathic atmosphere as well as taking a firm, directive stance that provides interactive regulation. What is less clear and often not explicit is the fact that the client's helplessness has a developmental component, i.e. they are in a child state and are to some extent feeling young and regressed. The therapist's safe presence then acquires an additional parental meaning, usually only tacitly acknowledged. With many clients this re-parenting intention and presence is a necessary ingredient – at least implicitly and to begin with – in order to establish a working alliance at all (Heitzler 2013).

### *The necessity of engaging with relational dynamics*

However, developmental trauma makes any kind of re-parenting task more complex, because the parental figure is the source of *both* love and trauma, *both* the rescuer *and* the perpetrator. This principle is recognised and supported by infant research, developmental studies, object relations theory and depth psychotherapy over many decades (Fairbairn, 1974; Stern, 1985; Lachman & Beebe, 2013).
The human capacity to recover from single-event trauma depends on the robustness of a person's emotional resources and their capacity to allow help in the form of interactive regulation. People who have experienced disorganised or insecure attachment (Ogden, Minton, Pain 2006: 48-58) and were not able to internalise 'good-enough' objects, lack a sense of safety and confidence in themselves and the world. This seriously affects their capacity to build a trusting alliance with *any* kind of therapist and make full or good use of therapeutic help.
We, therefore, cannot take it for granted that the client will experience the therapist as benign and supportive. In complex trauma, the issue of transference becomes unavoidable, as the client is likely to interact with the therapist *via* their traumatising early blueprint for relating (Heitzler 2011). The client then cannot but perceive and experience the therapist *through* the lens of their developmental wounding (Soth 2006a).
This tends to complicate the working alliance and has serious implications for the success of treatment. When the therapist's authoritative or loving-nourishing interventions and directions are received by the client *through* their internalised relational blueprint, the methods and techniques of trauma therapy cannot be expected to work in the same way that in principle we know they can.
These relational complications lead many therapists beyond their recognised therapeutic position and established comfort zone. As a starting point for helping our supervisees navigate this more complex relational landscape, we turn to the well-established notion of the 'drama triangle' (Karpman, 1968; Ney 1988).

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[2] one-person psychology is a term popularised, especially in the US, by Martha Stark (1999), in distinction from two-person psychology; in the UK the equivalent discussion would be in terms of the long-standing paradigm clash between 'medical model' versus relationship (Soth 2008, see also critique of Stark's model: Soth, 2015)

## *The 'drama triangle'*

This model conceptualises the three essential roles present in all traumatising relationships, specifically the victim, the perpetrator and the rescuer.
Because the victim usually felt isolated and powerless in the traumatic situation - without any help, ally or witness, the only agency available was to form in their mind an image of a rescuer that they longed for, but that never manifested. Naturally, therefore, this rescuer figure gets projected onto the therapist, who needs to be willing and able to accept the client's longing for that role, at least implicitly.
From the therapist's perspective, the 'rescuer' is certainly the most attractive pole of the triangle to inhabit, and many therapists tend to formulate their role – and the whole task of therapy itself - exclusively from this position[3] (Heitzler, 2011; Soth, 2007).

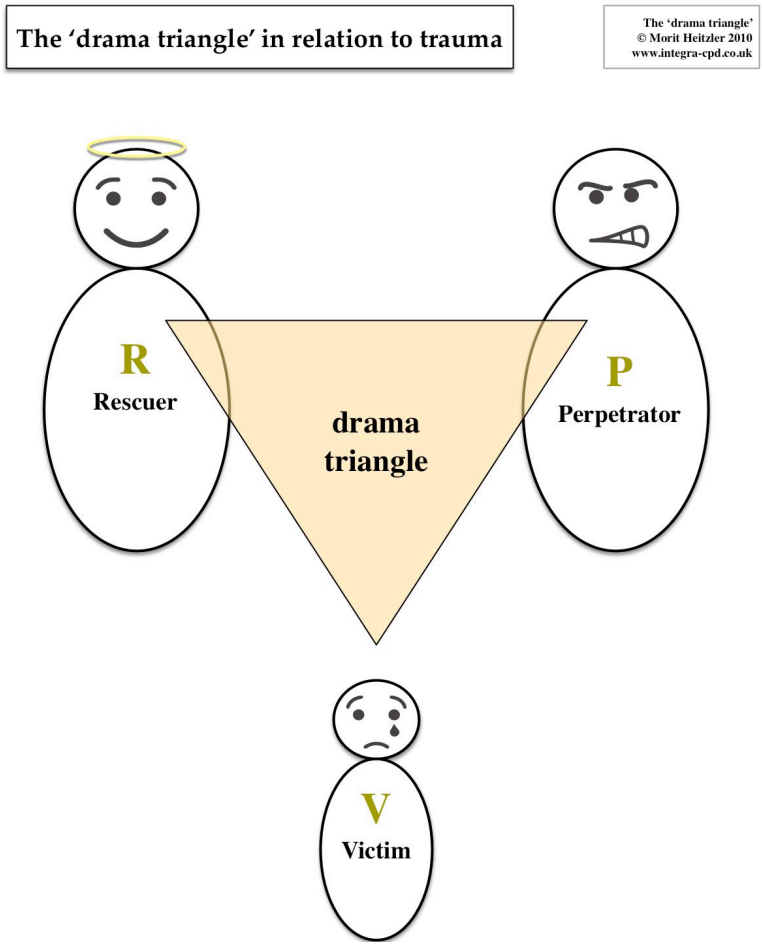


**Figure 2: The drama triangle**

It is beyond the scope of this article to explore the rescuer role in detail, but we can distinguish the following variations (which will become relevant in our case example):

**The therapist as rescuer**

1. 'fatherly': the doctor
2. 'motherly': the fairy godmother
3. (psycho-)educating: the teacher
4. instructive: the 'guide'
5. idealised: the saviour

Whilst recognising how necessary it is at times for the therapist to take any and all of the above authoritative, nurturing, educative and directive stances, the rescuer nevertheless becomes problematic as an *exclusive* position when dealing with developmental trauma.

## *<u>All</u> figures in the drama triangle are present in the field*

Developmental trauma, by definition, affects a child during its formative years. Impressionable and defenceless, it is susceptible to absorbing the trauma and building it into its psychic structure: the traumatising constellation becomes internalised as a 'working model' for all future attachments. As a result, the traumatised psyche becomes frozen in time and its complex internal landscape remains populated by the main protagonists, the victim and the perpetrator (Davies & Frawley, 1994; Reich, 1933; Johnson, 1994).

[3] It needs to be noted that the origins of the 'drama triangle' are in Transactional Analysis, where it was clearly understood as a 'game', with all three positions being needed to keep the dynamic going round in circles. Therapists in that tradition would clearly think of the rescuer role as an essential part of the 'game' and thus consider it a defensive avoidance - which therefore they would refuse to take on. With these terms having entered comon parlance, they have lost their strict original TA meaning. We are using all three terms in more colloquial fashion, responding to the way supervisees use them, in situations where there really *are* victims and perpetrators. Therefore the notion of the rescuer also becomes more ambiguous, both valid *and* problematic.

When this landscape is then projected into the therapeutic space, *all* figures in the drama triangle become charged presences in the field between client and therapist.
As tempting as it is for therapists to emphasise the rescuer position, the qualitative difference between single-event and developmental trauma is constituted by an important principle (illustrated by the example that follows): ***all* figures in the drama triangle are present in the field, and can become embodied spontaneously by client or therapist alike**.
There are no fixed roles, but victim, perpetrator and rescuer can switch unpredictably and from moment to moment between client and therapist. Aspects of the wounding relationship between these figures can become enacted by the therapeutic dyad in mercurial and disturbing ways, implicitly and explicitly, on somatic, emotional and mental levels (Heitzler 2013).

## *Example from supervision*

*Melanie is an experienced middle-aged white heterosexual therapist, trained in bodywork and trauma therapy. She has been seeing Jane, a 27-year old female client, weekly for 4 months when she brings her to supervision for the first time*[4]*.*
*Developmental trauma was an explicit aspect of Jane's presenting problem, as she linked her inability to form lasting relationships with her memories of her parents' volatile marriage. They divorced when she was 9. Her and her older brother had witnessed years of physical and emotional violence. He suffered with learning difficulties, leaving Jane with the role of the 'coper', carrying the family's hopes of achievement.*
*Melanie summarises the initial phase as easy and collaborative, feeling protective and nurturing towards Jane, and comfortably inhabiting what she describes as both 'fatherly' and 'motherly' positions – being both educative, directive, and proactively structuring as well as gentle and holding: "Jane quickly formed a positive, idealising transference towards me and describes me as 'wise and knowledgable'. She frequently expresses hope that I am the one who will soon help her achieve her dream: a solid, supportive and committed relationship with a partner. I am not sure I can do that, but I can help her work through some of the trauma. We agreed that her tight and hyper-tense body has been holding together her coping persona, but is carrying inside disturbing involuntary fear responses which get triggered numerous times a day."*

*"We are assuming that once the trauma is more fully processed, Jane's fear of commitment will ease. So I offered some psycho-education, explaining the neurobiology of her trauma reactions, then used mindfulness exercises and body scans, explored some of her resources. She has been practicing some guided imagery in the sessions and at home."*
*"A month ago Jane did meet a man and began forming a promising new relationship, which she is eager to not sabotage. This added a shared sense of urgency between us to accelerate the therapy, by working with her memories of her parent's rows. Yesterday we were right in the middle of processing a particular scenario (carefully chosen together for being less intense and more manageable), and she looked young and frightened. Suddenly she leans forward and says she would now like to talk about last night's date with her new boyfriend."*
*"I was taken aback - what a shame to divert now, in the middle of her regressed state! So I said: 'Perhaps we could leave some time at the end about the boyfriend?' I was determined to get her to complete the full re-telling of that particular fight, without dissociating or feeling overwhelmed. That would be an encouraging and empowering stepping stone!"*

*Melanie and I agreed that without doubt her perceptions and intentions were valid at that point. However, what then actually happened was unexpected. Melanie continued: "The atmosphere changed and Jane became even more frightened. Obediently, she went along with my instructions, but with a growing degree of dissociation, which I then pointed out to her. Suddenly, she gets angry, protesting against my observations, questions my motivation and then rants at me, doubting whether I can help her at all. I felt completely taken by surprise. Jane had reported exploding with ex-partners, but I've never been on the receiving end of her aggression before."*
*"Trying to re-establish some working alliance, I became defensive, tried pacifying, explaining and making promises – things I would normally never do, but to no avail. The session ended with Jane remaining angry and threatening to leave therapy altogether."*

[4] I have changed all names and identifying details and have the permission of the therapist to use this case for teaching purposes.

This example illustrates how *all* figures in the drama triangle are present in the field, and how the therapist needed to engage with *all* of them.
The therapist's directive instructions as well as her nourishing support were well received during the early stage and helped in forming some working alliance, in which the therapist was transferentially seen as 'the saviour'. But remaining in the rescuer position became more complicated as soon as the therapy approached the traumatic scenario, when the felt sense of the wounding explicitly entered the room (Soth, 2006a). At that moment, the two other figures of the 'drama triangle', the victim and the perpetrator, being inseparable aspects of the traumatic field, also began to manifest.
At first, the therapist unconsciously embodied the perpetrator, becoming controlling and focused on sticking to *her* agenda (although rationally, this was meant to be in service of the client's process). The client then regressed into the victim position, becoming frightened and submissive. When the therapist brought awareness to a fraction of this dynamic, still not fully comprehending that she had just lost her rescuer position, the roles switched and the client then moved into the perpetrator position, pushing the therapist into the victim role.
All this happened spontaneously, on implicit non-verbal levels, constituting an energetic re-enactment of the original traumatic scenario: effectively, the fight between the parents was replicated between client and therapist. The client left the session, still in the perpetrator position, threatening abandonment. The therapist was left in the victim position, feeling hopeless, scared and confused.

**The crucial question is: how can we apprehend this enactment of the traumatising blueprint early enough and deeply enough in order to not only contain it, but turn it into a here-and-now opportunity for transformation?**

## *The indifferent bystander and the trauma rectangle*

It is in the nature of enactments that they are disturbing to both partners in the therapeutic dyad, but especially the therapist: when we unexpectedly lose our therapeutic position, and find ourselves drawn into victim or perpetrator role, we are usually acutely aware that 'something is wrong', the alliance has been lost, and we are failing to perform our rescuer function (Soth, 2013). It is only natural at this point that we want to retreat and regroup. However, that can get us into another difficult position: the bystander.

*A few weeks later, after Melanie and Jane had recovered from the uncontained enactment described before, another dimension of it revealed itself. The reason Jane initiated a change of subject when she had felt most regressed was that it put her in touch with another - for her rather more urgent - moment of regression: she had wanted to talk about her date the previous evening because her new boyfriend had displayed some worryingly aggressive behaviour that had scared her. So her change of subject had not just been a diversion; it had also been a new, budding impulse to reach for support and help. Her coping persona was temporarily absent, and she was reaching towards Melanie from a scared place, something she could not have done towards either of her parents. But between the two of them, that unknown and unspoken need got missed at that point, and the enactment of the parental fight took over.*

In that moment, and more so when Melanie then became defensive and retreated, she manifested a fourth figure that we have come to identify and name the 'indifferent bystander'. This character is the witness who fails to become involved, an inverted negative image of the rescuer. In reality, this is usually a neglectful, unavailable parent or other relative, who averted their gaze when the child was abused or maltreated. Often this person was traumatised him/herself and - living in a state of dissociation – tends to see acts of abuse as 'normal'. In most cases of early childhood trauma, we find that the adult survivor carries feelings of both hurt and rage towards the bystander, similar to the feelings towards the abuser.
By including the bystander role, present in some form in most enactments, we extend the drama triangle into the trauma rectangle (see Figure 3).

Like the other roles, aspects of the 'indifferent bystander' can constellate *anywhere* in the therapeutic space: in the therapist, who might find themselves distracted, tired, uninterested; in the client feeling lethargic, doubting the value of therapy or the therapist's genuine care. In reaction against such doubts, it can also constellate via the therapist's frantic efforts to compensate for the tangible sense of neglectful absence created by the bystander. But usually it manifests, as in our example, by the therapist retreating behind their professional persona, after encountering too much disturbing intensity through an enactment.

## *Relational complications in trauma work*

This article establishes the qualitative difference between single-event and developmental trauma, and the relational complications that are bound to arise in the therapeutic relationship when any degree of developmental trauma is involved.
We have proposed that the traumatising scenario, involving all four positions of victim, persecutor, rescuer and bystander, becomes internalised and frozen into the child's bodymind. In this embodied, largely unconscious way, the wounding dynamic is carried and perpetuated within the trauma symptoms, only to manifest again once a safe enough healing space can be found, like the therapeutic relationship. In the deepening attachment between client and therapist, a relational container can be created, in which the traumatising scenario can become re-externalised. We proposed that at different moments the figures of the trauma rectangle can get constellated and embodied unexpectedly and spontaneously, with the therapeutic dyad likely to replicate and re-enact the wounding relationships between them (Soth, 2006b, 2006c, 2016).

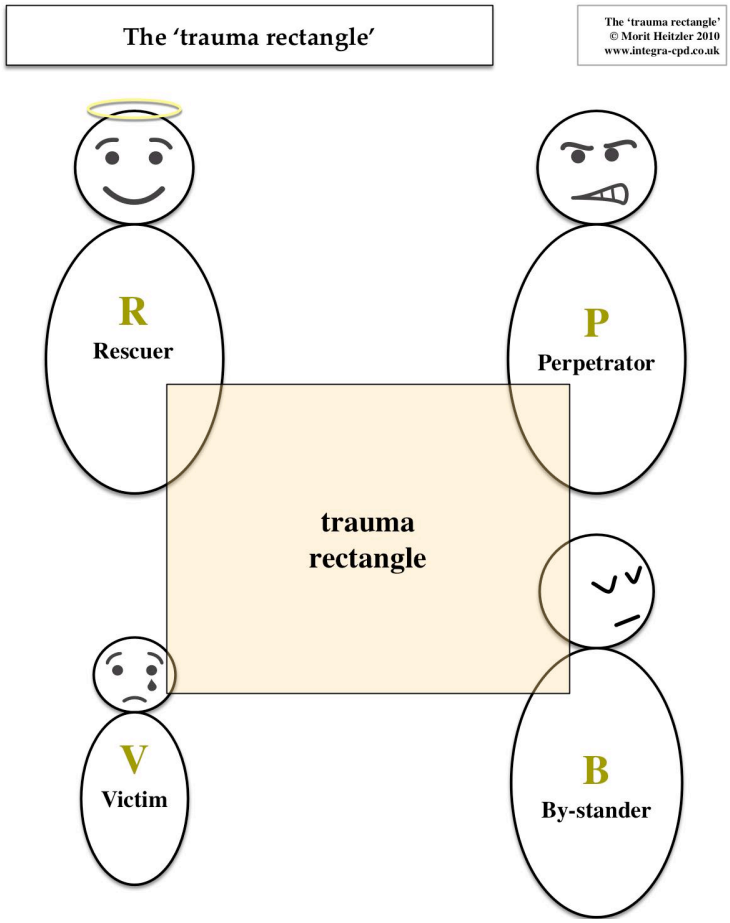


**Figure 3: The trauma rectangle**

Many of our supervisees are mortified when they find themselves hijacked by the enactment, because its full bodymind experience usually contradicts the therapist's (rescuer) stance and self-image, and often its primitive intensity takes the therapist beyond their comfort zone and habitual position. At this point therapists experience a loss of control, a sense of having lost their therapeutic position as well as the working alliance. Many of them will interpret this as their mistake or incompetence, when more likely it is a sign of their deep engagement.

But unless therapists are prepared and reassured that being hijacked by the various roles of the trauma rectangle is in the nature of the work, they are unlikely to be fully available to the experience. Without the therapist's availability to being thus hijacked and drawn into enactment, becoming a participant in it within the safety of the therapeutic boundaries, the client's unconscious suspects that the therapist is playing safe, using their knowledge defensively to remain protected and to escape the traumatic intensity which the client cannot help but feel at the mercy of.

It is beyond the scope of this article to expand on the various ways in which we are learning what helps supervisees process re-enactments of traumatic scenarios. Many of them rightly say that this feels like dangerous territory, often too close to re-traumatisation. But when supervisees themselves can feel held rather than jugded for their entanglements and 'mistakes', and when they survive enactments with their clients and then find as a consequence that the therapeutic relationship deepens, they begin to recognise with some confidence the potential of enactments in transforming long-standing and deeply held developmental trauma.

## *Biographies:*

### *Morit Heitzler:*

Morit is an experienced therapist, supervisor and trainer with a private practice in Oxford. She has been teaching on various training courses in the UK, Israel and in Europe, and regularly leads workshops and groups. Through her work in Israel, at the Traumatic Stress Service of the Maudsley Hospital, the Oxford Stress and Trauma Centre, her supervision at Oxford Refugee Resource, as well as her private practice, Morit has gained experience in treating a wide variety of PTSD symptoms and traumatised clients, including refugees and asylum seekers. Over two decades, she has been developing an integrative approach to trauma work, incorporating - within an overall relational perspective - Body Psychotherapy, attachment theory, EMDR, modern neuroscience and Family Constellations. In recent years she has been focussing on delivering intermediate and advanced CPD and supervision for trauma therapists, specifically on integrating the various trauma therapies. More information can be found on her website: www.heitzler.co.uk.

### *Michael Soth*

Michael is an integral-relational Body Psychotherapist, trainer and supervisor (UKCP), with more than 30 years' experience of practising and teaching from an integrative perspective. Drawing on concepts, values and ways of working from a broad-spectrum range of psychotherapeutic approaches across both psychoanalytic and humanistic traditions, he is interested in the therapeutic relationship as a bodymind process between two people who are both wounded and whole. He has written numerous articles and several book chapters and is a frequent presenter at conferences. Extracts from his published writing as well as summaries of presentations and hand-outs are available at www.integra-cpd.co.uk, or find him also on Facebook and Twitter (INTEGRA_CPD).

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