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The nature and importance of interpersonal dynamics in the treatment of disorders related to complex trauma

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Ce qui ne cesse pas de ne pas s'écrire.

- Lacan, sem. XX, p. 132.

As the quote of Lacan proposes, this dissertation is not finished, notwithstanding several versions have been carefully written, re-written, read and re-read, and a 'final' version was submitted. It is the process of producing this thesis that has left its marks in my personal and academic development, that showcases how I currently reflect, think, read, write and act, and will prescribe and influence all my continuous efforts. This dissertation is not a creation of myself alone, as it is a product of the relationship between me and the Other – a theme that is so manifest in this dissertation. Here, I want to take up the opportunity to thank some specific others that have contributed to this everlasting process.

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INTRODUCTION

The aim of this dissertation is to study interpersonal relations in complex trauma, including the consequences on an interpersonal level and the importance of working through core interpersonal relationship patterns in treatment. In this introduction, we outline the conceptual framework from which our focus on interpersonal features in trauma stems, drawing from Freudian and Lacanian psychoanalytic theory[1]. Further, we sketch the current state of the art concerning contemporary research into interpersonal aspects associated with complex trauma. Finally, we lay out our research questions and hypotheses, provide an overview of the different chapters and describe their interconnections.

[1] Parts of the introduction are based on Van Nieuwenhove, K. (2018). Talking about Trauma: Could I, Would I, Should I? *Psychoanalytische Perspectieven, 36*(3), 235-248

In everyday language, people use the term 'trauma' to denote shocking events or severely distressing experiences. In newspaper headliners, the concept is applied to refer to a wide range of circumstances, going from "ex-employee sues Facebook on account of trauma due to shocking posts" to "surviving the long-term trauma of sexual violence". In an opinion piece for *The New York Times*, Mark Epstein (2013) wrote "The Trauma of Being alive", in which he argues that trauma not only refers to major disasters, such as war experiences or a terrorist attack, but that smaller, sometimes ordinary life-events, such as a severe illness or the death of a loved relative, friend, even pet, may have a traumatic impact. In brief, there is a wide range of circumstances that could be considered 'traumatic'. As a consequence, it is not always clear when an event classifies as traumatic (Rosen & Lilienfeld, 2008). While acknowledging that certain events are generally considered traumagenic, the broad spectrum of possible reactions to experiencing such potentially traumatic event(s) implies that it is rather the subjective reaction that retroactively leads to defining the event as traumatic. This observation urges to differentiate between the event and the traumatic reaction more clearly. However, in the literature, trauma might refer to either or both the events and consequences, which leads to conceptual confusion. Therefore, in the following, we will make a clear distinction by using 'traumatic event' and 'traumatic reactions' to refer to the event and consequences, respectively.

Several attempts have been made to distinguish between different types of traumatic events (Herman, 1992; Terr, 1991; van der Kolk, 1995). Differentiation happens on the basis of whether or not the traumatic event is acute or chronic and whether or not the traumatic event was of a non-interpersonal or interpersonal nature (Verhaeghe, 2004). In this way, we can differentiate between acute or single-incident non-interpersonal traumatic events (e.g., a car accident, a natural disaster), single-incident interpersonal traumatic events (e.g., one-off assault, rape), chronic non-interpersonal traumatic events (e.g., famine) and chronic interpersonal traumatic events or 'complex trauma'[2] (e.g., childhood abuse) (Herman, 1992). In the *Diagnostic and Statistical Manual for Mental Disorders, fifth edition* (DSM-5, American Psychological Association, APA, 2013), no such distinction is made between different types of traumatic events, only a very broad definition of what constitutes a traumatic event is given, namely direct or indirect exposure, witnessing or learning that a relative or close friend was exposed to "actual or threatened death, serious injury or sexual violation." (p. 271). Being able to differentiate between different types of traumatic events might, however, be important, because research has shown that, on average,

[2] We do not use 'complex traumatic events' here, because the concept of 'complex trauma' was introduced by Herman (1992) as such. However, in the literature, it has been observed that complex trauma has been used to refer not only to prolonged and repeated traumatic events, but also to traumatic reactions associated to the exposure of such events (e.g., Resick et al., 2012).

chronic interpersonal traumatic events or complex trauma cause(s) more traumatic reactions than single-incident interpersonal traumatic events, which are more harmful than repeated non-interpersonal traumatic events, which, in their turn, are more damaging than being exposed to a single-incident non-interpersonal traumatic event (e.g., Ehring & Quack, 2010; Forbes et al., 2014). In other words, the reactions to diverse stressors can be placed on a continuum of complexity with more complex forms of traumatic events leading to more complex clinical syndromes (e.g., Cloitre et al., 2009; Herman, 1992). From a diagnostic perspective, this raises the question of whether or not the diagnosis of Posttraumatic Stress Disorder (PTSD, APA, 2014) is able to capture all symptoms associated with the experience of complex trauma (e.g., Stein & Allen, 2007). After all, complex trauma has been associated with a wide array of difficulties in multiple domains (e.g. López-Martínez et al., 2016), including symptoms associated with PTSD, such as hyperarousal, avoidance and numbing symptoms, but also affect-regulation difficulties, alterations in attention and consciousness and interpersonal difficulties (e.g., Cloitre, Garvert, Brewin, Bryant, & Maercker, 2013). To aggregate all possible symptoms, several alternative syndromes have been suggested, such as *Complex Posttraumatic Stress Disorder* (CPTSD, Herman, 1992), *Disorders of Extreme Stress, Not Otherwise Specified* (DESNOS, Ford, Courtois, Steele, van der Hart, & Nijenhuis, 2005), and *Developmental Trauma Disorder* (van der Kolk, 2005). These diagnostic categories have not been included in the DSM because research remains inconclusive as to whether the inclusion of these syndromes offers any added value over the existing PTSD diagnostic category (e.g., Resick et al., 2012; deJongh et al., 2016).

The impasse in the research field has consequences for clinical practice, because these different perspectives imply different therapy approaches. Whereas the adherents of the current PTSD nosology advocate evidence-based treatments for PTSD, such as exposure therapy, for all trauma cases, those who plea for a distinct nosology favour a more tailored treatment approach for people who experienced complex trauma. The latter promote the inclusion of a stabilization phase with a focus on symptom stability and emotional, behavioral and relational skills (e.g., Cloitre et al., 2011; Drozdek, 2015; Pressley & Spinazzola, 2015).

From our vantage point, the impasse in the literature will not be resolved until the underlying mechanisms between traumatic events and traumatic consequences are taken into consideration. The classic approach to conceptualize and study trauma departs from an implicit mechanical logic, meaning that the development of symptoms is basically understood as the logical consequence of the confrontation with (an) overwhelming external experience(s) (e.g., Shapiro & Laliotis, 2011). As a logical deduction, it follows that the exposure to more severe

traumatic events leads to more severe traumatic reactions, be it nosologically referred to as more or less severe expressions of PTSD or as manifestations of very distinct diagnostic categories. This mechanical logic places a potential treatment in a problematic perspective, because if the suffering of patients is only ascribed to external circumstances with no consideration for subjective processes in the development of symptoms, the subject should also not be involved in the appurtenant treatment. The focus of therapy then mainly lies on the external event(s) with the ultimate aim of treatment to be able to provide a coherent trauma narrative (e.g., APA, 2017; Peres, McFarlane, Nasello, & Moores, 2008; Shapiro & Laliotis, 2011), whether or not in a first phase some additional issues, such as symptom stabilization or the development of a safe therapeutic relationship, should be addressed.

This external way of thinking about trauma and the corresponding one-treatment-fits-all approach has already raised a lot of opposition, particularly because the subjective processes involved in the production of symptoms are not being taken into consideration (e.g., Bistoen, Vanheule, & Craps, 2014; Dulsster, 2015; Leys, 2000). However, a contextual or developmental perspective is essential to understand the formation of psychological difficulties (e.g., Briere & Jordan, 2009; Harvey, 1996), in particular the development of deep-rooted schemas – i.e., how the subject views him/herself, others, and the world – that are typically formed in relation between the subject and significant others (e.g., DePrince, Chu, & Pineda, 2011; Walsh, Fortier, & DiLillo, 2010). Below, we will break down the conventional conception of trauma and show how the relationship between subject and others is crucial to the understanding of (complex) trauma.

Trauma and the Other

The external logic in the conventional understanding of trauma consists of the idea that trauma-related symptoms arise because the traumatic event is too overwhelming to be represented, mentalized, assimilated or integrated in the mental apparatus (e.g., Shapiro & Laliotis, 2011). In other words, patients are unable to remember the traumatic event in a normal, associative way (Verhaeghe, 2004). Rather, they re-experience the event via intrusive flashbacks or nightmares (APA, 2013). Recent neuroimaging studies show a disruption between affective and linguistic processing systems, thereby supporting the thesis of an inherently *non-verbal* nature of traumatic recollections (Peres et al., 2008). Furthermore, it has been found that traumatic recollections are rather *re-experienced*, more *hic et nunc* (Michael, Ehlers, Halligan, & Clark, 2005) in comparison to regular, narrative auto-biographical memories (Ehlers, Hackmann, & Michael, 2004). These studies offer strong support for the inclination that

traumatic events are too overwhelming to be integrated in the mental apparatus. In other words, they clearly show *how* traumatic events are stored. However, what remains unclear is *why* the mental apparatus gets inundated and remains unable to process traumatic events in a normal, associative way. Here, the subjective processes in the production of (trauma-related) memories come to the fore.

In order to show that subjective processes are omnipresent in the process of memorization, we need to make a distinction between *experience* and *subjective representation* or *memory*. Hacking (1995) explains this by what he calls "retroactive redescription of the past". He postulates that the past itself is determinate and definite; that the sequence of events that took place would be verifiable only if it was captured on tape. However, the cameras would have only been able to capture the activities going on, i.e., the actuality, and not the intentions accompanying these activities, i.e, the subjective representation. This means that we can never fully access the external actuality, because by saying something about it, we enter the plain of signification and representation, which can never fully correspond to the actuality of the event. To illustrate this: "If a tree falls in a forest and several people were around to hear it, what sound did it make?" These people will all have encountered the same *actual* physical event. However, they probably would have perceived a different sound. One person could have perceived it as a noise disturbing the tranquility of the forest; whilst someone else might have perceived it as a marvelous sound of nature at work. People thus construct *meaning* by which the actuality prior to recollection ceases to exist. It is precisely this meaning-making process, which does not happen in a vacuum, that can help us to understand why people have different reactions or develop different symptoms after experiencing a (traumatic) event.[3]

Lacan (1973/1998) points out that "remembering always involves a limit" (p. 40) and that what is recounted does not correspond with what was experienced. In this way, Lacan makes a distinction between the *Real* and *reality.* The Real refers to the 'raw data', that which in effect cannot be articulated, whereas reality involves a subjective signification of the experience, which carries the illusion of a coherent representation of the experience, but nonetheless does not cohere or coincide with the 'raw data'. Therefore, Lacan situates reality in the register of the *Imaginary*. Further, Lacan postulates that the way reality/the imaginary is shaped "depends on the position of the subject. And the position of the subject (…) is essentially

[3] In his article "*Enfants de Chowchilla ou la fabuleuse naissance de 'l état de stress post-traumatique chez l' enfant*", Daniel Roy (2013) illustrates that when 26 children were kidnapped in the city of Chowchilla in California, notwithstanding they all went through the same actual experience, none of these children testified of having had to deal with the same traumatic event.

characterized by its place in the *Symbolic* world, in other words, in the world of speech." (Lacan, 1975/1991, p. 80).

This process of signification ensues in the relationship between subject and Other. Lacan makes a distinction between the other, with a lowercase letter, referring to others from flesh and blood, and the Other, with a capital letter, which also includes language and the influence of the broader cultural discourse. In the early developmental years, from the moment a baby *experiences* a certain arousal (e.g., hunger, temperature imbalance), it turns to the (m)Other to alleviate or satisfy the arousal (Verhaeghe, 2001). We make use here of the 'Other', with capital letter, because the caregiver – typically the mother – is also marked by the influence of the broader cultural discourse and has to resort to language to address the infant's needs. In this way, the mother has to translate the baby's arousal, by which her representations will never fully correspond with the felt arousal. Because a child is intrinsically characterized by a dependency upon others for its survival, it repeatedly has to turn to the Other for answers. In this continuous interplay between subject and Other, the Symbolic-Imaginary framework[4] is shaped, i.e., a seemingly coherent representational frame via which the subject's views him/herself, others, and the world, and via which relationships, pleasures, pains, goals and other inner or outer experiences are made sense of (Verhaeghe, 2004)[5].

Via Lacan's registers of the Real, the Imaginary and the Symbolic, we can now consider an alternative understanding of trauma in which subjective processes and the relationship between subject and Other are crucial in understanding the inability to process traumatic events. Whereas daily experiences are quite unnoticeably embedded and interpreted within the Symbolic-Imaginary framework, a traumatic experience is characterized as a brutal confrontation with the inability to do so (Bistoen, 2016; Chiriaco, 2012). In accordance to the contemporary understanding of trauma, Freud (1920/1961) conceptualized trauma in *Beyond the pleasure principle* as an event in which "there is no longer any possibility of preventing the mental apparatus from being flooded with large amounts of stimulus" (p. 23). Freud did, however, formulate a theory about the mechanism underlying the development of traumatic symptoms by stating that "another problem arises instead – the problem of mastering the amounts of stimulus which have broken in and of binding them, in the psychical sense, so that

[4] Because the registers of the Symbolic and Imaginary are inextricably intertwined (Cauwe, 2018), from here on out, we will refer to the representational framework as the Symbolic-Imaginary framework.
[5] In this way, the Symbolic-Imaginary framework bears resemblance to the internal working model in attachment theory (Bretherton & Munholland, 2008), cognitive schemas stemming from Piaget's developmental theory (Wadsworth, 2004) and the Core Conflictual Relationship Theme (CCRT) in psychodynamic psychotherapy (Luborsky, 1984).

they can be disposed of" (Freud, 1920/1961, p. 24). In this way, it is clear that Freud conceived symptoms as mechanisms of defense, which had to come in place because the existing coping mechanisms failed to deal with the increase of stimuli. He did not believe that the external event itself causes symptoms (Leys, 2000). In other words, the intrusive event by itself does not instigate the traumatic impact Rather, Freud (1920/1961) showed that it is the interplay between the outside and the inside that determines the position of the subject vis-à-vis a (traumatic) event. What we can conclude from this is that there is no objectifiable quantity of arousal that amounts to an excess. In contrast, what cannot be integrated or mastered by the mental apparatus of the subject differs from person to person.

Translated to Lacan's registers of the Real, the Imaginary and the Symbolic, we can state that trauma causes a breach in the existing meaning-making, Symbolic-Imaginary framework (the mental apparatus), resulting in a brutal confrontation with the Real (certain amounts of stimuli). In other words, the Symbolic-Imaginary framework fails to translate and veil the experience, by which the event cannot be represented and keeps insisting as a pure, real and unprocessed experience. Following this line of reasoning, we can begin to understand the mechanisms involved in the intrusive symptoms associated with trauma, namely the uncontrollable, compulsive repetition of traumatic scenes in nightmares or flashbacks (APA, 2013). Since trauma is typified by the absence of a connection with the Symbolic-Imaginary structure, the compulsion to repeat can be understood as repeated attempts to make this connection happen, to bind the traumatic event to representations (Freud, 1920/1961). That is, the intrusive symptoms are do-over attempts to, nonetheless, master the Real via the Other (Verhaeghe, 2001). The question that remains unanswered here is why some subjects succeed to process the intrusive events, whereas others remain stuck. As an answer to this question, we will set out how a disturbed dialectical exchange between subject and Other is associated with the inability to process the traumatic Real.

Trauma: A Breach in the Meaning-Making Process

The first possibility is that in the early developmental years, in the relation between subject and Other, an insufficient amount of words and representations, through which events can be thought and understood, were offered by the primary caregiver(s) or adopted by the infant. This corresponds with what in attachment theory is called the inability to mentalize, which refers to the capacity to interpret own and others' feelings, thoughts, and behaviours (Ehring & Quack, 2010; Stein & Allen, 2007). Verhaeghe and Vanheule (2005) define this situation under the denominator 'actual neurosis'. They argue that in a confrontation with a

traumatic event later in life, the subject, under the precondition of actual neurosis, lacks 'symbolic tools' to transform the traumatic Real (Verhaeghe & Vanheule, 2005). Instead, the accumulated tension is inscribed on the body, which leads to 'typical' clinical symptoms of PTSD, but also other immediate, unmediated and performant interventions on the body, such as automutilation and automedication. Kinet (2016) aptly describes how "all these phenomena are a mute emergency exit for the do-it-yourselfer. Mute, because without words, do-it-yourself because the road to the big Other has gone astray due to damaged trust." (p. 76, our translation). Treatment, then, boils down "to redoing a process that was not originally completed" (Verhaeghe & Vanheule, 2005, p. 503), referring to the primordial relationship between subject and Other. This entails that the therapist actively takes up the position of the Other (Kinet, 2016; Markey, 2006) in a safe and supportive relationship (Verhaeghe & Vanheule, 2005) to start the process of signification (Verhaeghe, 2004)[6].

A second possibility concerns the condition in which the process of signification has taken place, be it in an unsafe and traumatic relationship between subject and Other. The traumatic relationship then fundamentally colours the Symbolic-Imaginary framework from which meaning derives. In other words, the intersubjective, Symbolic-Imaginary framework is drenched with elements of the traumatic prehistory (Chiriaco, 2012).

This scenario corresponds to Freud's earliest accounts on trauma, in which emphasis was placed on (repressed) memory, when he argued that female hysterics "suffered from reminiscences" (Breuer & Freud, 1895, p. 58), referring to an increased excitation that could not be discharged due to traumatic events in childhood, that could not be verbalized, and remained unconscious (Verhaeghe, 2001). In accordance with current treatment guidelines, Freud initially believed that a complete remembering and verbalization of the traumatic past was necessary in order for hysterics to be able to discharge the excitation arising from the unconscious representations (Hacking, 1995). However, Freud ultimately had to give up the idea of getting to the bottom of it when he was confronted with the impossible task of differentiating between reality and fantasy[7] in the story of the patient. Because a complete verbalization was deemed impossible, Freud gradually changed his 'treatment plan', from the ultimate verbalization to what he called *working through* (Verhaeghe, 2001). Freud saw the fantasy of his patients as a *defense mechanism*, a way in which his patients could represent and

[6] It might not always be necessary or even counterproductive to aim at mentalization or signification in treatment (i.e., a Symbolic solution). Depending on the singularity of a particular case, it might as well be more beneficial to target a solution that directly affects the bodily excess (i.e., a Real solution) (e.g., Dulsster, 2015).
[7] Translated to Lacan's registers of the Real, Imaginary, and Symbolic, here, the reality refers to the actual experience or Real, whereas the fantasy refers to the Symbolic-Imaginary framework.

understand what originally could not be grasped (Verhaeghe, 2001). Translated to Lacans registers of the Real and the Symbolic: "the fantasy is an attempt to give meaning to a part of the Real that resists to the Symbolic." (Verhaeghe, 1998, p. 93). It serves as a regulator of the drive, a way to veil the Real, as a Symbolic-Imaginary configuration that structures the relation between subject, others and the world.

If we turn back to the scenario in which the Symbolic-Imaginary framework is formed in relation to a traumatic Other, we understand that the traumatic antecedents are covered up and veiled by the Symbolic-Imaginary structure. It allows an interpretation – and consequently, a regulation – of the traumatic scenes and gives meaning to the subject's (bodily) experience and his or her position vis-à-vis the (traumatic) Other. This, then, serves as a template to organize oneself and others in later relationships (Bistoen, 2016).

An important question here is why and when patients decide to enter treatment, because often a significant amount of time has passed since the traumatic experiences occurred (e.g., Kinet, 2016). "Life itself can stir up someone's phantasma, whereby s/he does not feel at home in it anymore" (Jonckheere, 2003, p. 47, our translation). This does not necessarily entail a brutal or sudden (traumatic) incident, which makes it much harder to trace back the encountered difficulties to the traumatic antecedents.[8] In this context, Freud explained the symptom formation in female hysterics via a mechanisms he called *Nachträglichkeit* (Bistoen et al., 2014). *Nachträglichkeit* can be understood as a retroactive conferral of meaning, by which a certain event in the past receives a traumatic character only through the occurrence of a more recent event, investing the earlier event with meanings or descriptions they did not have at the time they were experienced (Leys, 2000). Bistoen et al. (2014) note that this does not mean that the original event was traumatic when it was originally experienced and that it was repressed to only become conscious again at a later time. Rather, Bistoen et al. (2014) highlight that it is *the memory* that receives a traumatic connotation, by "arousing an affect which it did not arouse as an experience" due to "*a different understanding of what was remembered"* (Freud, 1895/1975, p. 356 as cited in Bistoen et al. 2014). In a way, the more recent event unveils the Real that was covered by the fundamental fantasy or Symbolic-Imaginary framework. So, notwithstanding the ability of signification, there are – in parallel with our first scenario – still

[8] In a way, there is not so much of a difference between patients with a (complex) trauma history and other (neurotic) patients, in that sense that the majority of the difficulties with which patients enter treatment can be understood as a symptomatic solution for a confrontation with the Real – which in broad terms always resolves around existential themes, such as sexuality and death – that could not be comprehended and processed by the Symbolic-Imaginary framework that was in place, therefore warranting a new position towards the Other (Verhaeghe, 2004).

traumatic, real elements which could not be represented, integrated or embedded in the discourse of the subject. Also here, the Symbolic-Imaginary framework failed to generate meaning. In treatment, it will be important to gain insight in where the existing Symbolic-Imaginary framework failed to generate meaning and where the Real emerges in the patient's discourse, which necessitates a new position in relation to the Other. In contrast with the general guideline to verbalize the encountered traumatic events (APA, 2017), the focus should not lie on the reproduction of a factual sequence, but rather to create a new individual discourse through which (new) meaning can be constructed (Declercq, 2000).

Complex Trauma and the other

Our theoretical disquisition above clearly shows that the relation between subject and Other is essential in understanding the fundamentals of trauma. It provides a strong thesis that for the diagnosis and the treatment of disorders related to trauma, emphasis should lie on the relationship between subject and Other, how the subject construes meaning and how he or she relates to others and the world. We have seen that primary relations between subject and significant others are pivotal in the formation of the Symbolic-Imaginary framework and the representational patterns from which subjects interpret and understand themselves, others and the world. Below, we focus our attention to the dimension of the relationship between subject and the other (including, but not limited to, relations with significant others, such as parents, siblings, romantic partner and the therapist) to discuss the current state of the art. More specifically, we will discuss the available empirical research on the relation between subject and others in complex trauma.

To recapitulate, complex trauma is defined as prolonged and repeated harmful events that typically occur in the interpersonal sphere (e.g., child abuse, sexual and/or physical abuse, neglect), frequently by the hands of primary caregivers (Herman, 1992; Kisiel et al., 2014; van der Kolk, 2005). Complex trauma thus encompasses both conditions discussed above in which trauma was explained via the problematic relationship between subject and Other, namely a) the situation in which the primary interaction between subject and Other resulted in the lack of a suitable Symbolic-Imaginary frame to process the traumatic Real and b) the circumstances in which the Symbolic-Imaginary frame was formed and coloured in relation to a traumatic Other.

There are several studies that support the idea that the experience of complex trauma is associated with a difficult relationship between subject and others. The associated interpersonal difficulties include issues of trust and early attachment disturbances (e.g., Cloitre, Stavall-McClough, Miranda, & Chemtob, 2004; Ebert & Dyck, 2004; van der Hart, Nijenhuis, & Steele,

2005), difficulties negotiating relationships or being able to have a sense of security and stability in relationships (Pearlman & Courtois, 2005; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005), and having altered suppositions, cognitions, or constructions about themselves in relation to others and the world (e.g., Arntz, 1994; Koss, Figueredo, & Prince, 2002; Newman, Riggs, & Roth, 1997). This aligns with what we have called the Symbolic-Imaginary framework. In the literature, this has also been referred to as *distorted relationship patterns.* Hodgdon, Kinniburgh, Gabowitz, Blaustein, and Spinazzola (2013), for instance, argue that trauma victims perceive the world as an unsafe and unpredictable place in which others are punitive, unavailable or rejecting, leaving the subject feeling powerless and helpless. Other studies on trauma-related disorders (e.g., borderline personality disorder) indicate that these individuals show ambivalence towards getting involved in intimate relationships with a desire to get close on the one hand, but also a tendency to distance themselves out of fear of being rejected and opposed by others, to which the subject responds with a tendency of opposing and hurting others (e.g., Drapeau & Perry, 2004a, 2004b; 2009).

Researchers are starting to emphasize the importance of *addressing interpersonal difficulties in the treatment of complex trauma* (e.g., Sharp, Fonagy, & Allen, 2012; van der Kolk et al., 2005). Considering the fact that complex trauma victims have great difficulty in trusting others, the formation of a stable therapeutic alliance is presumed to be a first and vital step in working with complex trauma victims (e.g., Cloitre et al., 2004, 2011; Ford et al., 2005). Further, it is argued that additional attention should be paid to the interpersonal difficulties complex trauma victims experience in their daily lives (e.g., Cloitre et al., 2009; van der Kolk et al., 2005). These observations correspond with the clinical recommendations we discussed in those cases in which the process of signification did not take place, warranting a do-over in a safe relationship in which the therapist has to take in the position of the Other (e.g., Verhaeghe & Vanheule, 2005).

Research up until now provides a direction to comprehend in what way subjects position themselves vis-à-vis others. However, the findings derived from mostly cross-sectional research designs, using self-report questionnaires (e.g. Zlotnick et al., 1996), do not allow an understanding of the dynamic and complex nature of interpersonal relationship patterns. Moreover, research concerning the concrete presence of these patterns in a therapeutic context remains scarce. In order to assess and address these issues effectively in therapy, there is a need to better understand the interpersonal dynamics in complex trauma and how they transpire in a therapeutic context (e.g., Ford et al., 2005; Newman et al., 1997).

Moreover, while research showed change in core interpersonal patterns to be a crucial element in explaining symptomatic change in general (e.g., Crits-Christoph, Connoly Gibbons, Temes, Elkin, & Gallop, 2010), the nature of this change process has to our knowledge never been studied in the context of complex trauma. Although the importance of investigating the process and mechanisms of change in psychotherapy is strongly recognized (e.g., Kazdin, 2007; Stiles, 2013; Wampold, 2007), research concerning these matters is still in its infancy. Following these lacunas in the research field, we outline our research questions, which are discussed in the following paragraphs.

Objectives and Research Questions

The overall aim of this project concerns the assessment of interpersonal patterns in complex trauma and the process of change. In order to investigate this in a systematic way, this is rigorously and as a system, we need to investigate 1) the structure of interpersonal patterns in complex trauma before therapy, 2) the structure of interpersonal patterns after therapy and, 3) the change processes in therapy through the dynamic interactions between the patient and the therapist (Toomela, 2007). Accordingly, we formulate three interconnected objectives (O) and four research questions (RQ).

Our first objective (O1) is to bring the abundant research studies on interpersonal features in complex trauma to one place and to provide a systematic review of the available writings. We found that trauma research stresses the importance of interpersonal features on three major levels: etiology, consequences, and therapy. Our literature review not only serves the purpose of summarizing the most prominent results, but also to illuminate the lacunas in these research areas and the importance of tackling them. As indicated above, significant questions remain on the level of the specificity of relationship patterns in complex trauma and the change process therein.

The second objective (O2) concerns the specificity of interpersonal patterns in complex trauma (RQ1) and the nature of changes in interpersonal patterns throughout therapy (RQ2). This boils down to the *structural component* of our research objectives, namely the structure of interpersonal patterns throughout treatment, which is a prerequisite to investigate process aspects (Toomela, 2007). To grasp the complexity of interpersonal relationship patterns, we additionally aim at providing an in-depth, clinically more elaborate description of the interpersonal patterns, which are currently lacking in the literature. This allows a better understanding of the way in which interpersonal patterns appear throughout therapy. It will provide an understanding of the dynamics in interpersonal patterns, which were hitherto only

studied at one moment, which further allows the refinement and/or the formulation of new hypotheses on trauma-related interpersonal functioning (Stiles, 2013).

Our final main objective (O3) is to provide a detailed, multi-angled and in-depth analysis of the *change processes* by focusing on the therapeutic interaction, how the therapeutic relationship is formed (RQ3) and how interventions are used to address interpersonal issues (RQ4). Furthermore, we aim at a detailed investigation of therapeutic interactions, how different types of interventions capture the process aspect and how therapists can deal with interpersonal difficulties inherent to complex trauma (e.g., attachment difficulties, mistrust) that complicate the relationship between therapist and patient. Figure 1 provides an comprehensive overview of the chapters in this dissertation and the research objectives.

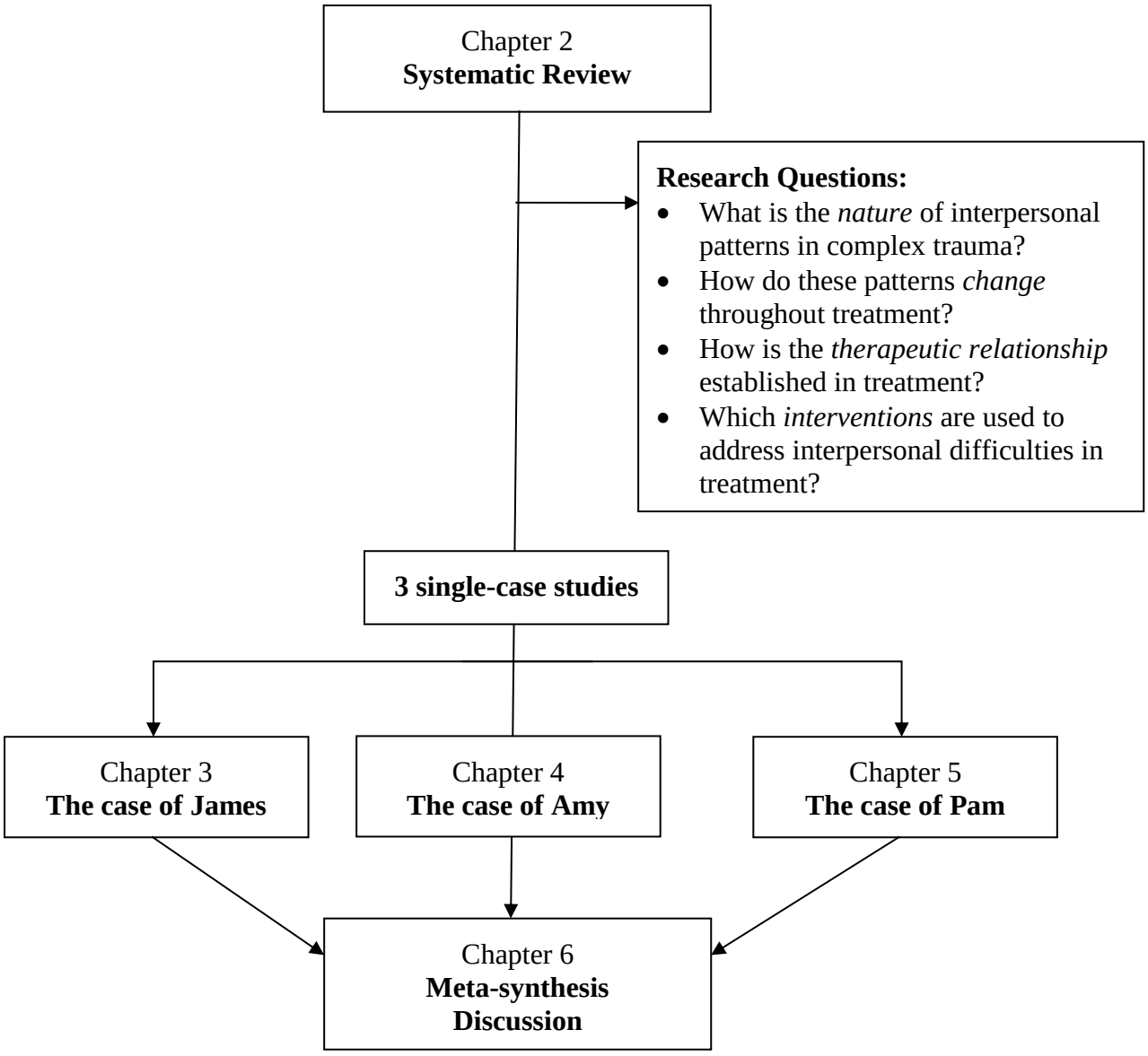

Figure 1: Overview of the chapters and research questions.

Method

In order to systematically review the literature, as proposed in O1, we completed a systematic review (cf. chapter 2). We conducted a systematic search on *Web of Science* using "complex trauma OR complex PTSD OR DESNOS[9]" AND "Interpersonal OR relation*" as our search terms. Out of the 395 results, we selected 94 articles, using the following criteria: a) the abstract or title should contain an explicit focus on interpersonal features in trauma, b) the primary diagnosis should be trauma-related, and c) articles should be in English. During a first reading of the articles, we used a snowball sampling technique to further select relevant works using the citation lists. We delineated three levels at which interpersonal features have a prominent place in trauma research – etiology, consequences, and therapy – and organized the literature accordingly, with 22, 39, and 33 articles covering mainly etiology, consequences, and therapy, respectively. We used principles of thematic analysis (Brown & Clarke, 2006) to identify common themes within the broader categories. In chapter 2, we discuss the key findings on interpersonal features in etiology, consequences and treatment and connections between the different levels are discussed.

Three systematic single case studies in a naturalistic setting were conducted to investigate O2 and O3 (cf. chapters 3, 4, and 5). Single case studies are indispensable for comprehending both structure and process in all of their dynamic complexities (Toomela, 2007) and for the expansion, modification and refinement of current ideas or theories (Desmet, 2018; Edwards, 2007; Stiles, 2003). Moreover, case formulations gain importance in the field of diagnostics and assessment in order to shift the emphasis from merely inventorying complaints and symptoms to attention for the broader (psychological) context and experience of the patient (Vanheule, 2015).

In order to meet prevailing scientific requirements (e.g., Dattilio, Edwards, & Fishman, 2010; Vanheule, 2002) and allow comparisons and transferability across cases (e.g., Levitt et al., 2018; Molenaar & Valsiner, 2005), we used a mixed-method design including multiple qualitative and quantitative measures assessed throughout the course of therapy. This multi-method approach enabled us to investigate our objectives and hypotheses in a rigorous, valid and reliable manner (e.g., Denzin & Lincoln, 2011; Edwards, 2007; Stinckens & Smits, 2010). In addition, the qualitative analyses allow contextualization of the findings and a thick description of therapeutic processes, thereby reducing the gap between practice and research

[9] Although we did not intent on focussing on diagnostic categories in our research, we included these search terms because 'complex trauma', as a concept to denote traumatic experiences, and 'complex PTSD' or 'DESNOS', which are diagnostic constructs, are often used interchangeably (e.g., Resick et al., 2012).

(Desmet, 2013; Edwards, 2007).

We drew our sample from the larger psychotherapy research projects, the Ghent Psychotherapy Study (GPS, Meganck et al., 2017) and the Single Case Studies, conducted at the department of Psychoanalysis and Clinical Consulting. The ethical committee of the Ghent University Hospital provided positive ethical advice on these larger process-outcome studies (EC/2015/0085; B670201318127). The GPS is a Randomized Controlled Trial in which patients either receive 16 to 20 sessions of Cognitive Behavioral Therapy or Supportive-Expressive Therapy for the treatment of Major Depression (Meganck et al., 2017). The Single Case Studies served as a pilot project in which patients received psychodynamic therapy, without any time constrictions. The research procedures are comparable and provide a wealth of data to conduct systematic, naturalistic case studies.

We used two inclusion criteria to select our cases: 1) the presence of a complex traumatic background (i.e., repeated and prolonged interpersonal traumatic events) as reported in the Clinical Diagnostic Interview (CDI, Westen, 2006), and 2) the patient received supportive-expressive psychodynamic therapy to ensure treatment focused on interpersonal themes. As our research objectives mainly require rich information on interpersonal dynamics (Curtis, Gesler, Smith, & Washburn, 2000; Patton, 2002), we did not set any further (diagnosis, outcome) requirements.

Table 1

Basic description of the cases.

	Case 1 (chapter 3)	**Case 2 (chapter 4)**	**Case 3 (chapter 5)**
Age and gender	24, male	26, female	33, female
Trauma history	Childhood physical abuse	Childhood physical and psychological abuse	Childhood physical and psychological abuse
Diagnosis	PTSD, DID	MDD	MDD, agoraphobia, Body Dysmorphic Disorder
SCS/GPS	SCS	GPS	GPS
Objectives	O2	O2, O3	O2, O3
Duration	39 sessions	20 sessions	20 sessions

Note. SCS = Single Case Studies; GPS = Ghent Psychotherapy Study; PTSD = Post Traumatic Stress Disorder; DID = Dissociative Identity Disorder; MDD = Major Depressive Disorder; O = objective. We only studied O3 in case 2 and case 3, because the research procedure of the GPS allowed a more structured investigation of the formation of the therapeutic alliance and the use of supportive and expressive interventions throughout treatment.

Below, we provide a brief overview of the research procedure. We only mention the measures used in our research. Basically, the research procedures of the GPS and SCS are comparable and only slightly diverge. In what follows, we will indicate where the research procedures deviate from each other. Basic descriptions of the cases are provided in Table 1.

The diagnostic procedure included the administration of the SCID-I and -II (First, Spitzer, Gibbon, & Williams, 2002; First, Gibbon, Spitzer, Williams, & Benjamin, 1997) and the Clinical Diagnostic Interview (CDI, Westen, 2006), a semi-structured narrative-based interview that assesses a broad range of intra- and interpersonal characteristics. This interview allows for an in-depth understanding of important past and current relationships that appear in the story of the patient (e.g., 'How would you describe your relationship with your mother/father/partner/…?' or 'Can you describe a specific situation or confrontation with him/her that typifies your relationship?'). These interviews were audiotaped and transcribed. During therapy, all sessions were audiotaped and transcribed according to preset standards.

To further assess trauma-related symptoms, we administered the Self-rating Inventory for Posttraumatic Stress Disorder (ZIL, Hovens, Bramsen, & van der Ploeg, 2009) pre, peri, and posttreatment. This self-report questionnaire was not administered in the SCS. In order to map interpersonal difficulties, comorbid symptoms and general well-being, we administered the Inventory of Interpersonal Problems-32 (IIP-32, Horowitz, Alden, Wiggins, & Pincus, 2000), the Beck Depression Inventory-II (BDI-II, Beck, Steer, & Brown, 1996) and the Symptom Checklist-90 (SCL-90, Derogatis, 1992) pre and post treatment, every fourth session and at 3-months, 6-months, 1-year and 2-year follow-up. After every fourth session, the patient also had to fill in the Working Alliance Inventory (WAI, Horvath & Greenberg, 1989) to assess the therapeutic relationship. This latter questionnaire was not administered in the SCS.

The Client Change Interview (CCI, Elliott, Slatick, & Urman, 2001), a semi-structured interview assessing therapeutic change with explicit attention to changes in interpersonal relationships and the experience of the therapeutic relationship, was administered peri- and post-treatment, as well as at 3-month, 6-month, 1-year and 2-year follow up. In the SCS, the CCI was only administered at 2-year follow-up.

In all three case studies, we provided a detailed and contextualized account of the patient, including both quantitative and qualitative data, using the principles of the Consensual Qualitative Research method for Case Studies (CQR-c, Jackson, Chui, & Hill, 2011). Preliminary analysis consisted of the (graphical) presentation of the evolutions in the available outcome and process measures. Via the Reliable Change Index (Jacobson & Truax, 1991), we determined whether there were significant changes in outcome throughout therapy.

To investigate O2, we used the Core Conflictual Relationship Theme method (CCRT, Luborsky & Crits-Christoph, 1998) to operationalize interpersonal patterns in a therapeutic context. The CCRT maps three dimensions of people's relationships to others: the subjective wishes with which one enters interpersonal relations (W), one's own personal appraisal of how the other interacts and responds to these wishes (RO) and the characteristic reactions of the self to this other (RS). To map the dominant CCRTs and the changes therein throughout therapy (O2), we conducted the CCRT method on narratives derived from the transcribed therapy sessions at the beginning (session 1 through 4) (RQ1), middle (session 9 through 12) and end (sessions 17 through 20) (RQ2) of treatment. Because in case 1, there was no set time-limit, the investigated therapy sessions differ. However, because we conducted the CCRT method in this case also at the beginning, middle and end of therapy, we ensured the comparability of the three cases. The CCRT method starts with selecting a minimum of seven relationship episodes (REs) within the narrative material. REs are relatively discrete episodes in which a person speaks about relationships with others. The CCRT method then maps three dimensions of people's allying with others: the subjective wishes (W), the response of the other (RO) and the characteristic reactions of the self to this other (RS). These components were rated separately by two researchers using the Standard Categories (Edition 2) provided by the CCRT manual, which includes 35 Ws, 30 ROs, and 31 RSs. Via consecutive consensus meetings, we systematized our research process. Consensus on the frequency of each component was achieved through detailed discussion and the final frequency with which each category occurred across the REs was computed to provide the dominant CCRT.

To study O3 in case 2 and case 3, we investigated the formation of the therapeutic alliance (RQ3) via a quantitative investigation of the evolution of the WAI-scores and a qualitative investigation of the CCIs. Further, we applied the *Penn Adherence/Competence Scale for SE Dynamic Psychotherapy* (PACS-SE, Barber & Crits-Christoph, 1996) to assess the frequency of different therapeutic techniques (RQ4). The scale consists of 9 items assessing general techniques (e.g., 'The therapist encourages the patient to explore the personal meaning of an event or feeling'), 9 items assessing supportive techniques (e.g., 'The therapist conveys a sense of respect, understanding and acceptance to the patient.'), and 27 items assessing expressive interventions (e.g., 'The therapist focuses attention on similarities among the patient's past and present relationships'). All therapist interventions – except 'mhm', which was considered a neutral intervention – were rated as general, supportive or expressive by two researchers, independent from each other. Through consecutive meetings, consensus was achieved (Jackson et al., 2011) and the frequencies per technique were computed for every

session. Research shows that, in general, working through the CCRT leads to therapeutic success and is necessary to bring about symptomatic change (e.g., Crits-Christoph et al., 2010). Expressive techniques specifically target the CCRT components (Luborsky & Crits-Christoph, 1998). However, a stable therapeutic alliance, which is fostered by supportive techniques, is considered an essential basis for this process. Especially in pathology related to complex trauma, where trust is a fundamental difficulty, the formation of the therapeutic relationship is considered quintessential (e.g., Cloitre et al., 2004; Ford et al., 2005). In line with Luborsky and Crits-Christoph (1998), we expect that at the beginning of treatment, more supportive techniques will be used, whereas, once a stable therapeutic alliance is established, progressively more expressive techniques will be introduced.

Finally, we synthesized our research findings in the discussion section (cf. chapter 6) using principles of qualitative meta-synthesis (e.g., Iwakabe & Gazzola, 2009). This approach allowed us to identify cross-case similarities and dissimilarities in terms of (changes in) interpersonal dynamics in cases with a complex trauma history and enabled us to explore possible alternative explanations for unique or distinctive features within the individual cases.

References

American Psychological Association (2017). *Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder (PTSD) in Adults*. Retrieved from https://apa.org/PTSD-guideline/

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Arntz, A. (1994). Treatment of borderline personality disorder: A challenge for Cognitive-Behavioral Therapy. *Behaviour Research and Therapy, 32*(4), 419-430.

Barber, J. P., & Crits-Christoph, P. (1996). Development of a Therapist Adherence/Competence Rating Scale for Supportive-Expressive Dynamic Psychotherapy: A Preliminary Report. *Psychotherapy Research, 6*(2), 81-94.

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Manual for the Beck Depression Inventory-II.* San Antonio, TX: The Psychological Corporation.

Bistoen, G. (2016). *Trauma, Ethics and the Political beyond PTSD: The Dislocations of the Real*. Houndsmills, Basingstoke: Palgrave Macmillan.

Bistoen, G., Vanheule, S., & Craps, S. (2014). Nachträglichkeit: A Freudian perspective on delayed traumatic reactions. *Theory & Psychology, 24*(5), 668-687.

Bracken, P. J. (2002). *Trauma: Culture, Meaning and Philosophy.* London and Philadelphia: Whurr Publishers.

Bretherton, I., & Munholland, K. A. (2008). Internal working models in attachment relationships: Elaborating a central construct in attachment theory. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 102-127). New York, NY, US: Guilford Press.

Briere, J., & Jordan, C. E. (2009). Childhood maltreatment, intervening variables, and adult psychological difficulties in women: An overview. *Trauma, Violence & Abuse, 10*(4), 375-388.

Brown, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101.

Cauwe, J. (2018). *Structural dimensions of transference in Lacanian treatment : a clinical-qualitative study*. Ghent University. Faculty of Psychology and Educational Sciences, Ghent, Belgium.

Cloitre, M., Courtois, C. A., Charuvastra, A., Carapezza, R., Stolbach, B. C., & Green, B. L.

(2011). Treatment of Complex PTSD: Results of the ISTSS Expert Clinician Survey on Best Practices. *Journal of Traumatic Stress, 24*(6), 615-627.

Cloitre, M., Garvert, D. W., Brewin, C. R., Bryant, R. A., & Maercker, A. (2013). Evidence for proposed ICD-11 PTSD and complex PTSD: A latent profile analysis. *European Journal of Psychotraumatology, 4*:10.3402/ejpt.v4i0.20706.

Cloitre, M., Stolbach, B. C., Herman, J. L., van der Kolk, B., Pynoos, R., Wang, J., & Petkova, E. (2009). A Developmental Approach to Complex PTSD: Childhood and Adult Cumulative Trauma as Predictors of Symptom Complexity. *Journal of Traumatic Stress, 22*(5), 399-408.

Cloitre, M., Stavall-McClough, K. S., Miranda, R., & Chemtob, C. M. (2004). Therapeutic Alliance, Negative Mood Regualtion, and Treatment Outcome in Child Abuse-Related Posttraumatic Stress Disorder. *Journal of Consulting and Clinical Psychology, 72*(3), 411-416.

Chiriaco, S. (2012). *Le désir foudroyé: Sortir du traumatisme par la psychoanalyse.* Paris: Navarin/Le Champ Freudien.

Cornelis, S. (2016). *Interactions between neurotic symptoms and interpersonal dynamics throughout psychodynamic psychotherapy: four empirical case studies.* Ghent University. Faculty of Psychology and Educational Sciences, Ghent, Belgium.

Curtis, S., Gesler, W., Smith, G, & Washburn, S. (2000). Approaches to sampling and case selection in qualitative research: Examples in the geography of health. *Social Science & Medicine,50,* 1001-1014.

Crits-Christoph, P., Connoly Gibbons, M. B., Temes, C. M., Elkin, I., & Gallop, R. (2010). Interpersonal Accuracy of Interventions and the Outcome of Cognitive and Interpersonal Therapies for Depression. *Journal of Consulting and Clinical Psychology, 78*(3), 420-428.

Dattilio, F., M., Edwards, D. J. A., & Fishman, D. B. (2010). Case studies within a mixed methods paradigm: Towards a resolution of the alienation between researcher and practitioner in psychotherapy research. *Psychotherapy Theory, Research, Practice, Training, 47*(4), 427-441.

Declercq, F. (2000). *Het reële bij Lacan: over de pulsie en de finaliteit van de analytische kuur.* Gent: Idesça.

DeJongh, A., Resick, P. A., Zoellner, L. A., van Minnen, A., Lee, C. W., Monson, C. M., . . . & Bicanic, I. A. (2016). Critical analysis of the current treatment guidelines for complex PTSD in adults. *Depression and Anxiety, 33*(5), 359-369.

Denzin, N. K., & Lincoln, Y. S. (2011). The Discipline and Practice of Qualitative Research. In N. K. Denzin & Y. S. Lincoln (Eds.), *The SAGE Handbook of Qualitative Research* (pp. 1-19). Los Angeles: SAGE Publications, inc.

DePrince, A. P., Chu, A. T., & Pineda, A. S. (2011). Links between specific posttrauma appraisals and three forms of trauma-related distress. *Psychological Trauma: Theory, Research, Practice, and Policy, 3*(4), 430-444.

Derogatis, L. R. (1992). SCL-90-R: *Administration, Scoring and procedures manual* (2nd ed.). Towson, MD: Clinical Psychometric Research Inc.

Desmet, M. (2013). Experimental versus naturalistic psychotherapy research: Consequences for researchers, clinicians, policy makers and patients. *Psychoanalytische Perspectieven, 31*(1), 59-78.

Desmet, M. (2018). *The pursuit of objectivity in psychology.* Borgerhoff en Lomberigts: Gent.

Drapeau, M., & Perry, J. C. (2004a). Childhood trauma and adult interpersonal functioning: A study using the Core Conflictual Relationship Theme Method (CCRT). *Child Abuse & Neglect, 28*(10), 1049-1066.

Drapeau, M., & Perry, J. C. (2004b). Interpersonal conflicts in borderline personality disorder: An exploratory study using the CCRT-LU. *Swiss Journal of Psychology, 63*(1), 53-57.

Drapeau, M., & Perry, J. C. (2009). The Core Conflictual Relationship Themes (CCRT) in Borderline Personality Disorder. *Journal of Personality Disorders*, *23*(4), 425-431.

Drozdek, B. (2015). Challenges in treatment of posttraumatic stress disorder in refugees: Towards integration of evidence-based treatments with contextual and culture-sensitive perspectives. *European Journal of Psychotraumatology*, *6*: 10.3402/ejpt.v6.24750.

Dulsster, D. (2015). Woorden die snijden. *Tijdschrift voor Psychoanalyse, 2,* 98-106.

Edwards, D. J. A. (2007). Collaborative versus Adversarial Stances in Scientific Discourse: Implications for the Role of Systematic Case Studies in the Development of Evidence-Based Practice in Psychotherapy. *Pragmatic Case Studies in Psychotherapy, 3*(1), 6-34.

Ehlers, A. Hackmann, A. & Michael, T. (2004). Intrusive reexperiencing in posttraumatic stress disorder: Phenomenology, theory, and therapy. *Memory, 12,* 403-415.

Ehring, T., & Quack, D. (2010). Emotion Regulation Difficulties in Trauma Survivors: The Role of Trauma Type and PTSD Symptom Severity. *Behavior Therapy, 41,* 587-598.

Elliott, R., Slatick, E., & Urman, M. (2001). Qualitative change process research on psychotherapy: Alternative strategies. *Psychologische Beiträge, 43,* 69-111.

Epstein, M. (2013, August 4). The Trauma of Being Alive. *The New York Times.* Retrieved from https://www.nytimes.com/2013/08/04/opinion/sunday/the-trauma-of-being-alive.html.

First, M. B., Gibbon, M., Spitzer, R. L, Williams, J. B. W., Benjamin, L. S. (1997). *Structured Clinical Interview for DSM-IV Axis II Personality Disorders, (SCID-II).* Washington, D.C.: American Psychiatric Press, Inc.

First, M. B., Spitzer, R. L, Gibbon, M., & Williams, J. B. W. (2002). *Structured Clinical Interview for DSM-IV-TR Axis I Disorders, Research Version, Patient Edition. (SCID-I/P).* New York, NY: Biometrics Research, New York State Psychiatric Institute.

Forbes, D., Lockwood, E., Phelps, A., Wade, D., Creamer M., Bryant, R. A., … O'Donnell, M. (2014). Trauma at the hands of another: Distinguishing PTSD patterns following intimate and nonintimate interpersonal and noninterpersonal trauma in a nationally representative sample. *The Journal of Clinical Psychiatry, 75*(2), 147-153.

Ford, J. F., Courtois, C. A., Steele, K., van der Hart, O., & Nijenhuis, E. R. S. (2005). Treatment of Complex Posttraumatic Self-Dysregulation. *Journal of Traumatic Stress, 18*(5), 437-447.

Freud, S. (1961). *Beyond the Pleasure Principle* (J. Strachey, Trans.). New York and London: W. W. Norton & Company. (Original Published in 1920).

Hacking, I. (2005). *Rewriting the soul. Multiple personality and the sciences of memory.* Princeton/Chichester: Princeton University Press.

Harvey, M. R. (1996). An ecological view of psychological trauma and trauma recovery. *Journal of Traumatic Stress, 9*(1), 3-23.

Herman, J. (1992). *Trauma and Recovery.* New York, NY: Basic Books.

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the working alliance inventory. *Journal of Counselling Psychology, 36,* 223-233.

Hodgdon, H., Kinniburgh, K., Gaowitz, D., Blaustein, M. E., &Spinazzola, J. (2013). Development and Implementation of Trauma-Informed Programming in Youth Residential Treatment Centers Using the ARC Framework. *Journal of Family Violence, 28,* 679-692.

Horowitz, L. M., Alden, L. E., Wiggins, J. S., & Pincus, A. L. (2000). *Inventory of Interpersonal Problems.* London: The Psychological Corporation.

Hovens, J. E., Bramsen, I., & van der Ploeg H. M. (2009). *Zelfinventarisatielijst Posttraumatische Stressstoornis*. Amsterdam: Pearson Assessment and Information B.V.

Iwakabe, S., & Gazzola, N. (2009). From single-case studies to practice-based knowledge: Aggregating and synthesizing case studies. *Psychotherapy Research, 19*(4-5), 601-611.

Jackson, J. L., Chui, H. T., & Hill, C. E. (2011). The Modification of Consensual Qualitative Research for Case Study Research: An Introdution to CQR-C. In C. E. Hill (Ed.), *Consensual Qualitative Research: Practical Resources for Investigating Social Science Phenomena* (pp. 285-303). Washington, DC: American Psychological Association.

Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59*(1), 12-19.

Jonckheere L. (2003). *Het seksuele fantasme voorbij*. Leuven: Acco.

Kazdin, A. E. (2007). Mediators and mechanisms of change in psychotherapy research. *Annual Review of Clinical Psychology, 3*, 1-27.

Kinet, M. (2016). *Trauma binnenstebuiten. Verbanden bij psychische wonden.* Antwerpen/ Apeldoorn: Garant.

Kisiel, C. L., Fehrenbach, T., Torgersen, E., Stolbach, B., Griffin, G., & Burkman, K. (2014). Constellations of Interpersonal Trauma and Symptoms in Child Welfare: Implications for a Developmental Trauma Framework. *Journal of Family Violence, 39*(1), 1-14.

Koss, M. P., Figueredo, A. J., & Prince, R. P. (2002). Cognitive Pediation of Rape's Mental, Physical, and Social Health Impact: Tests of Four Models in Cross-Sectional Data. *Journal of Consulting and Clinical Psychology, 70*(4), 926-941.

Lacan, J. (1991). *The seminar of Jacques Lacan. Book I. Freud's Papers on Technique 1953-1954*. (J. F. Forrester, Trans.). J.-A. Miller (Ed.). New York and London: W. W. Norton & Company. (Original published in 1975)

Lacan, J. (1998). *The seminar of Jacques Lacan. Book XI. The Four Fundamental Concepts of Psychoanalysis.* (A. Sheridan, Trans.). J.-A. Miller (Ed.). New York and London: W. W. Norton & Company. (Original published in 1973)

Levitt, H. M., Bamberg, M., Creswell, J. W., Frost, D. M., Josselson, R., & Suárez-Orozco, C. (2018). Journal article reporting standards for qualitative primary, qualitative meta-analytic, and mixed methods research in psychology: The APA Publications and Communications Board task force report. *The American Psychologist, 73*(1), 26-46.

Leys, R. (2000). *Trauma: A Genealogy.* Chicago: University of Chicago Press.

Luborsky, L. (1984). *Principles of psychoanalytic psychotherapy: A manual for supportive-*

expressive treatment. New York, NY: Basic Book.

Luborsky, L., & Crits-Christoph, P. (1998). *Understanding Transference: The Core Conflictual Relationship Theme Method* (2nd Ed.). Washington, DC: American Psychological Association.

Luyten, P., Blatt, S. J., & Corveleyn, J. (2006). Minding the Gap between Positivism and Hermeneutics in Psychoanalytic Research. *Journal of the American Psychoanalytic Association, 54*(2), 571-610.

Markey, S. (2006). Over de behandeling van aktuaalneurose: Een gevalstudie. *Psychoanalytische Perspectieven, 24*(3-4), 379-390.

McLeod, J. (2013). Increasing the Rigor of Case Study Evidence in Therapy Research. *Pragmatic Case Studies in Psychotherapy, 9*(4), 382-402.

Meganck, R., Desmet, M., Bockting, C., Inslegers, R., Truijens, F., De Smet, M., … Vanheule, S. (2017). The Ghent Psychotherapy Study (GPS) on the differential efficacy of supportive-expressive and cognitive behavioral interventions in dependent and self-critical depressive patients: Study protocol for a randomized controlled trial. *Trials,* 18, 126.

Michael, T., Ehlers, A., Halligan, S., & Clark, D.M. (2005). Unwanted memories of assault: What intrusion characteristics predict PTSD? *Behaviour Research and Therapy, 43,* 613- 628.

Molenaar, P. C. M., & Valsiner, J. (2005). How generalization works through the single case. A simple idiographic process analysis of an individual psychotherapy. *International Journal of Idiographic Science.*

Newman, E., Riggs, D. S., & Roth, S. (1997). Thematic Resolution, PTSD, and Complex PTSD: The Relationship Between Meaning and Trauma-Related Diagnoses. *Journal of Traumatic Stress, 10*(2), 197-213.

Patton, M. Q. (2002). Qualitative designs and data collection. In *Qualitative research and evaluation methods* 3rd ed., (pp. 228-247). London, England: Sage.

Pearlman, L. A., & Courtois, C. A. (2005). Clinical Applications of the Attachment Framework: Relational Treatment of Complex Trauma. *Journal of Traumatic Stress, 18*(5), 449-459.

Peres, J. F., McFarlane, A., Nasello, A. G., & Moores, K. A. (2008). Traumatic memories: Bridging the gap between functional neuroimaging and psychotherapy. *The Australian and New Zealand journal of psychiatry, 42*(6), 478-488.

Pressley, J. & Spinazzola, J. (2015). Beyond Survival: Application of a Complex Trauma Treatment Model in the Cristian Context. *Journal of Psychology & Theology, 43*(1), 8-22.

Resick, P. A., Bovin, M. J., Calloway, A. L., Dick, A. M., King, M. W., … & Wolf, E. J. (2012). A critical evaluation of the complex PTSD literature: implications for DSM-5. *Journal of Traumatic Stress, 25*(3), 241-51.

Rosen, G. M., & Lilienfeld, S. O. (2008). Posttraumatic stress disorder: An empirical evaluation of core assumptions. *Clinical Psychology Review, 28*(5), 837-868.

Roy, D. (2013). Enfants de Chowchilla ou la fabuleuse naissance de 'l état de stress post-traumatique chez l' enfant. In *Le Livret Trauma* (pp. 63-68). Retrieved from http://data.over-blog-kiwi.com/0/56/53/77/20150307/ob_ae754e_le-livret.pdf.

Shapiro, F., & Laliotis, D. (2011). EMDR and the Adaptive Information Processing Model: Integrative Treatment and Case Conceptualization. *Clinical Social Work Journal, 39*(2), 191-200.

Sharp, C., Fonagy, P., & Allen, J. G. (2012). Posttraumatic Stress Disorder: A Social-Cognitive Perspective. *Clinical Psychology Science and Practice, 19*(3), 229-240.

Stein, H., & Allen, J. G. (2007). Mentalizing as a framework for integrating therapeutic exposure and relationship repair in the treatment of a patient with complex posttraumatic psychopathology. *Bulletin of the Menninger Clinic, 71*(4), 273-290.

Stiles, W.B. (2003). When is a case study scientific research? *Psychotherapy Bulletin, 38,* 6-11.

Stiles, W. B. (2013). The Variables Problem and Progress in Psychotherapy Research. *Psychotherapy, 50*(1), 33-41.

Stinckens, N. & Smits, D. (2010). Het belang van systematisch casestudyonderzoek. *Tijdschrift Klinische Psychology, 40*(2), 94-105.

Terr, L. C. (1991). Childhood traumas: An outline and overview. *The American Journal of Psychiatry, 148*(1), 10-20.

Toomela, A. (2007). History of Methodology in Psychology: Starting Point, Not the Goal. *Integrative Psychological and Behavioral Science, 41,* 75-82.

van der Hart, O., Nijenhuis, E. R. S., & Steele, K. (2005). Dissociation: An Insufficiently Recognized Major Feature of Complex Posttraumatic Stress Disorder. *Journal of Traumatic Stress, 18*(5), 413-423.

Van der Kolk, B. A. (2005). Developmental Trauma Disorder. *Psychiatric Annals, 35*(5), 401-408.

van der Kolk, B. A., Roth, S., Pelcovitz, D., Sunday, S., & Spinazzola, J. (2005). Disorders of Extreme Stress: The Empirical Foundation of a Complex Adaptation to Trauma. *Journal of Traumatic Stress, 18*(5), 389-399.

Vanheule, S. (2002). Qualitative Research and its Relation to Lacanian Psychoanalysis. *Journal for the Psychoanalysis of Culture & Society, 7*(2), 336-342.

Vanheule, S. (2015). *Psychodiagnostiek anders bekeken: Kritieken op de DSM. Een pleidooi voor functiegerichte diagnostiek.* Tielt: Lannoo.

Van Nieuwenhove, K. (2018). Talking about Trauma: Could I, Would I, Should I? *Psychoanalytische Perspectieven, 36*(3), 235-248.

Verhaeghe, P. (2001). *Beyond Gender: From Subject to Drive.* New York, NY: Other Press.

Verhaeghe, P. (1998). Trauma and hysteria within Freud and Lacan. *THE LETTER (DUBLIN), 14*, 87-106.

Verhaeghe, P. (2004). *On being normal and other disorders: A manual for clinical psychodiagnostics.* New York, NY, USA: Other.

Verhaeghe, P., & Vanheule, S. (2005). Actual neurosis and PTSD: The impact of the other. *Psychoanalytic Psychology, 22*(4), 493-507.

Wadsworth, B. J. (2004). *Piaget's theory of cognitive and affective development: Foundations of constructivism.* Boston, MA: Allyn & Bacon.

Walsh, K., Fortier, M. A., & DiLillo, D. (2010). Adult Coping with Childhood Sexual Abuse: A Theoretical and Empirical Review. *Aggression and Violent Behavior, 15*(1), 1-13.

Wampold, B. E. (2007). Psychotherapy: The humanistic (and effective) treatment. *American Psychologist, 62*(8), 857-873.

Westen, D. (2006). *The Clinical Diagnostic Interview.* Atlanta, GA: Emory University.

Zlotnick, C., Zakriski, A. L., Shea, M. T., Costell, E., Begin, A., Pearlstein, T., & Simpson, E. (1996). The Long-Term Sequelae of Sexual Abuse: Support for a Complex Posttraumatic Stress Disorder. *Journal of Traumatic Stress, 9*(2), 195-205.

2

INTERPERSONAL FEATURES IN COMPLEX TRAUMA ETIOLOGY, CONSEQUENCES, AND TREATMENT: A LITERATURE REVIEW.[10]

Complex trauma is a much-debated construct and research findings are dispersed due to for example the lack of conceptual clarity about the core features constituting complex trauma and its sequalae. Recently, there has been a vast expansion of research studies on interpersonal features, which is fundamental in understanding complex trauma. The aim of this article is to provide a comprehensive overview of the literature with regard to this dimension. We found that trauma research stresses the importance of interpersonal features on three major levels. First, complex trauma is an umbrella term encompassing prolonged and repeated harmful events that typically occur in the interpersonal sphere. A second line of research focuses on the interpersonal difficulties associated with complex trauma, which can be broadly divided into two related categories: behavioural disruptions and distorted interpersonal schemata. Third, researchers address the importance of interpersonal difficulties in the treatment of complex trauma, especially the formation of the therapeutic alliance. Our literature review reveals that these three research areas are interconnected through the concept of core interpersonal schemata. We proclaim that further research should aim at a deeper understanding of the nature of these interpersonal schemata, the ways they develop, and the processes through which they can change.

Keywords: complex trauma; interpersonal trauma; interpersonal relationship patterns; therapeutic relationship; literature review

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Introduction

The concept of complex trauma was called into being because of the clinical and theoretical consideration that there should be a different category for the consequences of certain types of events (e.g., childhood abuse) that seem to be more intrusive, pervasive or harmful than others (e.g., a car accident) (Cloitre et al., 2009; Ehring & Quack, 2010; Herman, 1992; van der Kolk et al., 1996). Accordingly, complex trauma has been defined as the experience of prolonged and repeated atrocious events that typically occur in the *interpersonal* sphere (e.g., Herman, 1992; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005).

Experiencing such events can lead to a wide array of difficulties, in multiple domains, going from somatic complaints to fundamental personality disturbances (for recent reviews, see D'Andrea, Ford, Stolback, Spinazzola, & van der Kolk, 2012; López-Martínez et al., 2016). As Stein and Allen (2007) note, it is "difficult to aggregate the welter of symptoms into discrete diagnostic categories" (p. 278). Some of the symptoms are encompassed by the diagnosis of Posttraumatic Stress Disorder (PTSD). Other difficulties are often referred to as 'comorbid conditions' (van der Kolk et al., 2005), such as major depressive disorder, generalized anxiety disorder (Seng, D'Andrea, & Ford, 2014), somatoform disorder, and borderline personality disorder (van Dijke et al., 2012). Still other symptoms may not be captured by any psychiatric diagnosis at all. Syndromes as *Complex Posttraumatic Stress Disorder* (CPTSD, Cloitre, Garvert, Brewin, Bryant, & Maercker, 2013; Herman, 1992), *Disorders of Extreme Stress, Not Otherwise Specified* (DESNOS, Pelcovitz, van der Kolk, Roth, Mandel, Kaplan, & Resick, 1997; Ford, Courtois, Steele, van der Hart, & Nijenhuis, 2005), and *Developmental Trauma Disorder* (van der Kolk, 2005) were introduced to create a more comprehensive conception of complex traumatic consequences. They all describe the detrimental symptomatology associated with complex trauma, surpassing the avoidance, hyperarousal, and numbing symptoms associated with PTSD, with the inclusion of affect regulation difficulties, alterations in attention and consciousness, and *interpersonal* difficulties.

Van der Kolk and colleagues (2005) reason that patients with complex trauma histories complain more about functional impairments in affect and interpersonal functioning and that they request help in these domains, rather than seek treatment to alleviate their PTSD symptoms. Accordingly, the development of emotion regulation strategies and/or focusing on *interpersonal* problems have been put forward as main targets in the treatment of complex trauma-related pathologies (Blalock et al., 2013; Brown, Kallivayalil, Menselsohn, & Harvey, 2012; Cloitre et al., 2013; Cook, Riggs, Thompson, Coyne, & Sheikh, 2004; D'Andrea & Pole,

2012; Deprince, Chu, & Pineda, 2011; Jepsen, Langeland, & Heir, 2013; Stein & Allen, 2007; Tummala-Narra, 2014).

This brief introduction demonstrates that interpersonal features can be distinguished in complex trauma etiology, as well as its consequences and treatment. Unfortunately, these dimensions are often studied separately and from different and multiple perspectives, leaving research findings scattered and dispersed. This artificial disentanglement, moreover, does not allow a cohesive and coherent understanding of interpersonal features associated with complex trauma. To see how matters stand after more than three decades of theoretical and empirical enquiries, our objective is to bring the abundant writings on interpersonal features in trauma to one place and attempt to map how these different research fields are interrelated.

Screening the Literature

We conducted a search on Web of Science using "Complex trauma OR complex PTSD OR DESNOS" AND "Interpersonal OR relation*" as our search terms. Out of the 395 results, we selected 94 articles, using the following criteria: a) the abstract or title should contain an explicit focus on interpersonal features in trauma, b) the primary diagnosis should be trauma-related, and c) articles should be in English. To the extent of providing a critical and comprehensive exploration and discussion of research findings, we included both empirical and theoretical studies. During a first reading of the articles, we used a snowball sampling technique to further select relevant works using the citation lists. We delineated three levels at which interpersonal features have a prominent place in trauma research – etiology, consequences, and therapy – and organized the literature accordingly, with 22, 39, and 33 articles covering mainly etiology, consequences, and therapy, respectively. A list of the included articles and their main features can be found in Appendix A. We used principles of thematic analysis (Brown & Clarke, 2006) to identify common themes within the broader categories. In the following, we discuss the key findings on interpersonal features in the etiology, consequences and treatment of complex trauma, respectively. Connections between the different levels will be discussed in every section as appropriate.

Etiology: The Interpersonal Nature of Complex Trauma

Accidental or *single-incident trauma* refers to isolated distressing events, such as a car accident, a natural disaster or a one-off assault. The boundaries of what constitutes *complex trauma* are less clear. Minimally, complex trauma involves *prolonged* and *repeated* harmful, dangerous, extreme events (e.g., Cloitre et al., 2011; Herman, 1992; van der Kolk et al., 1996). Next to that, there seems to be agreement that complex trauma involves "harm-doing by people

to people" (Ebert & Dyck, 2004, p. 618) and thus contains an *interpersonal element* (e.g., Briere, Hodges, & Godbout, 2010; Herman, 1992; Spinazzola, Blaustein, & van der Kolk, 2005; van der Kolk et al., 1996). The vast majority of studies result in the conclusion that repeated interpersonal traumatic events cause more harm than (repeated) non-interpersonal traumatic events (e.g., Cloitre et al., 2013; Ehring & Quack, 2010; Forbes et al., 2014; Green et al., 2000; Newman et al., 1997).

In the literature, there is confusion regarding the *context* wherein the exposure to such repeated interpersonal atrocities can be defined as complex trauma. Some authors argue that complex trauma involves a developmental disruption and thus occurs at 'critical ages' (e.g., Lawson, Davis, & Brandon, 2013; van der Kolk et al., 1996). In this context, most frequently named examples of complex trauma fall within the category of childhood maltreatment, such as neglect, physical abuse, sexual abuse, and psychological abuse (e.g., Becker-Weidman, 2009; Lawson, 2009; Lawson et al., 2013; Spinazzola et al., 2005). Frequently, involvement of the caregiving system or the disruption of primary attachment bonds seems to be a prerequisite. The perpetrator, who is supposed to be a source of safety and stability, abuses and thereby betrays the child (e.g., Becker-Weidman, 2009; Cook et al., 2004; van der Kolk et al., 1996).

When the dimension of an *impossibility to escape* is included as a core-defining element of complex trauma (Herman, 1992), it is clear that other contexts could also be considered as complex traumatic situations. These contexts are also characterized by interpersonal situations in which others cannot be trusted and include being a victim of domestic violence, sex trafficking or slave trade, being a child soldier, and being a refugee or civilian war victim who has experienced torture, genocide, campaigns or other forms of organized violence (Herman, 1992; Newman, Riggs, & Roth, 1997).

Research is inconclusive as to whether age and chronicity are important factors to consider. For example, Roth, Newman, Pelcovitz, van der Kolk, and Mandel (1997) did not find that age of onset was associated with symptom severity, whereas van der Kolk et al. (2005) and Cloitre et al. (2009) found that younger and more chronically exposed individuals had higher odds of greater symptom complexity. Roth et al. (1997) on the other hand found that a combination of both physical and sexual abuse was more detrimental for mental health than physical abuse alone. Other research confirms the idea that cumulative childhood trauma, rather than age of onset, is associated with more severe symptomatic burden (e.g., Allen, Coyne, & Huntoon, 1998). Unfortunately, the above-mentioned studies solely focus on childhood maltreatment, which does not allow firm conclusions about exposure to repeated interpersonal traumatic events later in life. The observation that many war veterans also have a history of

childhood maltreatment (e.g., Newman, Orsillo, Herman, Niles, & Litz, 1995; Owens et al., 2009) might suggest that also in this population a developmental disruption is a prerequisite for emerging complex trauma symptoms. However, research on developmental perspectives in this population is scarce (Landes, Garovoy, & Burkman, 2013) and needs to expand to other complex traumatic situations, such as domestic violence.

In sum, research has focused extensively on providing support for the idea that being exposed to prolonged and repeated interpersonal traumatic events is associated with harmful and diverse patterns of psychological disturbances. Some inconsistencies remain, since there is no consensus about which contextual variables (age of onset, duration, frequency, type of event(s)) are important to consider. It is possible that in this context no general statements can be made, due to the very complex relations between many different variables. Our literature review did reveal that a more thorough understanding of the interpersonal sphere in which the traumatic experiences occur can help us to understand the development of interpersonal or other difficulties.

Interpersonal Development and Complex Interpersonal *Consequences*

The consequences of being exposed to complex traumatic events may not be predominantly caused by the experiences themselves, but rather result from the larger developmental context or social matrix in which they occurred (Briere & Jordan, 2009; Ford, Connor, & Hawke, 2008; Harvey, 1996; Thomson, Maccio, Deselle, & Zittel-Palamara, 2007). Forbes et al. (2014) found that victimization at the hands of intimates was more burdensome than victimization at the hands of nonintimates. Likewise, Kisiel et al. (2014a; 2014b) demonstrate that the involvement of the caregiver system has a unique effect on post-trauma consequences. They found that childhood maltreatment (i.e., sexual abuse, physical abuse, and/or family violence) was related to more and multiple difficulties when there also were attachment-based traumas (i.e., emotional abuse and/or severe neglect), even when controlling for the number of traumas experienced (Kisiel et al., 2014b). They also found that attachment problems were more prevalent when a caregiver was responsible (Kisiel et al., 2014a).

In the interaction with primary caregivers, pivotal developmental skills are attained, such as adaptive emotion regulation and coping skills (Briere et al., 2010; Cloitre et al., 2009; Ehring & Quack, 2010; Pearlman & Courtois, 2005) and effective interpersonal behaviour in order to be able to form and sustain supportive relationships (Harvey, 1996; van der Kolk et al., 2005). Drawing from attachment theory, the accomplishment of these early developmental processes is important to be able to successfully deal with adverse events. When the infant is

securely attached, it can turn to the primary caregivers, as they are a source of safety and support, and provide a template for how to react and respond in such circumstances (e.g., Briere et al., 2010; Harvey, 1996; Pearlman & Courtois, 2005; Zorzella, Muller, & Classen, 2014). In this way, attachment theory may help explain the – albeit inconclusive – finding that the age of onset is an important risk factor in the development of psychopathological reactions to traumatic events. When a secure attachment is established before the onset of traumatic experiences, individuals can draw from their natural support system to cope with adversities (Pearlman & Courtois, 2005; Tummala-Narra, 2014).

Early complex traumatic experiences at the hands of primary caregivers or other trusted people have been associated with insecure (disorganized) attachment (e.g., Allen et al., 1998; Jepsen et al., 2013), which compromises individual (e.g., self-perception, emotion regulation) and interpersonal (e.g., basic trust) developmental processes (Briere & Jordan, 2009; Messman-Moore & Resick, 2002; Pressley & Spinazzola, 2015; Zorzella et al., 2014). So, unlike in the event of accidental trauma, where it might be the case that *previous* behaviour and personality characteristics alter, complex childhood traumas "impact *the formation* of patterns of behaviour and beliefs about the self, world and others" (Resick et al., 2012a, p. 246, emphasis added). The erratic experiences influence the formation of schemas concerning the self and others to enable the child to adapt to the dysfunctional situation (Deprince et al., 2011).

Even though these abuse-related schemas allow endurance or even survival in the abusive home situation, they are "dysfunctional in coping with a world where abuse is not the norm" (Finkelhor, 1987, p. 355, as cited in Walsh, Fortier, & DiLillo, 2010). Engrained in the internal working model of the subject, specific ways of interacting are molded, setting up the background against which characteristic and recurrent ways of relating to others in adult life need to be understood (Briere & Jordan, 2009; Kisiel et al., 2014a; Kisiel et al., 2014b; Ma & Li, 2014; van der Kolk et al., 1996; von Sydow, 2002; Zilberstein & Messer, 2007). It has been found that people with a complex trauma history are guided by feelings of mistrust and suspiciousness in relation to others (Arntz, 1994; Ebert & Dyck, 2004; Harvey, 1996; Jepsen et al., 2013; Koss, Figueredo, & Prince, 2002; Lawson et al., 2013; Ma & Li, 2014; Tummala-Narra, Kallivayalil, Singer, & Andreini, 2012). Others and the world are perceived as dangerous (Hodgdon, Kinniburgh, Gabowitz, Blaustein, & Spinazzola, 2013; Lawson et al., 2013), malignant (Arntz, 1994; Tummala-Narra et al., 2012) and unpredictable (Hodgdon et al., 2013), which causes persistent doubts about safety (Ebert & Dyck, 2004; Tummala-Narra et al., 2012).

Next to the – sometimes inaccurately – negative expectations towards others, people

with a complex trauma history have a predominantly negative self-perception. The mental representation of the self is dominated by feelings of shame, guilt and self-blame (Allen, Huntoon, Evans, 1999; Cloitre et al., 2013; Ebert & Dyck, 2004; Harvey, 1996; Ma & Li, 2014), and hopelessness, helplessness and vulnerability (Adams, 2011; Allen et al., 1999; Arntz, 1994; Brown et al., 2012; Ebert & Dyck, 2004; Tummala-Narra et al., 2012). In relation to others, the belief that oneself is worthless and unlovable prevails (Adams, 2011; Cloitre et al., 2013). Subjects feel they are more prone (Tummala-Narra et al., 2012) or even more deserving (Lawson et al., 2013) of being exposed to abuse and pain.

In reviewing the literature, we noticed that these complex interpersonal schemata are regularly associated with interpersonal behavioural difficulties (e.g., Arntz, 1994; Briere & Jordan, 2009; Koss et al., 2002; Newman et al., 1997; Pearlman & Courtois, 2005; Roth et al., 1997). For instance, when a child's expression of certain emotions or needs is answered by parental disdain (either by passive rejection or active physical or emotional abusive responses), the expectation of these responses will lead to the inclination to not turn to caregivers in times of distress, which over time will generalize to all others (Gleiser, Ford, & Fosha, 2008). On the other hand, the need for soothing and support remains, which can result in dependent or even clinging behaviour. As a consequence of the paradoxical situation in which the caregiver is both the source of threat and the source of comfort, the child may display contrary behaviour of alienation and isolation (Amos, Segal, & Cantor, 2015; Zilberstein & Messer, 2007). The tendency to oscillate between wanting to be close to others and to favour distance, which is also a familiar pattern in adults who suffered complex trauma (Allen et al., 1998; Cloitre et al., 2009; Cook et al., 2004; Ford et al., 2005), are thus two sides of the same coin. They need to be understood as stemming from the same internal working model, rather than being two different dynamics between subject and others. In the same vein, the *need for control* and *anger, hostility, and aggressive behaviour* in adult relationships (Cloitre et al., 2009; Frueh, Turner, Beidel, & Cahill, 2001) can be understood (Howell, 2002; Liotti, 2013).

Other difficulties in interpersonal functioning involve problems in *communication* or negotiating relationships, including sexual boundaries (Brown et al., 2012; ; Pearlman & Courtois, 2005; van der Kolk et al., 2005). Marital problems consist, inter alia, of disruptions in emotional expressiveness, intimacy, and communication (Cook et al., 2004; Godbout, Sabourin, & Lussier, 2009), and a *heightened vulnerability for additional abuse or revictimization* (Harvey, 1996; Pearlman & Courtois, 2005). Although these interpersonal difficulties have not been directly associated with interpersonal schemata, it is reasonable to assume that they are also interconnected. For example, feeling more deserving of being exposed

to abuse and pain can help understand why subjects are more vulnerable to revictimization or relate to people that treat them in such a way.

Our literature study further revealed that disruptive schemata do not only occur in the context of interpersonal difficulties, but are also related to other core complex trauma associated features, such as affect and self-regulation difficulties and alterations in consciousness (e.g., Cloitre et al., 2009; Ehring & Quack, 2010; Lawson & Quinn, 2013; Ma & Li, 2014). Notwithstanding the idea of one overarching internal working model, the contradictory views of self, world and others may not sufficiently be integrated into a coherent representational scheme. This can result in dissociative states and behaviour (Gleiser et al., 2008; Howell, 2002; Liotti, 2013; Zilberstein & Messer, 2007).

Based on what we have discussed so far, it is clear that complex trauma is related to interpersonal difficulties in numerous ways, both in children and in adults. Existing research provides indications that allow delineating the nature of these interpersonal difficulties. However, the findings derived from mostly cross-sectional research designs, using (retrospective) self-report questionnaires, do not allow a full understanding of the dynamic and complex nature of interpersonal relationship patterns. Findings of cross-sectional studies can only provide confirmation of the isolated hypothesis that people exposed to prolonged interpersonal traumatic events suffer from a more complex constellation of symptoms as compared to people without a (complex) traumatic background (cf. etiology) and that being exposed to complex trauma correlates with the experience of interpersonal difficulties in adulthood. Furthermore, questionnaires only allow for a small scope, assessing for example marital discord or communication difficulties, which can only lead to a limited understanding of what these interpersonal difficulties precisely entail. What cannot be captured by isolated symptom checklists is the "patient's unique posttraumatic response" (Harvey, 1996, p. 8). Moreover, in the absence of longitudinal or prospective studies, the idea that childhood attachment difficulties associated with complex trauma influence adult interpersonal relationships remains a theoretical assumption, rather than an empirically supported hypothesis. There is a need for more longitudinal research to comprehend these connections at a deeper level. Nevertheless, it seems that dysfunctional interpersonal schemata, whether they are observed in children or adults, are critical in understanding complex trauma-related suffering. Given the omnipresence of interpersonal challenges and difficulties, numerous researchers stress the importance of addressing relationships in a therapeutic context (e.g., Herman, 1992; Pearlman & Courtois, 2005; van der Kolk et al., 2005).

Therapy: The Interpersonal in Complex Trauma Treatment

In view of the available literature, both clinicians and researchers propose a phase-based therapy approach as the most potent treatment option for complex trauma, both for adults (e.g., Cloitre et al., 2011; Ford et al., 2005) and children (e.g., Hodgdon et al., 2013; Kagan, Henry, Richardson, Trinkle, & LaFrenier, 2014; Kagan & Spinazzola, 2013). In a first phase, emphasis lies on patient safety, symptom stability or reduction, and the development or improvement of emotional, behavioral and relational skills (e.g., Cloitre et al., 2011; Drozdek, 2015; Pressley & Spinazzola, 2015). A first and vital step herein is the formation of a durable and workable therapeutic relationship (e.g., Arntz, 1994; Ford et al., 2005; Messman-Moore & Resick, 2002). Whereas the therapeutic situation in itself often suffices to induce a good working alliance early in therapy, clinical inquiry indicates this is not the case when treating patients with a complex trauma history (Ebert & Dyck, 2004; Herman, 1992; Gleiser et al., 2008; Lawson et al., 2013).

The formation of the therapeutic relationship or working alliance in the treatment of complex trauma is a double-edged sword. A trusting relationship with the therapist – as a new relational experience – is believed to provide the grounds to revise and rework (past) attachment difficulties (Blalock et al., 2013; Lawson et al., 2013; Pearlman & Courtois, 2005; Pressley & Spinazzola, 2015). However, precisely the expression of these difficulties, in the form of the compromised ability to trust and rely on others in general, leads to great difficulties in building a workable therapeutic relationship (Ebert & Dyck, 2004; Gleiser et al., 2008; Zorzella et al., 2014). Other factors that can create difficulties in developing a therapeutic relationship are patients' emotional and relational instability (Doukas, D'Andrea, Doran, & Pole, 2014; Pearlman & Courtois, 2005), as well as their feelings of being an inconvenience to the therapist and unworthy of being helped (Messman-Moore & Resick, 2002). Lawson et al. (2013) also emphasize that non-specific therapist factors, such as empathy and warmth, may not suffice to install a safe and healing context. It seems that patients' *perception* of the therapist (e.g., a human being who genuinely cares versus a professional merely providing tools to feel better) particularly influences the foundation of the therapeutic relationship (Lawrence & Lee, 2014). So, "the therapeutic relationship is not solely defined by therapist factors (i.e., what the therapist gives), but also by patient's *experience* (i.e., what the patient receives)" (Gleiser et al., 2008, p. 350).

Nevertheless, it is important to understand that, especially in the context of complex trauma, therapist factors – namely countertransference reactions – can impede the formation of a workable therapeutic relationship. This corresponds with the idea that patients' past traumatic

relationship experiences get re-enacted in the therapeutic context (Dalenberg, 2004; Herman, 1992; Pressley & Spinazzola, 2015; Zorzella et al., 2014). For instance, clinging behavior can lead to reactions of wanting to rescue or re-parent the patient (Pearlman & Courtois, 2005), whereas an avoidant, manipulative or even aggressive demeanor can lead to resentment, disapproval, and even rejecting or angry behavior on the therapist's side (Dalenberg, 2004; Lawson, 2009). Recognizing and understanding their own position in the therapeutic dyad allows therapists to create a *different* and repairing relational experience in which strong emotions can be experienced in a safe environment and can be dealt with in a more constructive manner (Adams, 2011; Blalock et al., 2013; Pressley & Spinazzola, 2015). Education and supervision can be useful tools in this regard (Ford, Chapman, Conner, & Cruise, 2012; Pearlman & Courtois, 2005). Also, maintaining clear therapy boundaries is often recommended (Dalenberg, 2004; Pearlman & Courtois, 2005). Another, more general rule for good practice is to allow the patient agency in their own therapy. In the context of complex trauma, this seems vital, since agency allows the patient to remain in control and to not have to feel subjected to the – possible or expected manipulative and harmful – power the therapist may exert (Arntz, 1994; Ford et al., 2012; Liotti, 2013). Next to that, it expresses respect for and confidence in the patient's readiness for change (Lawson et al., 2013).

There are some treatment models that only target first phase goals (e.g., Gleiser et al., 2008; Jepsen et al., 2013; Zorzella et al., 2014). If not, first phase strategies are considered as a prerequisite for more in-depth trauma processing in the second phase of therapy. During this phase, there is a focus on trauma exploration and processing of traumatic memories to enable accommodation, assimilation or integration of the traumatic experiences. Often, exposure techniques are recommended in this phase (e.g., Cloitre et al., 2011; Drozdek, 2015). Yet, questions remain about the necessity of directly targeting the traumatic experience through exposure techniques (e.g., Ford et al., 2005; Gleiser et al., 2008). There is evidence that the exploration or remembering of the traumatic events can lead to adverse effects (e.g., D'Andrea & Pole, 2012), especially in the early stages of treatment (e.g., Cloitre, Koenen, Cohen, & Han, 2002; Cloitre, Stovall-McClough, Miranda, & Chemtob, 2004; Zilberstein & Messer, 2007). Accordingly, it has been suggested that exposure should always be applied amenably and with caution (Landes et al., 2013). For example, in STAIR Narrative Therapy, a widely spread and accepted manualized treatment, the applied gradual exposure techniques have been modified by adding three components, one of which is to identify negative interpersonal schemas in the trauma narrative. Within the frame of the therapeutic relationship, these negative schemas can then be contrasted with the more adaptive schemas facilitated in the first phase of the therapy

(Cloitre et al., 2002). Here, treatment is actually more focused on the interpersonal difficulties associated with complex trauma than with the traumatic events themselves. The positive results in outcome studies (Cloitre et al., 2002; Cloitre et al., 2010) provide some preliminary support for the idea that exposure, per se, is not necessary to provide successful treatment. It has been suggested that other types of interventions, in which techniques to alter distorted thoughts and beliefs play a more central role, can be as or even more effective than exposure-focused approaches (e.g., Arntz, 1994; Gleiser et al., 2008; Lawson, 2009; Leenarts, Diehle, Doreleijers, Jansma, & Lindauer, 2013).

Finally, in the terminating and consolidating phase, patients' daily interpersonal, vocational, recreational and spiritual pursuits are central themes (Drozdek, 2015; Ford et al., 2005; Pressley & Spinazzola, 2015). The main intention of this phase is that the changes that have been produced inside the therapy room are brought outside. Paying attention to the transition to the community in therapy creates time and space for the patient to (re-)engage in relationships and to be able to function and cope in a world where abuse is not the norm (Ford et al., 2005; Walsh et al., 2010).

Opposite to this phase-based treatment strategy, some researchers argue that there should not be any special amendments to the treatment of complex trauma in comparison to the treatment of PTSD (e.g., DeJongh et al., 2016). Their arguments rely on the fact that research has shown that the established evidence-based treatments for PTSD are effective for resolving PTSD and related symptoms (e.g., DeJongh et al., 2016; Resick et al., 2012a; Resick, Wolf, Wiltsey Stirman, & Bovin, 2012b). However, the question remains whether these interventions are beneficial for alleviating more complex associated (often interpersonal) difficulties (e.g., Briere & Jordan, 2009; Dorrepaal et al., 2014). After three decades of research, also in this research arena the Sisyphean struggle continues, which is especially cumbersome for clinicians wanting to be informed about appropriate treatment strategies. In our opinion, the key to a potential solution lies in understanding and exploring the process treatment-seeking patients go through. Since debates mainly center on the necessity of a preliminary stabilization phase, it is mandatory to study the (establishment of a good) working alliance in complex trauma treatment in-depth. More qualitative, longitudinal and (multiple) case studies (Gleiser et al., 2008; Lawson, 2009; Newman et al., 1997; Kisiel et al., 2014a; Kisiel et al., 2014b; Lawson & Quinn, 2013) are needed to allow a thorough and comprehensive understanding of treatment and to advance the field.

Discussion

Our literature review covered three levels at which interpersonal features prominently appear in the complex trauma research. We found that a common thread across all three research areas are beliefs about the self, (in relation to) others and the world. When complex trauma occurs during attachment development, abuse-related schemata are formed, which develop into deeply engrained interpersonal patterns that cause difficulties on multiple levels of interpersonal functioning (intimacy, trust, communication, et cetera). However, attachment styles are also flexible and dynamic in nature, providing the opportunity for change through new relational experiences (Pearlman & Courtois, 2005; Tummala-Narra et al., 2012). Therapy should create a place where these dysfunctional interpersonal patterns can be revised and reworked. In this way, therapy implies a sort of do-over of the process of attachment development, in which there is the opportunity to rework inner working models, in order to create a new way of relating. However, interpersonal problems inevitably transpire in a therapeutic context as well, primarily in the (difficult) formation of a trusting working alliance, which makes attending to and changing interpersonal patterns a strenuous and demanding challenge.

The importance and centrality of interpersonal dynamics and related difficulties has been well established. However, significant questions remain both at the level of etiology, consequences, therapy, and their interconnections.

At the level of etiology, the question remains which contextual factors are crucial for generating complex trauma-related suffering. Especially, connections between childhood maltreatment and adult exposure to prolonged and repeated atrocities require further investigation. The observation that war veterans with complex symptoms often report a childhood abuse history raises the question if war experiences serve as a trigger for earlier wounds to revive, which would indicate that a developmental approach is more appropriate than an exclusive focus on the here and now. However, it is also reasonable to assume that in the aftermath of repeated interpersonal trauma in adulthood other factors (e.g., social support) influence chances of developing symptoms, which would warrant the exploration of other trajectories. Prospective and longitudinal investigations are needed to allow more comprehensive knowledge of how exposure to certain events is connected to psychopathology, both in childhood and in adulthood. The importance thereof lies in their potential value to inform researchers, diagnosticians and clinicians.

At the level of complex trauma consequences, researchers and theoreticians have yet to determine whether or not constellations as complex PTSD or DESNOS are valid denominators to encompass all of the consequences associated with the experience of complex trauma as compared to a single diagnosis of PTSD (Resick et al., 2012a; Resick et al., 2012b) and/or Borderline Personality Disorder (Ford & Courtois, 2014). There are studies that support the inclusion of a discrete CPTSD diagnosis (e.g., Cloitre, Garvert, Weiss, Carlson, & Bryant, 2014; Cloitre et al., 2013; Elklit, Hyland, & Shevlin, 2014) and competing studies that point to a more dimensional view with exposure to complex trauma leading to more severe expressions of PTSD (e.g., Newman et al., 1997; Teodorescu, Heir, Hauff, Wentzel-Larsen, & Lien, 2012). Empirical evidence thus remains inconclusive at best (DeJongh et al., 2016; Resick et al., 2012a, Resick et al., 2012b). It has been argued that the use of different quantitative measures to demarcate and operationalize prominent areas of impairment impedes research progress (DeJong et al., 2016; Ford, 2015; Wildschut, Langeland, Smit, & Draier, 2014). As mentioned above, quantitative studies have only a limited value for interpretation (Cook et al., 2004; Frueh et al., 2001; Ford et al., 2005) and if research wants to take up the task of informing clinical practice, it will be necessary to provide a more qualitative, detailed and in-depth description of the nature of the fundamental areas of impairment, such as interpersonal difficulties. Since these difficulties do not appear in a vacuum, it will be important to take into account other domains of functioning as well and to consider a more contextual or developmental account of the patient's problems (Briere & Jordan, 2009; Ford et al., 2008; Harvey, 1996; Tarocchi, Aschieri, Fantini, & Smith, 2013; van der Kolk et al., 2005). Unfortunately, the persistent debates and critiques about diagnostic categories draw attention away from an in-depth exploration of the clinical presentation of individuals seeking help. A more qualitative, thorough understanding of the core features of complex trauma would make a shared understanding of the prominent areas of impairment possible, which might provide a way out of the impasse.

Comparable to the discussion about the need to distinguish between (single-incident) PTSD and more complex trauma-related pathologies, there is debate about appropriate treatment strategies. Some argue that already-established treatments of PTSD suffice to treat complex trauma-related symptoms (e.g., DeJongh et al., 2016). Others raise doubt about the utility of classic interventions and propose specific interventions to alleviate suffering caused by more complex related symptoms, such as affect-dysregulation and interpersonal difficulties (e.g., van der Kolk et al., 2005). Above, we argued that a more in-depth exploration of treatment processes could stop stagnation in the field. Taking into account the lacunas discussed concerning etiology and consequences, it is probable that advances in those two areas would

create more grounded principles on which treatment guidelines could be built.

Granting this review does not present new research, we contend it has both clinical and academic value as we put forward some suggestions to expand our knowledge. Future research could attend to the specificity of relationship patterns in complex trauma and the change processes therein. Process studies not only provide opportunities to broaden our understanding on the exact nature of dysfunctional interpersonal patterns. They would also benefit the field by providing more practical treatment guidelines. Process studies allow a more systematic and in-depth investigation of *how* therapists can deal with interpersonal difficulties inherent to complex trauma (e.g., attachment difficulties, mistrust) that complicate the relationship between therapist and patient and how interventions can be used to further address interpersonal issues. Exploring these issues will provide more detailed and multi-angled knowledge of the mechanisms of change, which in turn can result in increasingly focused and differentiated treatment goals and guidelines for the treatment of disorders related to complex trauma.

We are aware that there are definitely limitations to our review of the literature. It is possible that our search terms were too restrictive to cover all relevant publications in the field. We might have missed a number of publications that used different key words (e.g., cumulative trauma) and/or had a more specific focus on child maltreatment (e.g., Developmental Trauma Disorder). Moreover, we concentrated extensively on the interpersonal features in complex trauma, with only minimal reference to other core features, such as affect-dysregulation and alterations in consciousness. While this focus allowed covering the interpersonal dimension in-depth, the interrelations of other core features with interpersonal features warrant future in-depth study and discussion. All in all, we attempted to cover one piece of the puzzle, and, based on our review, it seems that interpersonal features make up a vital piece to which all other pieces are connected.

References

Adams, K. (2011). The abject self: Self-states of relentless despair. *International journal of group psychotherapy, 61*(3à, 332-364.

Allen, J. G., Coyne, L., & Huntoon, J. (1998). Complex posttraumatic stress disorder in women from a psychometric perspective. *Journal of Personality Assessment, 70*(2), 277-298.

Allen, J., Huntoon, J., & Evans, R. (1999). Complexities in complex posttraumatic stress disorder in inpatient women: Evidence from cluster analysis of MCMI-III personality disorder scales. *Journal of Personality Assessment, 73*(3), 449-471.

Amos, J., Segal, L., & Cantor, C. (2015). Entrapped Mother, Entrapped Child: Agonic Mode, Hierarchy and Appeasement in Intergenerational Abuse and Neglect. *Journal of Child and Family Studies, 24*(5), 1442-1450.

Arntz, A. (1994). Treatment of borderline personality disorder: A challenge for Cognitive Behavioral Therapy. *Behaviour Research and Therapy, 32*(4), 419-430.

Becker-Weidman, A. (2009). Effects of early maltreatment on development: A descriptive study using the Vineland Adaptive Behavior Scales-II. *Child Welfare, 88*(2), 137-161.

Blalock, J. A., Minnix, J. A., Mathew, A. R., Wetter, D. W., McCullough, J. P., & Cinciripini, P. M. (2013). Relationship of Childhood Trauma to Depression and Smoking Outcomes in Pregnant Smokers. *Journal of Consulting and Clinical Psychology, 81*(5), 821-830.

Briere, J., Hodges, M., & Godbout, N. (2010). Traumatic stress, affect dysregulation, and dysfunctional avoidance: A structural equation model. *Journal of Traumatic Stress, 23*(6), 767-774.

Briere, J., & Jordan, C. E. (2009). Childhood maltreatment, intervening variables, and adult psychological difficulties in women: An overview. *Trauma, Violence & Abuse, 10*(4), 375-388.

Brown, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101.

Brown, N. C., Kallivayalil, D., Mendelsohn, M., & Harvey, M. R. (2012). Working the double edge: Unbraiding pathology and resiliency in the narratives of early-recovery trauma survivors. *Psychological Trauma: Theory, Research, Practice, and Policy, 4*(1), 102-111.

Cloitre M., Courtois, C. A., Charuvastra, A., Carapezza, R., Stolback, B. C., & Green, B. L. (2011). Treatment of Complex Trauma: Resutls of the ISTSS Expert Clinician Survey on Best Practices. *Journal of Traumatic Stress, 24*, 615-627.

Cloitre, M., Garvert, D. W., Brewin, C. R., Bryant, R. A., & Maercker, A. (2013). Evidence for proposed ICD-11 PTSD and complex PTSD: A latent profile analysis. *European Journal of Psychotraumatology, 4*:10.3402/ejpt.v4i0.20706.

Cloitre, M., Garvert, D. W., Weiss, B., Carlson, E. B., & Bryant, R. A. (2014). Distinguishing PTSD, Complex PTSD, and Borderline Personality Disorder: A latent class analysis. *European Journal of Psychotraumatology, 5*: 10.3402/ejpt.v5.25097.

Cloitre, M., Koenen, K. C., Cohen, L. R., & Han, H. (2002). Skill training in affective and interpersonal regulation followed by exposure: A phase-based treatment for PTSD related to childhood abuse. *Journal of Consulting and Clinical Psychology, 70*(5), 1067-1074.

Cloitre, M., Stolbach, B. C., Herman, J. L., van der Kolk, B., Pynoos, R., … Petkova, E. (2009). A Developmental Approach to Complex PTSD: Childhood and Adult Cumulative Trauma as Predictors of Symptom Complexity. *Journal of Traumatic Stress, 22*(5), 399-408.

Cloitre, M., Stovall-McClough, K. S., Miranda, R., & Chemtob, C. M. (2004). Therapeutic Alliance, Negative Mood Regulation, and Treatment Outcome in Child Abuse-Related Posttraumatic Stress Disorder. *Journal of Consulting and Clinical Psychology, 72*(3), 411-416.

Cloitre, M., Stovall-McClough, K. C., Nooner, K., Zorbas, P., Cherry, S., Jackson, C. L., Gan, W., & Petkova, E. (2010). Treatment of PTSD related to childhood abuse: A randomized controlled trial. *The American Journal of Psychiatry, 167*(8), 915-924.

Cook, J. M., Riggs, D. S., Thompson, R., Coyne, J. C., & Sheikh, J. I. (2004). Posttraumatic Stress Disorder and Current Relationship Functioning Among World War II Ex-Prisoners of War. *Journal of Family Psychology, 18*(1), 36-45.

Dalenberg, C. (2004). Maintaining the safe and effective therapeutic relationship in the context of distrust and anger: Countertransference and complex trauma. *Psychotherapy Theory Research & Practice, 41*(4), 438-447.

D'Andrea, W., Ford, J., Stolback, B., Spinazzola, J. & van der Kolk, B. A. (2012). Understanding Interpersonal Trauma in Children: Why We Need a Developmentally Appropriate Trauma Diagnosis. *American Journal of Orthopsychiatry, 82*(2), 187-200.

D'Andrea, W., & Pole, N. (2012). A Naturalistic Study of the Relation of Psychotherapy Process to Changes in Symptoms, Information Processing, and Physiological Activity in Complex Trauma. *Psychological Trauma Theory, Research, Practice and Policy, 4*(4), 438-446.

DeJongh, A., Resick, P. A., Zoellner, L. A., van Minnen, A., Lee, C. W., Monson, C. M., . . . & Bicanic, I. A. (2016). Critical analysis of the current treatment guidelines for complex PTSD in adults. *Depression and Anxiety, 33*(5), 359-369.

DePrince, A. P., Chu, A. T., & Pineda, A. S. (2011). Links between specific posttrauma appraisals and three forms of trauma-related distress. *Psychological Trauma: Theory, Research, Practice, and Policy, 3*(4), 430-444.

Dorrepaal, E., Thomaes, K., Hoogendoorn, A. W., Veltman, D. J., Draijer, N., & van Balkom, A. J. L. M. (2014). Evidence-based treatment for adult women with child abuse-related complex PTSD: A quantitative review. *European Journal of Psychotraumatology, 5*: 10.3402/ejpt.v5.23613.

Doukas, A., D' Andrea, W., Doran, J., & Pole, N. (2014). Psychophysiological predictors of working alliance among treatment-seeking women with complex trauma exposure. *Journal of Traumatic Stress, 27*(6), 672-679.

Drozdek, B. (2015). Challenges in treatment of posttraumatic stress disorder in refugees: Towards integration of evidence-based treatments with contextual and culture-sensitive perspectives. *European Journal of Psychotraumatology, 6*: 10.3402/ejpt.v6.24750.

Ebert, A., & Dyck, M. J. (2004). The experience of mental death: The core feature of complex posttraumatic stress disorder. *Clinical Psychology Review, 24*, 617-635.

Ehring, T., & Quack, D. (2010). Emotion Regulation Difficulties in Trauma Survivors: The Role of Trauma Type and PTSD Symptom Severity. *Behavior Therapy, 41*, 587-598.

Elklit, A., Hyland, P., & Shevlin, M. (2014). Evidence of symptom profiles consistent with posttraumatic stress disorder and complex posttraumatic stress disorder in different trauma samples. *European Journal of Psychotraumatology, 5*: 10.3402/ejpt.v5.24221.

Forbes, D., Lockwood, E., Phelps, A., Wade, D., Creamer, M., Bryant, R. A., … & O'Donnell, M. (2014). Trauma at the Hands of Another: Distinguishing PTSD Patterns Following Intimate and Nonintimate Interpersonal and Noninterpersonal Trauma in a Nationally Representative Sample. *Journal of Clinical Psychiatry, 75*(2), 147-153.

Ford, J. D. (2015). Complex PTSD: Research directions for nosology/assessment, treatment, and public health. *European Journal of Psychotraumatology*, 6, 27584.

Ford, J. D., Connor, D. F., & Hawke, J. (2008). Complex trauma among psychiatrically impaired children: A cross-sectional, chart-review study. *The Journal of Clinical Psychiatry, 70*(8), 1155-1163.

Ford, J. D. & Courtois, C. A. (2014). Complex PTSD, affect dysregulation, and borderline personality disorder. *Borderline Personality Disorder and Emotion Dysregulation, 1*(1), 9.

Ford, J. D., Courtois, C. A., Steele, K., van der Hart, O., & Nijenhuis, E. R. S. (2005). Treatment of Complex Posttraumatic Self-Dysregulation. *Journal of Traumatic Stress, 18*(5), 437-447.

Frueh, B. C., Turner, S. M., Beidel, D. C., & Cahill, S. P. (2001). Assessment of social functioning in combat veterans with PTSD. *Aggression and Violent Behavior, 6,* 79-90.

Gleiser, K., Ford, J. D., & Fosha, D. (2008). Contrasting exposure and experiential therapies for complex posttraumatic stress disorder. *Psychotherapy, 45*(3), 340-360.

Green, B. L., Goodman, L. A., Krupnick, J. L., Corcoran, C. B., Petty, R. M., Stockton, P., & Stern, N. M. (2000). Outcomes of single versus multiple trauma exposure in a screening sample. *Journal of Traumatic Stress, 13*(2), 271-286.

Godbout, N., Sabourin, S., & Lussier, Y. (2009). Child Sexual Abuse and Adult Romantic Adjustment: Comparison of Single- and Multipe-Indicator Measures. *Journal of Interpersonal Violence, 24*(4), 693-705.

Harvey, M. R. (1996). An ecological view of psychological trauma and trauma recovery. *Journal of Traumatic Stress, 9*(1), 3-23.

Herman, J. L. (1992). *Trauma and Recovery.* New York, NY: Basic Books.

Hodgdon, H., Kinniburgh, K, Gabowitz, D., Blaustein, M. E., & Spinazzola, J. (2013). Development and Implementation of Trauma-Informed Programming in Youth Residential Treatment Centers Using the ARC Framework. *Journal of Family Violence, 28,* 679-692.

Howell, E. F. (2002). Back to the "States" Victim and Abuser States in Borderline Personality Disorder. *Psychoanalytic Dialogues, 12*(6), 921-957.

Jepsen, E. K. K., Langeland, W., & Heir, T. (2013). Impact of dissociation and interpersonal functioning on inpatient treatment for early sexually abused adults. *European Journal of Psychotraumatology, 4*: 10.3402/ejpt.v4i0.22825.

Kagan, R., & Spinazzola, J. (2013). Real Life Heroes in Residential Treatment: Implementation of an Integrated Model of Trauma and Resiliency-Focused Treatment

for Children and Adolescents with Complex PTSD. *Journal of Family Violence, 28*(7), 705-715.

Kagan, R., Henry, J., Richardson, M., Trinkle, J., & LaFrenier, A. (2014). Evaluation of Real Life Heroes Treatment for Children with Complex PTSD. *Psychological Trauma: Theory, Research, Practice, and Policy, 6*(5), 588-596.

Kisiel, C., Fehrenbach, T., Stolbach, B., Briggs, E. C., Layne, C. M., … & Spinazzola, J. (2014a). Examining Child Sexual Abuse in Relation to Complex Patterns of Trauma Exposure: Findings from the National Child Traumatic Stress Network. *Psychological Trauma: Theory, Research, Practice, and Policy*, *6*(1), 29-39.

Kisiel, C. L., Fehrenbach, T., Torgersen, E., Stolbach, B., Griffin, G., & Burkman, K. (2014b). Constellations of Interpersonal Trauma and Symptoms in Child Welfare: Implications for a Developmental Trauma Framework. *Journal of Family Violence, 39*(1), 1-14.

Koss, M. P., Figueredo, & Prince, R. P. (2002). Cognitive Mediation of Rape's Mental, Physical, and Social Health Impact: Tests of Four Models in Cross-Sectional Data. *Journal of Consulting and Clinical Psychology, 70*(4), 926-941.

Landes, S. J., Garovoy, N. D., & Burkman, K. M. (2013). Treating complex trauma among veterans: Three stage-based treatment models. *Journal of Clinical Psychology, 69*(5), 523-533.

Lawrence, V. A., & Lee, D. (2014). An exploration of people's experiences of compassion-focused therapy for trauma, using interpretative phenomenological analysis. *Clinical psychology & psychotherapy, 21*(6), 495-507.

Lawson, D. M. (2009). Understanding and Treating Children Who Experience Interpersonal Maltreatment: Empirical Findings. *Journal of Counseling & Development, 87*(2), 204-215.

Lawson, D. M., Davis, D., & Brandon, S. (2013). Treating complex trauma: Critical interventions with adults who experienced ongoing trauma in childhood. *Psychotherapy, 50*(3), 331-335.

Lawson, D. M., & Quinn, J. (2013). Complex trauma in children and adolescents: Evidence-based practice in clinical settings. *Journal of Clinical Psychology, 69*(5), 497-509.

Leenarts, L. E., Diehle, J., Doreleijers, T. A., Jansma, E. P., & Lindauer, R. J. (2013). Evidence-based treatments for children with trauma-related psychopathology as a result of childhood maltreatment: A systematic review. *European Child & Adolescent Psychiatry, 22*(5), 269-283.

Liotti, G. (2013). Phobias of Attachment-Related Inner States in the Psychotherapy of Adult Survivors of Childhood Complex Trauma. *Journal of Clinical Psychology: In Session, 69*(11), 1136-1147.

Lopez-Martinez, A. E., Serrano-Ibanez, E. R., Ruiz-Parraga, G. T., Gomez-Perez, L., Ramirez-Maestre, C., & Esteve, R. (2016). Physical Health Consequences of Interpersonal Trauma: A Systematic Review of the Role of Psychological Variables. *Trauma Violence & Abuse*. doi: 10.1177/1524838016659488

Ma, E. Y., & Li, F. W. (2014). Developmental trauma and its correlates: A study of Chinese children with repeated familial physical and sexual abuse in Hong Kong. *Journal of Traumatic Stress, 27*(4), 454-460.

Messman-Moore, T. L., & Resick, P. A. (2002). Brief treatment of complicated PTSD and Peritraumatic Responses in a Client with Repated Sexual Victimization. *Cognitive and Behavioral Practice, 9,* 89-99.

Newman, E., Orsillo, S.M., Herman, D. S., Niles, B. L., & Litz, B. T. (1995). Clinical Presentation of Disorders of Extreme Stress in Combat Veterans. *The Journal of Nervous and Mental Disease, 183*(10), 628-632.

Newman, E., Riggs, D. S., & Roth, S. (1997). Thematic Resolution, PTSD, and Complex PTSD: The Relationship Between Meaning and Trauma-Related Diagnoses. *Journal of Traumatic Stress, 10*(2), 197-213.

Owens, G., P., Dashevsky, B., Chard, K., M., Mohamed, S., Haji, U., Heppner, P. S., & Baker, D. G. (2009). The Relationship between Childhood Trauma, Combat Exposure, and Posttraumatic Stress Disorder in Male Veterans. *Military Psychology, 21*, 114-125.

Pearlman, L. A., & Courtois, C. A. (2005). Clinical Applications of the Attachment Framework: Relational Treatment of Complex Trauma. *Journal of Traumatic Stress, 18*(5), 449-459.

Pelcovitz, D., van der Kolk, B., Roth, S., Mandel, F., Kaplan, S., & Resick, P. (1997). Development of a criteria set and a structured interview for disorders of extreme stress (SIDES). *Journal of Traumatic Stress, 10*(1), 3-16.

Pressley, J. & Spinazzola, J. (2015). Beyond Survival: Application of a Complex Trauma Treatment Model in the Cristian Context. *Journal of Psychology & Theology, 43*(1), 8-22.

Resick, P. A., Bovin, M. J., Calloway, A. L., Dick, A. M., King, M. W., … & Wolf, E. J. (2012a). A critical evaluation of the complex PTSD literature: implications for DSM-5. *Journal of Traumatic Stress, 25*(3), 241-51.

Resick, P. A., Wolf, E., Wiltsey Stirman, S., & Bovin, M. J. (2012b). Advocacy through science: Reply to comments on Resick et al. (2012). *Journal of Traumatic Stress, 25*(3), 260-263.

Roth, S., Newman, E., Pelcovitz, D., van der Kolk, B., & Mandel, F. S. (1997). Complex PTSD in victims exposed to sexual and physical abuse: Results from the DSM-IV Field Trial for Posttraumatic Stress Disorder. *Journal of Traumatic Stress, 10*(4), 539-555.

Seng, J. S., D'Andrea, W., & Ford, J. D. (2014). Complex Mental Health Sequelae of Psychological Trauma Among Wemen in Prenatal Care. *Psychological Trauma, 6*(1), 41-49.

Spinazzola, J., Blaustein, M., & van der Kolk, B. A., (2005). Posttraumatic stress disorder treatment outcome research: The study of unrepresentative samples? *Journal of Traumatic Stress, 18*(5), 425-436.

Stein, H., & Allen, J. G. (2007). Mentalizing as a framework for integrating therapeutic exposure and relationship repair in the treatment of a patient with complex posttraumatic psychopathology. *Bulletin of the Menninger Clinic, 71*(4), 273-290.

Tarocchi, A., Aschieri, F., Fantini, F., & Smith, J. D. (2013). Therapeutic Assessment of Complex Trauma: A Single-Case Time-Series Study. *Clinical Case Studies, 12*(3), 228-245.

Teodorescu, D. S., Heir, T., Hauff, E., Wentzel-Larsen, T., & Lien, L. (2012). Mental health problems and post-migration stress among multi-traumatized refugees attending outpatient clinics upon resettlement to Norway. *Scandinavian Journal of Psychology, 53*(4), 316-332.

Tummala-Narra, P., Kallivayalil, D., Singer, R., & Andreini, R. (2012). Relational experiences of complex trauma survivors in treatment: Preliminary findings from a naturalistic study. *Psychological Trauma: Theory, Research, Practice, & Policy, 4*(6), 640-648.

Tummala-Narra, P. (2014). Cultural identity in the context of trauma and immigration from a psychoanalytic perspective. *Psychoanalytic Psychology, 31*(3), 396-409.

van der Kolk, B. A. (2005). Developmental Trauma Disorder. Toward a rational diagnosis for children with complex trauma histories. *Psychiatric Annals, 35*(5), 401-408.

van der Kolk, B. A., Pelcovitz, D., Roth, S., Mandel, F. S., McFarlane, A., & Herman, J. L. (1996). Dissociation, somatization, and affect dysregulation: The complexity of adaptation of trauma. *The American Journal of Psychiatry, 153*(7), 83-93.

van der Kolk, B. A., Roth, S., Pelcovitz, D., Sunday, S., & Spinazzola, J. (2005). Disorders of Extreme Stress: The Empirical Foundation of a Complex Adaptation to Trauma. *Journal of Traumatic Stress, 18*(5), 389-399.

van Dijke, A., van der Hart, O., van Son, M., van der Heijden, P., Ford, J. D., & Buhring, M. (2012). Complex Posttraumatic Stress Disorder in Patients With Borderline Personality Disorder and Somatoform Disorders. *Psychological Trauma: Theory, Research, Practice, and Policy, 4*(2), 162-168.

von Sydow, K. (2002). Systemic Attachment Theory and Therapeutic Practice: A Proposal. *Clinical Psychology and Psychotherapy, 9*, 77-90.

Walsh, K., Fortier, M. A., & DiLillo, D. (2010). Adult Coping with Childhood Sexual Abuse: A Theoretical and Empirical Review. *Aggression and Violent Behavior, 15*(1), 1-13.

Wildschut, M., Langeland, W., Smit, J. H., & Draijer, N. (2014). Survivors of early childhood trauma: Evaluating a two-dimensional diagnostic model of the impact of trauma and neglect. *European Journal of Psyhotraumatology, 5:* 10.3402/ejpt.v5.21824.

Zilberstein, K., & Messer, E. A. (2010). Building a Secure Base: Treatment of a Child with Disorganized Attachment. *Clinical Social Work Journal, 38*, 85-97.

Zorzella, K. P., Muller, R. T., & Classen, C. C. (2014). Trauma group therapy: The role of attachment and therapeutic alliance. *International Journal of Group Psychotherapy, 64*(1), 24-47.

Appendix A: Focus, Type and Sample, and Summary of the Included Review Articles

Author(s)	Focus	Type and sample	Summary
Adams (2011)	C T	conceptual + case illustrations adult group therapy	conceptual outline of abject self, with illustrations from adult group therapy
Allen, Coyne, & Huntoon (1998)	A	cross-sectional N=166 adults inpatient treatment for trauma-related disorders self-report questionnaires	predominant insecure attachment in traumatized sample + cumulative trauma related to higher symptom severity
Allen, Huntoon, & Evans (1999)	B	cross-sectional N=227 female adults inpatient treatment for trauma-related disorders self-report questionnaires	cluster analysis reveals five meaningful clusters (alienated, withdrawn, aggressive, suffering, and adaptive) to distinguish between the heterogeneity of symptoms and personality disturbances
Amos, Segal, & Cantor (2015)	A	conceptual mother-child dyad	etiological model for transgenerational mother-child maltreatment drawing from attachment theory and agonic/hedonic modes of relationships
Arntz (1994)	C T	conceptual + case illustration (adult female) phase-based treatment	association between borderline, childhood trauma and dysfunctional schemas + outline of phase-based treatment with focus on therapeutic alliance
Becker-Weidman (2009)	A C	cross-sectional N=57 children chronic early maltreatment parent/caregiver self-report survey	adopted and foster children with reactive attachment disorder show delays in several developmental processes
Blalock et al. (2013)	T	longitudinal N=248 female adults interpersonally focused therapy structured interviews + self-report questionnaires	traumatic history influences depression and smoking outcomes and should therefore be taken into account when choosing appropriate treatment strategies
Briere, Hodges, & Godbout (2010)	A	cross-sectional N=418 adults trauma-exposed general population self-report questionnaires	cumulative interpersonal trauma predicts dysfunctional avoidance, whereas non-interpersonal traumas do not

Briere & Jordan (2009)	C	literature review female adults	association between childhood maltreatment and complex constellation of adult psychological outcome + developmental context
Brown, Kallivayalil, Mendelsohn, & Harvey (2012)	C T	qualitative N=20 adults complex trauma survivors in treatment semi-structured interview + clinician-report questionnaire	sources of vulnerability (e.g., issues of trust) and resiliency (e.g., social support) are examined via a grounded theory approach. Implications for treatment are discussed
Cloitre et al. (2011)	C T	cross-sectional N=50 adults experts on PTSD and cPTSD web based survey	affect dysregulation and relationship disturbances were rated as the most substantial contributors to impairment + a phase-based treatment approach was rated as the most preferable treatment strategy
Cloitre, Garvert, Brewin, Bryant, & Maercker (2013)	A C	cross-sectional N=302 adults treatment-seeking trauma-exposed adults self-report questionnaires	trauma type distinguishes between three classes: low symptoms, PTSD (single-incident), and cPTSD (childhood abuse)
Cloitre, Garvert, Weiss, Carlson, & Bryant (2014)	C	cross-sectional N=280 female adults treatment-seeking childhood-exposed adults structured interviews + self-report questionnaires	Latent class analysis supports separate diagnostic categories of cPTSD and BPD
Cloitre, Koenen, Cohen, & Han (2002)	T	longitudinal N=58 adult women PTSD related to childhood abuse structured interviews + self-report questionnaires	Patients receiving two-phase cognitive-behavioural treatment improved significantly (symptom severity, functional impairments) in comparison to the waiting list control condition
Cloitre et al. (2009)	A	cross-sectional N=582 adult women, 152 children clinical sample structured interviews + self/caregiver-report questionnaires	cumulative childhood trauma predicts symptom severity (cPTSD) in both samples
Cloitre, Stovall-McClough, Miranda, & Chemtob (2004)	T	longitudinal N=34 female adults	early therapeutic alliance ratings predict symptom severity (PTSD) at posttreatment, mediated by improved emotion-regulation

		childhood abuse-related PTSD structured interviews + self-report questionnaires
Cloitre et al. (2010)	T	longitudinal N= 104 female adults childhood abuse-related PTSD structured interviews + self-report questionnaires
Cook, Riggs, Thompson, Coyne, & Sheikh (2004)	C	cross-sectional N = 331 male adults ex-prisoners of war self-report questionnaires
Dalenberg (2004)	C	qualitative N=132 adults completed long-term trauma therapy semi-structured interview
D'Andrea, Ford, Stolback, Spinazzola, & van der Kolk (2012)	C	review children
D'Andrea & Pole (2012)	C	longitudinal N=27 adult women severe interpersonal violence history laboratory tests + self-report questionnaires
DeJongh et al. (2016)	C T	review
DePrince, Chu, & Pineda (2011)	B	cross-sectional N=425 adults trauma-exposed population self-report questionnaires
Dorrepaal et al. (2014)	C	review childhood abuse
Doukas, D'Andrea, Doran, & Pole (2014)	T	longitudinal N= 27 female adults

		childhood abuse-related PTSD structured interviews + self-report questionnaires
Cloitre et al. (2010)	T	longitudinal N= 104 female adults childhood abuse-related PTSD structured interviews + self-report questionnaires
Cook, Riggs, Thompson, Coyne, & Sheikh (2004)	C	cross-sectional N = 331 male adults ex-prisoners of war self-report questionnaires
Dalenberg (2004)	C	qualitative N=132 adults completed long-term trauma therapy semi-structured interview
D'Andrea, Ford, Stolback, Spinazzola, & van der Kolk (2012)	C	review children
D'Andrea & Pole (2012)	C	longitudinal N=27 adult women severe interpersonal violence history laboratory tests + self-report questionnaires
DeJongh et al. (2016)	C T	review
DePrince, Chu, & Pineda (2011)	B	cross-sectional N=425 adults trauma-exposed population self-report questionnaires
Dorrepaal et al. (2014)	C	review childhood abuse
Doukas, D'Andrea, Doran, & Pole (2014)	T	longitudinal N= 27 female adults

		a phase-based approach is associated with higher improvement (e.g., symptom severity, functional impairment) and less adverse effects (e.g., drop-out)
Cook, Riggs, Thompson, Coyne, & Sheikh (2004)	C	ex-prisoners of war with PTSD had significantly more marital problems than ex-prisoners of war without PTSD
Dalenberg (2004)	C	patients are more satisfied when therapists deal with their anger in an authentic, honest and responsible way
D'Andrea, Ford, Stolback, Spinazzola, & van der Kolk (2012)	C	literature review on the complex constellation of symptoms associated with interpersonal victimization in childhood
D'Andrea & Pole (2012)	C	outcome comparison between 12 sessions of prolonged exposure, stress inoculation training and psychodynamic therapy
DeJongh et al. (2016)	C T	critical evaluation of the construct validity of cPTSD and treatment guidelines for cPTSD
DePrince, Chu, & Pineda (2011)	B	post-trauma appraisal strategies contribute to symptom severity above and beyond characteristics of the traumatic events
Dorrepaal et al. (2014)	C	findings indicate that cognitive behaviour therapy is most established in reducing PTSD symptoms, but is limited for treating cPTSD symptoms
Doukas, D'Andrea, Doran, & Pole (2014)	T	pretherapy physiological measures of arousal predict patients' ratings of the therapeutic alliance

		extreme interpersonal violence, treatment-seeking self-report questionnaires + psychophysiological measures	
Drozdek (2015)	C T	conceptual + case illustration N= 1 adult male refugees	proposal for an Integrative Contextual Model for the assessment and treatment of refugees with prolonged and repeated trauma histories
Ebert & Dyck (2004)	C	conceptual torture victims	conceptual outline of the experience of mental death as mediating between trauma and symptom development
Ehring & Quack (2010)	A	cross-sectional N=616 adults convenience sample web-based survey	early-onset chronic interpersonal trauma is associated with higher emotion regulation difficulties than late-onset interpersonal, early-onset non-interpersonal and single-incident early-onset interpersonal trauma
Elklit, Hyland, & Shevlin (2014)	C	cross-sectional N= 1,251 adults bereaved parents, sexual/physical trauma self-report questionnaires	participants with cPTSD are more impaired than participants with PTSD only or low PTSD/cPTSD + trauma history is not determining for diagnosis
Forbes et al. (2014)	A	cross-sectional N=1,012 adults nationally representative sample structured interview	intimate interpersonal trauma is associated with higher symptom severity than non-intimate and non-interpersonal trauma
Ford (2015)	C T	review children	critical evaluation of diagnostic category of cPTSD and current treatment guidelines
Ford, Connor, & Hawke (2008)	A	cross-sectional N=397 children inpatient child psychiatry chart review + teacher-report questionnaires	complex trauma subgroups on the basis of trauma history with differentiable complex constellations of symptoms
Ford & Courtois (2014)	C	review adults	review on differentiation between PTSD, cPTSD and BPD in terms of comorbidity, clinical phenomenology and neurobiology

Ford, Courtois, Steele, van der Hart, & Nijenhuis (2005)	T	conceptual	conceptual outline of three-phase treatment model for complex posttraumatic self-dysregulation + discussion on clinical and research implications
Frueh, Turner, Beidel, & Cahill (2001)	C	review veterans with PTSD	Critical evaluation of assessment strategies for interpersonal dysfunction
Gleiser, Ford, & Fosa (2008)	C	conceptual	argumentation that prolonged exposure might be effective for treating PTSD, whereas experiential therapy might be more effective for treating cPTSD
Green et al. (2000)	A	cross-sectional N=1,909 adults convenience sample of college women self-report questionnaires	multiple interpersonal trauma is associated with higher symptom severity than multiple non-interpersonal trauma
Godbout, Sabourin, & Lussier (2009)	B	cross-sectional N=1,092 adults general population self-report questionnaires	the relationship between childhood sexual abuse and marital difficulties is mediated by attachment representations
Harvey (1996)	C T	conceptual	conceptual outline of ecological model to describe trauma response and trauma recovery from a multidimensional perspective
Herman (1992)	A C T	conceptual adults	conceptual outline of the construct of complex trauma, its consequences and a phase-based treatment strategy
Hodgdon, Kinniburgh, Gabowitz, Blaustein, & Spinazzola (2013)	C	conceptual children residential treatment	conceptual outline of the several stages of Attachment, Regulation and Competency treatment
Howell (2002)	A C	conceptual BPD	conceptual outline of developmental model to describe dissociative and aggressive symptoms
Jepsen, Langeland, & Heir (2013)	C	longitudinal N=48 adults inpatients with CSA histories self-report questionnaires	The interaction between primary dissociation and interpersonal functioning affects first-phase trauma inpatient treatment outcome

Kagan & Spinazzola (2013)	T	conceptual + case illustration N=1 adolescent female residential treatment	outline of Real Life Heroes treatment and research, illustrated with a clinical case
Kagan, Henry, Richardson, Trinkle, & LaFrenier (2014)	T	longitudinal N=119 children child and family service programs self/caregiver-report questionnaires	children demonstrated significant improvements in symptom severity and functional impairment after receiving Real Life Heroes treatment
Kisiel et al. (2014a)	A	cross-sectional N=1,751 children outpatient trauma mental health services parent + clinician-report questionnaires	trauma histories are indicative for symptom severity and attachment difficulties
Kisiel et al. (2014b)	A	cross-sectional N=16,212 children child welfare clinician-report questionnaire	interpersonal violence combined with attachment-based traumas is associated with higher levels of psychological symptoms and functional impairment
Landes, Garovoy, Burkman (2013)	C T	conceptual combat veterans	discussion on connections between PTSD, cPTSD, and BPD among veterans + outline of Dialectical Behavior Therapy, Seeking Safety and STAIR Narrative Therapy
Lawrence & Lee (2014)	T	qualitative N=7 adults Compassion-Focused Therapy semi-structured interviews	importance of emotional experience of therapy and the therapeutic alliance via Interpretative Phenomenological Analysis
Lawson (2009)	C T	review children	review of psychological and physiological consequences of childhood maltreatment, protective and risk factors, and implications for treatment
Lawson, Davis, & Brandon (2013)	T	Conceptual + case examples adults	focus on the importance of alliance repair, developing reflective functioning and motivational enhancement in the treatment of individuals exposed to complex trauma

Lawson & Quinn (2013)	T	review children and adolescents	overview and discussion of existing treatments for children and adolescents exposed to complex trauma
Leenarts, Diehle, Doreleijers, Jansma, & Lindauer (2013)	C	systematic review children and adolescents	although trauma-focused cognitive-behavioural therapy is the best-supported treatment to date, a phase-based approach is suggested for more complex cases
Liotti (2013)	C T	conceptual + case illustration N= 1 adult female	dissociation as an expression of disorganized attachment with contrary wishes for closeness and distance + aim of treatment to integrate both wishes
Lopez-Martinez et al. (2016)	C	review adults	review on the relation between interpersonal trauma, physical health and psychological variables
Ma & Li (2014)	C	cross-sectional N= 366 children clinical and school settings self-report questionnaires	abused children showed attachment difficulties and higher symptom severity than comparison groups, which supports the relevance of the Developmental Trauma Disorder framework
Messman-Moore & Resick (2002)	T	case-study N=1 female adult Cognitive Processing Therapy self-report questionnaires	description of the components of Cognitive Processing Therapy + results from the case-study indicate that no special amendments should be made for the treatment of complex traumatization
Newman, Orsillo,Herman,Niles, & Litz (1995)	C	cross-sectional N=10 male adults treatment-seeking combat veterans semi-structured interview + self-report questionnaires	results indicate that the DESNOS framework is applicable for combat veterans
Newman, Riggs, & Roth (1997)	A	cross-sectional N=84 adults treatment seeking adults structured interviews + self-report questionnaire	higher thematic disruption in PTSD + cPTSD compared to PTSD alone + influence of interpersonal nature of traumatic events

Owens et al. (2009)	A C	cross-sectional N=299 male adults treatment seeking veterans self-report questionnaires	childhood trauma predicts symptom severity, especially when combat exposure is low
Pearlman & Courtois (2005)	T	conceptual	focus on the therapeutic alliance, drawing from attachment theory
Pelcovitz, van der Kolk, Roth, Mandel, Kaplan, & Resick (1997)	B	cross-sectional N=520 adults treatment-seeking and community sample structured interview	validation for the Structured Interview for Disorders of Extreme Stress
Pressley & Spinazzola (2015)	T	conceptual + case illustrations adult Christian clients with childhood trauma histories	outline and clinical illustrations of the implementation of Component-Based Psychotherapy with a focus on affected (religious) belief systems
Resick et al. (2012a)	C	conceptual	critical evaluation of the construct validity of cPTSD
Resick, Wolf,Wiltsey Stirman, & Bovin (2012b)	C	conceptual	critical evaluation of the construct validity of cPTSD
Roth, Newman, Pelcovitz, van der Kolk, & Mandel (1997)	A	cross-sectional N=234 adolescents and adults treatment-seeking and community participants structured interviews	cumulative trauma predicted symptom severity, whereas age of onset and chronicity did not
Seng, D'Andrea, & Ford (2014)	C	cross-sectional N=1,581 adult women community sample of pregnant women structured interview + self-report questionnaires	distinct interpersonal trauma histories are associated with symptoms of PTSD + depression, PTSD + affect/interpersonal dysregulation, somatization and Generalized Anxiety Disorder
Spinazzola, Blaustein, & van der Kolk (2005)	C	review adults	critical evaluation research studies concerning the treatment of adult PTSD
Stein & Allen (2007)	T	conceptual + case illustration N=1 adult female	conceptual outline of mentalization and creating a new relational experience in treatment, illustrated with a clinical case

Tarocchi, Aschieri, Fantini, & Smith (2013)	C T	case-study N=1 adult female multiple interpersonal childhood trauma	conceptual outline of Therapeutic Assessment. Time-series study + significant symptom improvement in a single case
Teodorescu, Heir, Hauff, Wentzel-Larsen, & Lien (2012)	C	cross-sectional N=61 adults multi-traumatized refugees structured interviews +self-report questionnaires	a diagnosis of both PTSD and DESNOS, in comparison to a diagnosis of PTSD only, is associated with higher symptom severity and socio-economic problems
Tummala-Narra, Kallivayalil, Singer, & Andreini (2012)	C	qualitative N=21 adults complex trauma victims in treatment	relational experiences and treatment implications are discussed from three central themes: issues of safety, forming new ways of relating, and changing sense of self
Tummala-Narra (2014)	C T	conceptual interpersonal violence and immigration	cultural identity and implications for therapy are discussed from a psychoanalytic framework
Van der Kolk (2005)	A C	conceptual children	conceptual outline of Developmental Trauma Disorder
Van der Kolk et al. (1996)	C	cross-sectional N=520 adults treatment-seeking and community sample structured interviews + self-report questionnaires	early-onset interpersonal trauma is associated with higher symptom severity than late-onset interpersonal trauma
Van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola (2005)	A	cross-sectional N=528 adolescents and adults treatment-seeking + community sample structured interviews + questionnaire	age of onset and chronicity predicted symptom severity (PTSD and/or DESNOS) + discussion on comorbidity and treatment implications
Van Dijke et al. (2012)	A	cross-sectional N=472 adults inpatient psychiatric treatment centres structured interviews + self-report questionnaires	DESNOS symptoms were most prevalent in patients with comorbid BPD and somatoform disorders
Von Sydow (2002)	A	conceptual	critical comparison of attachment theory and family systems theory with a proposal for an integrative systematic attachment theory
Walsh, Fortier, & DiLillo (2010)	C	review childhood sexual abuse, female adults	theoretical and empirical review of coping strategies + need to study processes

Wildschut, Langeland, Smit, & Draijer (2014)	C	study protocol	proposition of a two-dimension model by which distinct diagnosis are captured by level of emotional neglect and severity of traumatization
Zilberstein & Messer (2010)	A C T	review + case illustration N=1 male child disorganized attachment	theoretical and empirical review of attachment disorganization + focus on attachment, self-regulation and reworking past experiences in clinical case illustration
Zorzella, Muller, & Classen (2014)	T	longitudinal N= 62 female adults Women Recovering from Abuse Program self-report questionnaires	attachment classification influences clients' experience the therapeutic relationship

Note: A = Etiology; C = Consequences, T = Therapy; BPD = Borderline Personality Disorder; CSA = Childhood Sexual Abuse; PTSD = Posttraumatic Stress Disorder; cPTSD = Complex Posttraumatic Stress Disorder; DESNOS = Disorders of Extreme Stress, Not Otherwise Specified.

3

CORE CONFLICTUAL RELATIONSHIP PATTERNS IN COMPLEX TRAUMA: A SINGLE-CASE STUDY.[11]

Dysfunctional interpersonal patterns constitute one of the core features of complex trauma. Supportive-expressive psychodynamic theory operationalizes these interpersonal patterns via the Core Conflictual Relationship Theme (CCRT, Luborsky & Crits-Christoph, 1998), by defining the main Wish, Response of Other and Response of Self in patients' habitual ways of interacting with others. Unfortunately, research regarding the specific contents of these CCRT components in complex trauma is scarce and adopts a static approach in studying interpersonal patterns. By means of a longitudinal single case study of a supportive-expressive psychodynamic therapy with a man with a complex traumatic background, this study provides an in-depth description of the nature and change in the CCRT. In this particular case, the wish to be respected by others and to be close to others was on the forefront throughout the entire therapy. At the beginning of therapy, others were perceived as distant and rejecting, rendering the patient feeling disappointed and dependent. As the therapy progressed, the patient perceives his interactions as more satisfying, being able to self-confidently express himself with others being accepting and understanding towards him, satisfying his main wishes. This case illustrates the importance of understanding and addressing the CCRT in the broader narrative of the patient and the dynamic nature of change throughout a therapy process.

Keywords: single-case study; psychodynamic therapy; Core Conflictual Relationship Theme; interpersonal dynamics; complex trauma; interpersonal trauma.

[11] This chapter is based on: Van Nieuwenhove, K., Meganck R., Cornelis, S., & Desmet, M. (2018). Core conflictual relationship patterns in complex trauma: A signle-case study. *Psychodynamic Practice.* doi:10.1080/14753634.2018.1498801

Introduction

Complex trauma has been defined as the experience of prolonged and repeated events that typically occur in the interpersonal sphere where escape is not possible, frequently because a caregiver is involved (e.g., childhood sexual, physical and/or emotional abuse) (Herman, 1992; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005).

Pervasive interpersonal trauma can lead not only to injurious symptomatic burden – including avoidance, hyperarousal, and numbing symptoms associated with Posttraumatic Stress Disorder (PTSD, American Psychological Association, APA, 2002), affect regulation difficulties, alterations in attention and consciousness, and somatization – yet also to deeply disturbed interpersonal relationships (Herman, 1992; van der Kolk et al., 2005). Issues of trust and early attachment disturbances (Cloitre Stovall-McClough, Miranda, & Chemtob, 2004; van der Hart, Nijenhuis, & Steele, 2005; Verhaeghe & Vanheule, 2005), difficulties negotiating relationships, and difficulties to have a sense of security and stability in relationships (Pearlman & Courtois, 2005; van der Kolk et al., 2005) are only a few examples of the interpersonal difficulties associated with complex trauma. Complex traumatic experiences fundamentally color the person's positions, suppositions, cognitions, or constructions about themselves in relation to others and the world (Hodgdon, Kinniburgh, Gabowitz, Blaustein, & Spinazzola, 2013; Newman, Riggs, & Roth, 1997). They are guided by feelings of mistrust and others and the world are perceived as dangerous and unpredictable (Arntz, 1994; Ebert & Dyck, 2004; Koss, Figueredo, & Prince, 2002; Lawson, Davis, & Brandon, 2013). Next to the negative expectations of others, a negative self-perception prevails, consisting of feelings of shame, guilt, self-blame, hopelessness, helplessness, vulnerability, and worthlessness (Allen, Huntoon, & Evans, 1999; Arntz, 1994; Ebert & Dyck, 2004).

From myriad theoretical perspectives, distorted interpersonal dynamics can be understood as manifestations of deep-rooted relations between the person and significant others (e.g., Liotti, 2004; von Sydow, 2002; Zilberstein & Messer, 2007). From a psychodynamic point of view, it is assumed that during development specific ways of interacting are molded through repeated interactions with primary caregivers, setting up the background against which characteristic and recurrent ways of relating to others need to be understood (Luborsky, 1984; Verhaeghe, 2004). In supportive-expressive psychodynamic therapy, the main objective is working through specific relationship patterns, which are operationalized by means of the core conflictual relationship theme (CCRT; Luborsky & Crits-Christoph, 1998). The construct of the CCRT characterizes people's habitual ways of interacting with others, and describes how

conflicts within these relationships may arise. Specifically, it describes the typical wish (W), the perceived response of others (RO), and the way the patient responds him or herself (RS) in interactions.

There are only a handful of studies describing these CCRT components in trauma-related disorders. Okey, McWhirter, and Delaney (2000), for example, examined the CCRT in 20 Vietnam veterans with PTSD. The authors concluded that the dominant CCRT contained the wish (W) to be close and accepted, while others (RO) are rejecting and opposing, leaving patients (RS) disappointed an depressed on the one hand, and opposing and hurting others on the other hand. In contrast, Drapeau and Perry (2009) found that, in a sample of 68 inpatients with Borderline Personality Disorder (BPD), a disorder often associated with complex trauma, as compared to 139 inpatients with other personality disorders, the wish (W) to be distant from others, to hurt others, to be like others, and to be hurt occurred more frequently in patients with BPD. Moreover, in BPD, others were more likely to be perceived (RO) as controlling and bad, and the participants themselves (RS) felt less helpful, self-confident, and open. Again contrasting previous findings, Chance, Bakeman, Kaslow, Farber, and Burge-Callaway (2000) found in a sample of 22 inpatients with BPD a predominant wish (W) to be loved and understood, others being mostly perceived (RO) as rejecting and feelings (RS) of depression and disappointment. Still other CCRT components transpired in the recent study by Shafran, Shar, Berant, and Gilboa-Schechtman (2016) in which these components were examined in a sample of 31 treatment seeking adolescents with a PTSD diagnosis after exposure to a single traumatic event as compared to 29 adolescents without a PTSD diagnosis. Their results indicate that adolescents suffering from PTSD are more likely to wish (W) to be distant from their peers, to experience their parents as dominant and controlling (RO), and to respond more passively (RS).

Whereas findings of cross-sectional research convincingly show that, on group level, the exposure to complex trauma is associated with interpersonal difficulties, they are limited because self-report questionnaires can only assess very specific areas of impairment and therefore only allow a fragmented understanding of what interpersonal difficulties in complex trauma specifically entail (Van Nieuwenhove & Meganck, 2017). Moreover, they say little about the specific contexts in which the nomothetic findings apply (Fishman & Messer, 2013). Also, the abovementioned studies using a more qualitative approach, like the CCRT method, are mainly based on small-scale, cross-sectional samples from a very specific population (e.g., Vietnam veterans, Okey et al., 2000), which only allow general and precautious statements on the investigated population. In order to address the CCRT effectively in therapy, there is a need

to better understand the dynamic and complex nature of interpersonal relationship patterns in complex trauma (Ford, Courtois, Steele, van der Hart, & Nijenhuis, 2005; Newman et al., 1997). Also, while research showed change in the CCRT to be a crucial element in explaining symptomatic change in, for instance, depression (Crits-Christoph, Connoly Gibbons, Temes, Elkin, & Gallop, 2010; Luborsky & Crits-Christoph, 1998), the nature of change in the CCRT components has to our knowledge never been studied in the field of complex trauma. The purpose of this study is to examine the specificity of the CCRT and the nature of changes in the CCRT components in a case of complex trauma. Case studies are particularly suited to gain an in-depth understanding of the way in which CCRT components appear and change throughout therapy (e.g., Hill et al., 2011; Cornelis et al., 2016). To allow inductive generalization (Fishman & Messer, 2013), which warrants an in-depth, clinically more elaborate 'thick description' of the specific context in which the CCRT components were studied, and thus the circumstances to which our findings might translate, we will embed our results within the broader context of the therapeutic process.

Method

Participants

Client. James[12], a Caucasian male, is 23 years old the moment he entered therapy. Concerning the traumatic context of his childhood, James describes how his father was both verbally and physically aggressive towards him and his brothers, while his mother remained a passive witness. According to DSM-IV criteria (APA, 2002), James received the diagnosis of Posttraumatic Stress Disorder (PTSD). Because of different behavior, attitudes, thoughts and feelings in periods of time for which there is amnesia, James also meets the basic criteria of Dissociative Identity Disorder (DID). Furthermore, James also suffers from thorough interpersonal difficulties and anger outbursts.

Therapist. The therapist is a Caucasian male, whom, the moment therapy started, is 30 years old and has 4 years of clinical experience. He has a doctor's degree in clinical psychology, is formally trained in Psychoanalytic Therapy and received additional training in Psychodynamic Psychotherapy (Leichsenring & Schauenburg, 2014; Blagys & Hilsenroth, 2000). The treatment of James consisted of 41 therapy sessions in which supportive techniques were used to establish a workable therapeutic relationship and a safe environment in which the patient could openly

[12] In order to guarantee the anonymity of the participant and his allies, we made use of pseudonyms. Moreover, all information that would lead to the identification of the patient has been removed or anonymized.

speak and expressive interventions were used to encourage the patient to talk about current and past interpersonal problems, work through how these were connected with the (traumatic) relationships in his childhood with primary caregivers and to resolve these issues (Book, 1998; Luborsky, 1984).

Procedure

Data Collection. We drew our data from a larger research project at the department of Psychoanalysis and Clinical Consulting at Ghent University. In this project, naturalistic case material is gathered for the purpose of systematic outcome and process studies. Only patients who are willing to give their informed consent on the complete research procedure and use of the data for research and publication purposes are included. The research procedure consists, among other things, of audio recordings of the therapy sessions, therapist reports, and the administration of self-report questionnaires. From this single case databank, we selected James, a rich information case in the context of our research questions (Patton, 2002). The patient describes a traumatic background and experiences complex trauma-related symptoms (e.g., PTSD, interpersonal difficulties). Further, therapy mainly focused on current interpersonal difficulties, which related to early childhood experiences. In this way, we could explore the CCRT as it naturally occurs in therapy.

There were three diagnostic intake sessions (Int1-Int3) including the administration of the SCID-I and –II (First, Spitzer, Gibbon, & Williams, 2002; First, Gibbon, Spitzer, Williams, & Benjamin, 1997) and the Clinical Diagnostic Interview (CDI, Westen, 2006), a semi-structured narrative-based interview that assesses a broad range of inter- and intrapersonal characteristics. A test battery was administered before and after treatment to assess symptoms associated with depression (Beck Depression Inventory, BDI-II, Beck, Steer, & Brown, 1996) interpersonal difficulties (Inventory of Interpersonal Problems, IIP-32, Horowitz, Alden, Wiggins, & Pincus, 2000) and overall symptomatic burden (Symptom Checklist, SCL-90-R, Derogatis, 1992). There were 41 therapy sessions (Th1-Th41). All sessions were audiotaped and transcribed verbatim by graduate students. These transcriptions were controlled for accuracy and completeness, and corrections/additions were made where necessary.

Data-analysis. We conducted the CCRT method (Luborsky & Crits-Christoph, 1998) on narratives derived from the transcripts of the intake meetings and therapy sessions to map de dominant CCRTs. The CCRT method consists of first selecting about 10 relationship episodes (REs) within the narrative material. REs are relatively discrete episodes in which a person speaks about relationships with others and should reach pre-defined levels of completeness (i.e., the level of detail with which a concrete exchange between the patient and a main other person

is described and contains information regarding the wish, the response of the other person and the self) to be selected for further analysis. The CCRT method then maps three dimensions of people's allying with others: the subjective wishes with which one enters interpersonal relations (W), one's own personal appraisal of how the other interacts and responds to these wishes (RO) and the characteristic reactions of the self to this other (RS). We first made use of tailor made categories to code the REs. Afterwards, these components were rated using the Standard Categories (Edition 2) provided by the method, which includes 35 Ws, 30 ROs, and 31RSs. These two steps provide the most reliable way of arriving to the dominant CCRT (Luborsky & Crits-Christoph, 1998). The frequency with which each category occurred across the REs was computed to provide the dominant CCRT.

We systematized the entire research process using principles of Consensual Qualitative Research Method for case studies (CQR-c; Jackson, Chui, & Hill, 2011), in which consensus through a series of meetings in a primary research team (first and third author) is achieved and an auditor (second author) challenges the findings of the primary research team and provides feedback following the consecutive steps in the research process.

Two researchers (first and third author) conducted the two steps of the CCRT method independently from each other on transcripts of the beginning, middle and end of therapy. In a first series of meetings, we discussed the available REs of the first phase and arrived at consensus about on which REs to perform the second step of the CCRT method. We conducted this first step on the interview material of the first two intake meetings and first two therapy sessions, in order to map the dominant CCRT at the beginning of treatment. The number of coded sessions depended upon the richness of the available REs. Ultimately, we selected nine REs within these transcriptions. In a second series of meetings, we arrived to consensus concerning the CCRT categories. In order to map change in the CCRT, we repeated this process for therapy sessions 20 through 22. These sessions were selected since this was a clear turning point in therapy. Between sessions 19 and 20 James attempted suicide. In the following sessions there was a prominent change in the way James talked about his relationships. Finally, we conducted the CCRT method on therapy sessions 37 to 41, to provide a characterization of the CCRT at the end of therapy.

Results

Clinical Case Summary

In order to be able to frame the results in the broader narrative, an outline of the therapeutic process is provided (Jackson et al., 2011). In this overview, we focus on the interpersonal relationships James talks about, as well as on his symptomatic burden.

James first contacts the therapist in order to address his 'dissociative states', in which he does things he cannot remember afterwards. James describes episodes in which he cheated on his girlfriend or bought expensive devices, which he could not remember afterwards.

The dissociative states seem to manifest themselves when James feels conflicted, either by issues concerning sexuality or money. The diagnostic process made clear how this could be traced back to James' troublesome youth. James explains how emotions and sexuality were never discussed and intimate issues were always handled with great secrecy. He further mentions that he was not allowed to earn any money, since there was enough work around the house, work for which he did not get paid. James states that he always followed the instructions of his very demanding father to avoid both verbal and physical aggression. Inside he felt outraged, condemning the unjust nature of both his father's abuse and the passive reactions of his mother.

This pattern of obeying whilst being frustrated and scared seems to repeat itself in his adult relationships. James mentions that his former girlfriend Patricia and his girlfriend at that time, Rebecca, were both very dominant regarding how to spent money. Especially Rebecca would be very restrictive in terms of sexual activities. He explains how he increasingly avoided (talking about) sexuality for the purpose of not upsetting her. In the same vein as he explained how he would, internally infuriated, obey his father, James describes at different points how he obliged to the wishes of others, whilst being frustrated or disappointed on the inside. This occurred on several occasions with Rebecca, for instance, when she refused making love without explanation or demanded him doing chores before he could buy something he wanted.

Between sessions 19 and 20, James committed a suicide attempt. James explicitly linked his attempt to Rebecca not being there for him when therapy got tough. Rather than actually wanting to die, the suicide attempt could be seen as an appeal to the other, as a way to as of yet get a message across. James states the rejection of Rebecca made him really angry. The therapist intervenes by pointing out that his former anger towards Rebecca was present in his dissociative symptoms as well. When James responds saying he felt it was more disappointment than anger, the therapist proposed that the disappointment could be the conscious response, whereas the

anger manifested itself unconsciously in his symptoms, noting James had very strict norms when it came to expressing his anger. James could connect his disappointment and frustration to anger, an emotion he was unable to bear for multiple reasons. Since James strongly linked anger and frustration to his father's abuse and injustice, in his later relationships, he was unable to bear these emotions. He makes explicit how he would bottle his frustrations up; just upon the moment he let it all out. So, in the dissociative states, the intolerable frustration and anger found an outlet.

At first, James was angry because his suicide attempt failed, but soon felt relieved, when he noticed how Holly, a good friend, and his mother were there for him. Not much after his suicide attempt, James started a relationship with Holly. In comparison to his former relationships, he concludes that being able to talk about everything is the greatest strength in their relationship. Although they sometimes argue, they always find a way to talk things through. He states that he breaks the tradition in his family to create a great taboo around delicate issues. In this way, James was finally able to express his emotions, including anger and frustration, in his current relationships. The experience and expression of these emotions were no longer unbearable and did not need to be repressed. In this way, the dissociative states, which can be understood as an unconscious symptomatic solution, were unnecessary.

From an interview three years after therapy had ended, we learn that James is married to Holly and that they have two children. Although they experience ups-and-downs in their relationship, he still feels they can openly discuss their issues and that they complement one another. Also in relation to his parents, there is a more open communication. He describes the experience of being a real family; something he did not experience in the past and did not believe was ever a possibility.

Symptoms and Outcome Assessment

James scores on the outcome measures suggest severe depression (BDI-II = 37, Beck et al., 1996), overall very high symptom burden (SCL-90-R = 277, Derogatis, 1992) and above average interpersonal problems (IIP-32 = 49, Horowitz et al., 2000). James' high scores on IIP-32 subscales 'Socially Inhibited' (10) and 'Nonassertive' (12) suggest James has significant difficulties with expressing feelings and a lack of self-confidence in interactions, respectively, and overall significant difficulty with social disapproval (Horowitz et al., 2000). Further, he scores above average on the subscale 'Overly Accommodating' (9), indicating he would go to great lengths to please other people. After treatment termination, James scores suggest minimal depressive complaints (BDI-II = 1), very low overall symptom burden (SCL-90-R = 91) and no

significant interpersonal difficulties (IIP-32 = 7). His subscales scores, ranging between 0 and 3, suggest his interpersonal issues have been resolved. According to the RCI (Jacobson &Truax, 1991), reliable clinical change was achieved on all scales (BDI-II: RCI= -7.55, $p < .05$; IIP-32: RCI = -8.65, $p < .05$; SCL-90-R: RCI = -12.33, $p < .05$).

Evolution in the Core Conflictual Relationship Theme

Table 1 provides information regarding the dominant CCRT for phase 1 (from Int1 to Th2), phase 2 (from Th20 to Th22) and phase 3 (from Th37 to Th41).

CCRT phase 1. At the beginning of therapy, James talks about both current and past relationships. There were eight relationship episodes in which he elaborated on interactions with his romantic partners, six with his recently ex-girlfriend Rebecca (6 RE) and two with his ex-girlfriend Patricia (2 RE) . Next to that, he talks about a past situation at high school (1 RE). Overall, the dominant CCRT can be described as the wish (W)'to be close to others' and to be important to others (W 'to be respected'). These wishes get frustrated, since others are perceived as (RO-negative) 'rejecting' and 'distant', which renders James feeling (RS-negative) 'disappointed', 'unloved' and 'depressed'. We will illustrate the dominant CCRT components with a relationship episode derived from Int1, concerning James' cheating on his ex-girlfriend Rebecca.

> If we were making love, then then then you could see, and she admitted it too, that she was thinking: What will I wear tomorrow? Should I put on mascara or not? She wasn't concerned with… we are making love right now. I thought.. well, let's wait and see what happens. But it didn't improve. […] If I asked her about it, she totally shut down completely. After a while, you stop asking

In this episode, we derived the wish (W) 'to be close' and the wish 'to be loved'. Rebecca's perceived reaction got interpreted as (RO-negative) 'rejecting' and 'distant'. James' response of waiting it out and not get into it can be understood as a more submissive/passive or dependent reaction (RS-negative, 'feel disappointed', 'am dependent', 'feel unloved').

Since in this first phase his relationship problems (intake) and break-up (first therapy sessions) are at the forefront, it is not surprising that most relationship episodes (6 REs) concern James' relationship with Rebecca. In these episodes, he mostly expresses the wish (W) 'to be close to' her and to be treated fairly (W 'to be respected'). The latter mainly concerns issues in which she disregards him when she takes certain decisions, like going out all evening with other men and expecting him to pick her up afterwards. In these accounts, he also perceives her as

Table 1: The dominant wish (W), response other (RO) and response self (RS) throughout therapy.

	#	W	RO	RS
Phase 1	9	to be respected (6)/ to be close to others (5)/ to be loved (4)/ to help others (3)/ to not be hurt (2)/ to be helped (2)	Negative are rejecting (6)/ are distant (6)/ are not trustworthy (3)/ are not understanding (3)/ don't respect me (2)	Negative feel disappointed (7)/ am dependent (5)/ feel unloved (4)/ feel depressed (4)/ feel angry (2) Positive understand (2)/ am helpful (2)
Phase 2	10	to be respected (7)/ to be close to others (7)/ to be liked (4)/ to be understood (2)	Negative are anxious (3)/ are not trustworthy (2) Positive respect me (7)/ are helpful (4)/ are accepting (3)/ like me (3)/ are open (3)/ loves me (3)/ are understanding (2)/ give me independence (2)/ are happy (2)	Negative am uncertain (4)/ feel disappointed (3) Positive feel respected (6)/ feel comfortable (6)/ feel loved (6)/ feel happy (4)/ am independent (4)/ feel accepted (3)/ am open (3)/ am helpful (2)
Phase 3	10	to be respected (10)/ to be close to others (6)/ to be opened up to (5)/to assert myself (4)/ to have control over others (3)/to respect others (2)/to be liked (2)/ to help others (2)	Negative don't respect me (4)/ oppose me (3)/ don't trust me (2)/ are distant (2)/ are out of control (2)/ are bad (2) Positive are open (5)/are understanding (4)/ respect me (4)/ are accepting (3)/ like me (3)/are cooperative (3)/give me independence (2)/are dependent (2)	Negative feel disappointed (3)/ feel angry (3) Positive am self-confident (5)/ feel respected (4)/ am open (4)/ feel comfortable (4)/ am self-controlled (3)/ feel accepted (2)/like others (2)/ am helpful (2)/ am controlling (2)/feel happy (2)/ feel loved (2)

Note. #: amount of REs, W: the dominant wish, RO: response other, RS: response self, (x) amount of REs in which the CCRT component occurs.

(RO-negative) being ‘untrustworthy’, ‘rejecting’ and ‘distant’, which renders him feeling (RS-negative) ‘disappointed’, ‘depressed’ and ‘unloved’.

The other three relationship episodes concern two episodes with his ex-girlfriend Patricia and one episode concerning a school event. His ex-girlfriend cheated on him when he explicitly encouraged her to take a trip to clear her head. Later, he still stresses that he wanted to help (W ‘to help others’) her and did not want to lose her (W ‘to be respected’, ‘to be loved’), but that she did not want to have anything to do with him anymore (RO-negative ‘are rejecting’, ‘are distant’). The episode at school concerns a situation in which there was a strike because a certain girl would be expelled because *she didn’t have enough money* for school. After everyone got up, he stood firm, wanting justice.

CCRT phase 2. In the second phase, James mainly talks about current interactions with others in the aftermath of his recent suicide attempt. As Table 1 illustrates, the wishes do not particularly change in the second phase. Contradictory to the first phase, however, the reactions of others are now more positively perceived (RO-positive ‘respect me’, ‘are helpful’, ‘loves me’). James now feels (RS-positive) ‘respected’ and ‘loved’. A relationship episode we selected from Th20 concerning his relationship with Molly illustrates this:

> Tuesday, when I woke up and when I saw my mother was there and Holly was there, then I felt like actually I totally don’t need her [Rebecca], because those people, well, Holly is really. [...] she immediately called my mother and then she effectively came from the moment she knew I was awake, she immediately came and that’s not something that everybody would just do, but Holly does. […] so we see each other quite a lot and it’s not that she meets up just because I wouldn’t be alone. Euhm, but she meets up just because she likes it and that’s quite positive.

In this relationship episode, we derived the wish (W) ‘to be close to’ Holly and to be important to her (W ‘to be respected’). Holly’s unconditional presence can be interpreted as (RO-positive) ‘respecting’ and ‘helpful’ and shows how she ‘likes him’, rendering James’ feeling (RS-positive) ‘loved’, ‘comfortable’ and ‘respected’.

Whereas previously his relationship with Rebecca dominated the therapy sessions, there are now only two instances (2 REs) where James elaborates on his relationship with her. His relationship with Holly (5 REs) is now more on the forefront, as well as his stance in the relationship towards his mother (1 RE) and his colleagues (2 REs). The episodes often concern his wish (W) ‘to be close to others’ and to be important to others (W ‘to be respected’). These two wishes seem to be interconnected, meaning he not merely wants proximity because others feel obligated (e.g., considering his recent suicide attempt), but rather wanting others to be by his side because they value him and consider him important in their lives.

The relationship episode with his mother concerns her perceived reaction to his suicide attempt. Whereas he was anticipating his mother to be critical (RO-negative, ‘are rejecting’), asking questions to be able to understand why he had done this, why he had hurt them, she was now understanding and respecting (RO-positive ‘are understanding’, ‘respect me’), not asking these particular questions. This made James feel (RS-positive) ‘respected’, 'comfortable’ and ‘loved’. Also in relation to his colleagues, he felt surprised by their supportive (RO-positive ‘help me’, ‘respect me’) and loving (RO-positive ‘love me’) reactions, making him feel (RS-positive), once again, ‘respected’, ‘comfortable’ and ‘loved’.

CCRT phase 3. In the last phase of treatment, the relationship episodes concern specific current interactions with Holly (4 REs), his mother and brother (2 REs), his colleagues (2 REs) and ex-girlfriends (2 REs). As table 1 shows, the dominant wishes remain the same up to the end of therapy (W ‘to be respected’, ‘to be close to others’). However, the perceived reaction of others and the perception of his own reaction change in comparison to both phase 1 and phase 2, and the CCRT now consists of a more variable and nuanced pallet of perceived positive and negative reactions. Remarkably, his own reactions remain positive throughout the interactions, even when the reactions of others are initially interpreted negatively. For example, James describes sequences in which there is a certain conflict in his relationship with Holly. First, Holly is considered opposing (RO-negative, ‘oppose me’, ‘are rejecting’, ‘are angry’), but after talking things through, he perceives her as (RO-positive) ‘respecting’, ‘understanding’ and ‘cooperative’. He feels he is (RS-positive) more ‘open’, ‘self-confident’ and ‘self-controlled’ in dealing with these situations. The next relationship episode from Th35, in which a rather trivial quarrel with Holly is discussed, illustrates this:

> I was like ‘it’s my birthday and I would like to go out for dinner’ and she reacted rather cattish, but then she… Ten minutes later I said: ‘I honestly think you should not react this way. Isn‘t it normal I want to do something fancy for my birthday?’ and then she admitted she was just acting out because she was hungry. In the end, we had a great time and a lovely service at the restaurant.

There is also a discrete episode in which he wished his mother would (W) ‘open up’ to him. Instead of remaining a passive bystander, as he would have done before, he now actively expressed himself (RS-positive ‘am open’), which led to an open conversation (RO-positive ‘are accepting’, ‘are open’). So, this last phase also contained passages in which James expressed the urge to discuss delicate and intimate topics with others in which he then also allowed himself to stand firm and get his own ideas across. Although others not always respond immediately cooperative, James opens up in a self-controlled and self-confident way, which leads to a satisfactory interaction.

Discussion

This study concerned the specificity of the CCRT in complex trauma and the nature of changes in the CCRT components throughout the course of psychotherapy. In line with the findings of Okey et al. (2000) and Chance et al. (2000), we found that James' main wish was to be close to others and to be respected by others. He strongly perceived others as rejecting, which made him feel disappointed, dependent and frustrated. The wish to be close to others and the perceived rejection of others can be interpreted as a rendition of what is described in the literature as *unmet dependency needs* (Steele, van der Hart, & Nijenhuis, 2001), or broader *attachment difficulties* (Cloitre et al., 2004). These attachment difficulties are associated with complex trauma victims perceiving the world as an unsafe and unpredictable place in which others are punitive, unavailable and rejecting, making the patient feel powerless and helpless (e.g., Hodgdon et al., 2013). James' history demonstrates how this theory translates in a particular case. His parents, on whom James had to rely as a child, did not allow him any agency. James felt he did not have a choice as he obeyed his father out of fear for verbal or physical retaliation. James had learned not to express his anger and to keep his frustrations to himself. He interiorly condemned the aggressiveness of his father, making anger an intolerable and unbearable feeling. Furthermore, he could not express his anger and frustration because of the expectation that others would be rejecting and would distance themselves.

The CCRT at the beginning of therapy also clearly shows how James feels dependent upon others in his adult relationships. His fear for abandonment coerces him to help others, despite their sometimes crude intentions and despite the anger and frustration he feels. This position renders him powerless and helpless in his current social interactions. This is also strongly reflected in James' scores on the IIP-32 subscales, which suggest he suffered from issues of being nonassertive, socially inhibited and overly accommodating.

The therapeutic context produced a new relational experience for James. The therapist provided a safe environment in which James could increasingly express his feelings of anger and frustration and could openly speak about intimate topics (e.g., his sexual relationships) without having to fear retaliatory actions from the therapist. For instance, the therapist did not react with disappointment or restraint after he had learned about the suicide attempt. Rather, the therapist invited James to talk about what had happened. Overall, the therapist asserted an accepting, understanding and neutral stance in exploring these issues.

Throughout therapy, we see that James' main wish to be close to others does not change (Luborsky & Crits-Christoph, 1998; see also Wiseman & Tishby, 2017, p. 295). Whereas in the

second phase there seems to be an idealization of interactions with others, in the third phase, James appears to be able to take a more realistic stance towards relationships. Rather than considering others and their reactions as all good or all bad, a more nuanced view allows him a more dynamic approach in interpersonal relationships. By working through the CCRT, James' interpersonal difficulties and other symptoms alleviated. It enabled him to communicate his own desires without fear for retaliation and to tolerate and express anger and frustration in his relationships.

Care is warranted when drawing conclusions from this explorative study. "One observation or one case offers only a small piece of evidence, but repeated observation […] across a series of cases provides a way of constructing a database of evidence on which clinical theory [and clinical practice] can be built." (Dattillio, Edwards, & Fishman, 2010, p. 436, our addition). In the case of James, the inability to experience and express feelings of anger or hostility was on the forefront. It is mandatory to study how anger and hostility appear in other cases and if similar processes can be uncovered. However, it is reasonable to assume that in other cases of complex trauma other core issues might play a more vital role. After all, CCRT components do not appear statically and must always be understood within the patient's broader narrative.

Furthermore, the case of James might not be considered a pristine case of complex trauma, even though in clinical practice there is no such thing as 'a typical case' (van der Kolk et al., 2005). While clinical guidelines generally recommend a phase-based treatment strategy, in which a first phase targets symptom stabilization and a second phase focuses on working through the traumatic experience (e.g., Cloitre et al., 2004; Herman, 1992), James' dissociative symptoms and interpersonal problems could readily be traced back to the interpersonal sphere, allowing supportive-expressive psychotherapy. More extreme cases in which there are multiple and segregated self-states would perhaps not initially benefit from an interpersonal focus in therapy and would warrant a more specialized approach.

Another limitation to this study is that we did not test therapy adherence systematically or provided an in-depth examination of the change processes at work. In supportive-expressive psychodynamic therapy, supportive techniques are designed to foster the therapeutic relationship, whereas expressive techniques focus on identifying and changing the CCRT (e.g., Book, 1998). In the case of James, it was clear that expressive techniques could be implemented from the start, with supportive techniques serving the purpose of maintaining the already

established alliance. However, a more systematic investigation of how different types of interventions appear in therapeutic interactions could allow capturing the process in more detail.

In conclusion, this study warrants for an integrative approach in trauma research and clinical practice, in order to properly comprehend the nature and change of interpersonal relationship patterns in psychodynamic therapy for patients with a complex trauma background.

References

American Psychological Association (2002). *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition Text Revision. Washington, DC: Author.

Arntz, A. (1994). Treatment of borderline personality disorder: A challenge for Cognitive Behavioral Therapy. *Behaviour Research and Therapy, 32*(4), 419-430.

Allen, J., Huntoon, J., & Evans, R. (1999). Complexities in complex posttraumatic stress disorder in inpatient women: Evidence from cluster analysis of MCMI-III personality disorder scales. *Journal of Personality Assessment, 73*(3), 449-471.

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Manual for the Beck Depression Inventory-II.* San Antonio, TX: The Psychological Corporation.

Blagys, M. D., & Hilsenroth, M. J. (2000). Distinctive Features of Short-Term Psychodynamic Interpersonal Psychotherapy: A Review of the Comparative Psychotherapy Process Literature. *Clinical Psychology: Science and Practice, 7*(2), 167-188.

Book, H. E. (2004). The CCRT approach to working with patient narratives in psychodynamic psychotherapy. In L. Angus & J. McLeod (Eds.), *The handbook of narrative and psychotherapy–practice, theory and research* (pp. 71–85). Thousand Oaks, CA: Sage.

Chance, S. E., Bakeman, R., Kaslow, N. J., Farber, E., & Burge-Callaway, K. (2000). Core conflictual relationship themes in patients diagnosed with borderline personality disorder who attempted, or who did not attempt, suicide. *Psychotherapy Research, 10*(3), 337-355.

Cloitre, M., Stovall-McClough, K. S., Miranda, R., & Chemtob, C. M. (2004). Therapeutic Alliance, Negative Mood Regulation, and Treatment Outcome in Child Abuse-Related Posttraumatic Stress Disorder. *Journal of Consulting and Clinical Psychology, 72*(3), 411-416.

Crits-Christoph, P., Connoly Gibbons, M. B., Temes, C. M., Elkin, I., & Gallop, R. (2010). Interpersonal Accuracy of Interventions and the Outcome of Cognitive and Interpersonal Therapies for Depression. *Journal of Consulting and Clinical Psychology, 78*(3), 420-428.

Cornelis, S., Desmet, M., Meganck, R., Cauwe, J., Inslegers, R., Willemsen, J., Van Nieuwenhove, K., Vanheule, S., Feyaerts, J., & Vandenbergen, J. (2016). Interactions Between Obsessional Symptoms and Interpersonal Dynamics: An Empirical Single

Case Study. *Psychoanalytic Psychology* (Advance online publication). doi: http://dx.doi.org/10.1037/ pap0000078

Dattilio, F. M., Edwards, D. J. A., & Fishman, D. B. (2010). Case studies within a mixed methods paradigm: Towards a resolution of the alienation between researcher and practitioner in psychotherapy research. *Psychotherapy Theory, Research, Practice, Training, 47*(4), 427-441.

Derogatis, L. R. (1992). *SCL-90-R: Administration, Scoring and Procedures Manual* (2nd ed.). Towson, MD: Clinical Psychometric Research Inc.

Drapeau, M., & Perry, J. C. (2009). The Core Conflictual Relationship Themes (CCRT) in Borderline Personality Disorder. *Journal of Personality Disorders, 23*(4), 425-431.

Ebert, A., & Dyck, M. J. (2004). The experience of mental death: The core feature of complex posttraumatic stress disorder. *Clinical Psychology Review, 24*, 617-635.

First, M. B., Gibbon, M., Spitzer, R. L., Williams, J. B. W., & Benjamin, L. S. (1997). *Structured Clinical Interview for DSM-IV Axis II Personality Disorders, (SCID- II).* Washington, DC.: American Psychiatric Press, Inc.

First, M. B., Spitzer, R. L., Gibbon, M., & Williams, J. B. W. (2002). *Structured Clinical Interview for DSM-IV-TR Axis I Disorders, Research Version, Patient Edition, (SCID-I/P).* New York, NY: Biometrics Research, New York State Psychiatric Institute.

Fishman, D. B., & Messer, S. B. (2013). Pragmatic case studies as a source of unity in applied psychology. *Review of General Psychology, 17*, 156–161.

Ford, J. F., Courtois, C. A., Steele, K., van der Hart, O., & Nijenhuis, E. R. S. (2005). Treatment of Complex Posttraumatic Self-Dysregulation. *Journal of Traumatic Stress, 18*(5), 437-447.

Herman, J. L. (1992). *Trauma and Recovery.* New York, NY: Basic Books.

Hill, C. E., Chui, H., Huang, T., Jackson, J., Liu, J., & Spangler, P. (2011). Hitting the wall: A case study of interpersonal changes in psychotherapy. *Counselling and Psychotherapy Research, 11*, 34-42.

Hodgdon, H., Kinniburgh, K, Gabowitz, D., Blaustein, M. E., & Spinazzola, J. (2013). Development and Implementation of Trauma-Informed Programming in Youth Residential Treatment Centers Using the ARC Framework. *Journal of Family Violence, 28*, 679-692.

Horowitz, L. M., Alden, L. E., Wiggins, J. S., & Pincus, A. L. (2000*). Inventory of Interpersonal Problems*. London: The Psychological Corporation.

Jackson, J. L., Chui, H. T., & Hill, C. E. (2011). The Modification of Consensual Qualitative Research for Case Study Research: An Introdution to CQR-C. In C. E. Hill (Ed.), *Consensual Qualitative Research: Practical Resources for Investigating Social Science Phenomena* (pp. 285-303). Washington, DC: American Psychological Association.

Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59*(1), 12-19.

Koss, M. P., Figueredo, & Prince, R. P. (2002). Cognitive Mediation of Rape's Mental, Physical, and Social Health Impact: Tests of Four Models in Cross-Sectional Data. *Journal of Consulting and Clinical Psychology, 70*(4), 926-941.

Lawson, D. M., Davis, D., & Brandon, S. (2013). Treating complex trauma: Critical interventions with adults who experienced ongoing trauma in childhood. *Psychotherapy (Chic), 50*(3), 331-335.

Liotti, G. (2004). Trauma, dissociation and disorganized attachment: Three strands of a single braid. *Psychotherapy: Theory, research, practice, training, 41*, 472-486.

Luborsky, L. (1984). *Principles of psychoanalytic psychotherapy: A manual for supportive-expressive treatment.* New York, NY: Basic Books.

Luborsky, L., & Crits-Christoph, P. (1998). *Understanding Tranference: The Core Conflictual Relationship Theme* (2nd Ed.). Washington, DC: American Pscyhological Association.

Newman, E., Riggs, D. S., & Roth, S. (1997). Thematic Resolution, PTSD, and Complex PTSD: The Relationship Between Meaning and Trauma-Related Diagnoses. *Journal of Traumatic Stress, 10*(2), 197-213.

Okey, J. L., McWhirter, J. J., & Delaney, M. K. (2000). The Central Relationship Patterns of Male Veterans with Posttraumatic Stress Disorder: A Descriptive Study. *Psychotherapy, 37*(2), 171-178.

Patton, M. Q. (2002). Qualitative Desings and Data Collection. In *Qualitative research and evaluation methods* (3rd Ed., pp. 228-247). London, England: Sage.

Pearlman, L. A., & Courtois, C. A. (2005). Clinical Applications of the Attachment Framework: Relational Treatment of Complex Trauma. *Journal of Traumatic Stress, 18*(5), 449-459.

Shafran, N., Shahar, G., Berant, E., & Gilboa-Schechtman, E. (2016). Representations of Self and Parents, and Relationship Themes, in Adolescents with Post Traumatic Stress Disorder (PTSD). *Journal of Abnormal Child Psychology, 44,* 887-899.

Solomon, E. P., & Heide, K. M. (1999). Type III Trauma: Toward a More Effective Conceptualization of Psychological Trauma. *International Journal of Offender Therapy and Comparative Criminology, 42*(2), 202-210.

Steele, K., van der Hart, O., & Nijenhuis, E. R. S. (2001). Dependence in the treatment of complex posttraumatic stress disorder and dissociative disorders *Journal of Trauma and Dissociation, 2*(4), 79-116.

van der Hart, O., Nijenhuis, E. R. S., & Steele, K. (2005). Dissociation: An insufficiently Recognized Major Feature of Complex Posttraumatic Stress Disorder. *Journal of Traumatic Stress, 18*(5), 413-423.

van der Kolk, B. A., Roth, S., Pelcovitz, D., Sunday, S., & Spinazzola, J. (2005). Disorders of Extreme Stress: The Empirical Foundation of a Complex Adaptation to Trauma. *Journal of Traumatic Stress, 18*(5), 389-399.

Van Nieuwenhove, K., & Meganck, R. (2017). Interpersonal Features in Complex Trauma Etiology, Consequences, and Treatment: A Literature Review. *Journal of Aggression, Maltreatment, & Trauma,* DOI: 10.1080/10926771.2017.1405316

Verhaeghe, P. (2004). *On Begin Normal and Other Disorders: A Manual for Clinical Psychodyagnostics*. London: Karnac Books Ltd.

Verhaeghe, P., & Vanheule, S. (2005). Actual Neurosis and PTSD: The Impact of the Other. *Psychoanalytic Psychology, 22*(4), 493-507.

von Sydow, K. (2002). Systemic Attachment Theory and Therapeutic Practice: A Proposal. *Clinical Psychology and Psychotherapy, 9,* 77-90.

Westen, D. (2006). *The Clinical Diagnostic Interview.* Atlanta, GA: Emory University.

Wiseman, H. & Tishby, O. (2017) Applying relationship anecdotes paradigm interviews to study client–therapist relationship narratives: Core conflictual relationship theme analyses, *Psychotherapy Research, 27*(3), 283-299.

Zilberstein, K., & Messer, E. A. (2010). Building a Secure Base: Treatment of a Child with Disorganized Attachment. *Clinical Social Work Journal, 38,* 85-97.

4

WORKING THROUGH CHILDHOOD TRAUMA-RELATED INTERPERSONAL PATTERNS IN PSYCHODYNAMIC TREATMENT: AN EVIDENCE-BASED CASE STUDY.[13]

Adult interpersonal difficulties are considered one of the core consequences of childhood trauma exposure. However, research concerning the nature of interpersonal patterns associated with childhood trauma is scarce. The aim of this case study of a supportive-expressive psychodynamic therapy with a woman with a traumatic background, is to provide a detailed understanding of the nature of interpersonal patterns at the beginning and throughout therapy, and to provide an in-depth investigation of the therapeutic process. The Core Conflictual Relationship Theme method (Luborsky & Crits-Christoph, 1998) and the Penn Adherence/Competence Scale for Supportive Expressive Dynamic Psychotherapy (Barber & Crits-Christoph, 1996) were applied to study dominant interpersonal patterns and therapeutic interventions, respectively. At the beginning of therapy, the patient was unable to safely express herself since others were perceived as critical and rejecting. This relationship pattern originated in her primary (traumatic) childhood relationships and was repeated in her adult relationships. As treatment progresses, the patient aspired more proactively to assert herself and felt more self-confident in interactions, although she consistently perceived the reactions of others in a negative way. The neutral, acknowledging and empowering attitude of the therapist created a new relational experience, through which change (on the interpersonal level) appears to be achieved. We conclude that to adequately address interpersonal difficulties in therapy, it is fundamental to recognize dominant interpersonal patterns and to apprehend their dynamics within the broader context of the case.

[13] This chapter is based on: Van Nieuwenhove, K., Truijens, F., Meganck R., Cornelis, S., & Desmet, M. (2018). Working Through Childhood Trauma-Related Interpersonal Patterns in Psychodynamic Treatment: An Evidence-Based Case Study. *Psychological Trauma: Theory, Research, Practice and Policy* (in press).

Introduction

Over the past three decades, the centrality of interpersonal features related to childhood trauma has been well established, both in terms of etiology, consequences, and treatment (Van Nieuwenhove & Meganck, 2017, for a review). On the level of etiology, research has shown that (prolonged) interpersonal traumata, such as childhood physical, sexual and/or psychological abuse, have more detrimental psychological effects than non-interpersonal traumata, such as a natural disaster or a car accident (e.g., Ehring & Quack, 2010). In her pioneering book, *Trauma and Recovery*, Judith Herman (1992) introduced the concept of complex trauma to demarcate these experiences of prolonged and repeated interpersonal traumatic events from experiences of more isolated (non-)interpersonal traumata to highlight the more complex psychological consequences, such as affect regulation difficulties, alterations in attention and consciousness, somatization, identity disruptions, harmful behavior, and disturbed interpersonal relationships.

Following Herman's (1992) work and drawing from developmental theories, it is assumed that childhood traumatic experiences fundamentally alter a subject's relation to others and the world (e.g., Hodgdon, Kinniburgh, Gabowitz, Blaustein, & Spinazzola, 2013). Both are likely to be deemed untrustworthy, dangerous and unpredictable, leaving subjects feeling vulnerable, ashamed, guilty, hopeless, and worthless. Findings of retrospective, cross-sectional studies support the hypothesis that being exposed to childhood trauma correlates with the experience of substantial interpersonal difficulties (e.g., Cook et al., 2004; Kisiel et al., 2014). However, research findings based on self-report questionnaires are limited because they can only assess very specific areas of interpersonal impairment. Consequently, they provide little information about the specific nature of the interpersonal difficulties. Therefore, significant questions remain regarding the dynamic and complex nature of interpersonal patterns in childhood trauma (e.g., Ford, Courtois, Steele, van der Hart, & Nijenhuis, 2005; Newman, Riggs, & Roth, 1997; Van Nieuwenhove & Meganck, 2017).

There are only a handful of studies that approach interpersonal features in childhood trauma with a qualitative research design. A number of these studies use the Core Conflictual Relationship Theme (CCRT) method (Luborsky & Crits-Christoph, 1998) to operationalize specific relationship patterns and to define the typical wish (W), the perceived response of others (RO), and the way the subject responds him or herself (RS) in interactions. Results indicate that people with repeated and prolonged interpersonal trauma exposure enter interactions with a primary wish to be loved and understood (Chance, Bakeman, Kaslow,

Farber, & Burge-Callaway, 2000) or, contrastingly, to oppose, hurt and control others (Drapeau & Perry, 2009). Others are perceived as rejecting, opposing (Chance et al., 2000), controlling and bad (Drapeau & Perry, 2009). Consequently, patients feel unreceptive (Drapeau & Perry, 2009) and disappointed and depressed (Chance et al., 2000). These studies provide a general and static taxonomy of interpersonal features in very specific populations, such as patients with Borderline Personality Disorder, a disorder that showed to be strongly associated with childhood trauma (e.g., Herman, Perry, & van der Kolk, 1989). Unfortunately, this does not yet provide a full, in-depth and dynamic understanding of interpersonal patterns related to childhood trauma. The seemingly contrasting finding, for instance, that the experience of interpersonal trauma is associated with either a wish to be loved or to oppose, could be explained by the clinical observation that subjects tend to oscillate between wanting to be close to others and to isolate themselves from others (e.g., Cook et al., 2004). From a developmental perspective, this contradictory behavior can be understood as a repetition of the interpersonal dynamics that were established in early childhood, in which the primary caregivers were both soothing and threatening (e.g., Gleiser, Ford, & Fosha, 2008). The abovementioned studies, because of their cross-sectional and static approach, do not allow for such a dynamic reading of the interplay between different CCRT components. Therefore, there is a need for more process-focused studies, which allow a more thorough understanding of the dynamic connections between different CCRT components. A comprehensive understanding of the dynamic and complex nature of interpersonal patterns is also vital to address interpersonal difficulties adequately in therapy (Ford et al., 2005; Newman et al., 1997). Moreover, there is a great need to broaden our understanding of how interpersonal dynamics transpire in a therapeutic setting between patient and therapist. Clinical inquiry indicates that core interpersonal issues, such as distrust, are present in the therapeutic context as well (Pearlman & Courtois, 2005). This causes the formation of a safe and trusting alliance to be a strenuous and demanding task and a first priority in the treatment of patients with a childhood trauma background (e.g., Ford et al. 2005; Herman, 1992).

Research on the formation and manifestation of the therapeutic relationship is, however, scarce. It has been put forward that treatment should pay additional attention to the interpersonal difficulties patients with a childhood trauma background experience in their daily lives (e.g., van der Kolk et al., 2005). In psychodynamic therapy, the main objective is working through specific relationship patterns, which are operationalized by means of the CCRT (Leichsenring & Schauenburg, 2014; Luborsky, 1984). Albeit the importance of investigating processes and mechanisms of change in psychotherapy is strongly recognized (Stiles, 2013; Wampold, 2007),

research concerning change processes in the treatment of childhood trauma is still in its infancy. Consequently, there still is a lot to be learned about which interventions are useful or counterproductive, not only to establish a workable therapeutic alliance, but more generally in reducing interpersonal difficulties and producing therapeutic gains.

We conclude that in order to advance the field, it is essential to have a more thorough and comprehensive understanding of the treatment process. Therefore, there is a need for more qualitative or mixed-method, longitudinal, and (multiple) case study approaches to investigate the nature of interpersonal patterns in general and in the context of the therapeutic relationship specifically (e.g., Gleiser et al., 2008; Kisiel et al., 2014; Newman et al., 1997). Case studies are particularly suited to broaden our understanding of interpersonal patterns in childhood trauma in the therapeutic context. They allow for an in-depth exploration of the nature of dysfunctional interpersonal patterns as they naturally unfold in therapy. Also, they offer a means to investigate the process of change in the dynamic interchange between patient and therapist (Stiles, 2013; Toomela, 2007).

The aim of this study is threefold, namely to examine 1) the specificity of the CCRT components, 2) the nature of changes in the CCRT components, and 3) how this is embedded within the therapeutic context in a case with a history of childhood trauma. Concerning the latter, we aim to study the (establishment of the) working alliance and the therapeutic process by mapping specific therapeutic interventions. In psychodynamic therapy, supportive techniques aim to foster the therapeutic relationship, whereas expressive techniques focus on interpreting and changing core interpersonal dynamics (Luborsky, 1984). Since distrust is considered a fundamental difficulty for people with a childhood trauma background (e.g., Hodgdon et al., 2013), which should be addressed in therapy by focusing on the formation of the therapeutic alliance (e.g., Pearlman & Courtois, 2005), we expect more supportive techniques at the beginning of treatment. Once a stable therapeutic alliance is established, we expect more expressive techniques will be used.

Method

Participants

Client. Amy, a Caucasian female, was 26 years old the moment she entered therapy. Amy has a history of childhood physical and psychological abuse perpetrated by her father, while her mother remained a passive witness. According to the *Diagnostic and Statistical Manual for Mental Disorders, fourth edition* (DSM-IV, American Psychiatric Association, APA, 2000) criteria, Amy received the diagnosis of Major Depressive Disorder (MDD). There were no other

axis-I or axis-II disorders diagnosed. In order to guarantee the anonymity of the participant, we used a pseudonym. Moreover, all information that would lead to the identification of the patient has been removed or anonymized. Ethics committee approval was obtained by the Ghent University Hospital (B670201523446), see Meganck et al. (2017).

Therapist. The therapist is a Caucasian female, who was 30 years old and had seven years of clinical experience when the therapy started. She is formally trained in Psychoanalytic Therapy and received an additional training in Short Term Psychodynamic Psychotherapy (STPP, Leichsenring & Schauenburg, 2014; Luborsky, 1984). The therapy consisted of 20 weekly sessions of STPP. Session duration ranged between 46 and 70 minutes (M= 58.6 minutes).

Procedure

Case Selection. We drew our data from the Ghent Psychotherapy Study (GPS; for a full description of the research procedure and all measures, see Meganck et al., 2017). Without knowledge on outcome, we purposefully selected the case of Amy, using the following criteria: a) the presence of a childhood traumatic background as reported in the Clinical Diagnostic Interview (CDI, Westen, 2006), and b) a case of a patient receiving STPP to ensure treatment focuses on interpersonal themes. As our research objectives mainly require rich information on interpersonal dynamics, we did not set any further (diagnostic) requirements. During the CDI, Amy describes a traumatic background of childhood physical and psychological abuse. She explains how her father systematically, albeit unpredictably, acted violently towards her and her siblings, sometimes causing injuries that required medical assistance. Furthermore, Amy mentions several incidents in which her father insulted and threatened her. For instance, he frequently called her insane and threatened to put her in a mental institution. Amy explains how her upbringing fundamentally affects past and current relationships. She describes herself as very self-conscious and prudent in interactions because she is in constant anticipation of what the consequences might be. She has a constant fear of being labelled crazy. Amy enters therapy to regain stability in her relationships and to come to terms with her past.

Data Collection and Measures. Only the measures used in this study are mentioned. For the full research procedure and instruments used, see Meganck et al. (2017). Before the start of therapy, a member of the GPS research team conducted the CDI (Westen, 2006) and Structured Clinical Interview for DSM-IV axis I and -II disorders (SCID-I, SCID-II, First, Spitzer, Gibbon, & Williams, 2002; First, Gibbon, Spitzer, Williams, & Benjamin, 1997) and administered a test battery as a baseline measurement for, among others, symptoms associated with PTSD (Self-rating Inventory for Posttraumatic Stress Disorder, ZIL, Hovens, Bramsen, & van der Ploeg,

2000), depressive symptoms (Beck Depression Inventory, BDI-II, Beck, Steer, & Brown, 1996), interpersonal difficulties (Inventory of Interpersonal Problems, IIP-32, Horowitz, Alden, Wiggins, & Pincus, 2000), and overall symptomatic burden (Symptom Checklist, SCL-90-R, Derogatis, 1992). During therapy, all sessions were audiotaped and transcribed. Every fourth session, a test battery was administered to map symptomatic change and to assess the therapeutic relationship, including the BDI-II, IIP-32, SCL-90-R, and the Working Alliance Inventory (WAI, Horvath & Greenberg, 1989). Post treatment, the same test battery was administered as a post-measurement for, among others, PTSD symptoms, depression, interpersonal difficulties and overall well-being. Finally, the Client Change Interview (CCI, Elliott, Slatick, & Urman, 2001), a semi-structured interview assessing the experience of the therapeutic process and therapeutic change, was administered peri- and post-treatment by the same member of the GPS research team.

Data-analysis. To assess *outcome*, we provide descriptive statistics on the outcome measures, using the Reliable Change Index (RCI, Jacobson & Truax, 1991). To map the dominant CCRTs and the changes therein throughout therapy, we conducted the *CCRT method* (Luborsky & Crits-Christoph, 1998) on narratives derived from the transcribed therapy sessions at the beginning (sessions 1 through 4), middle (sessions 9 through 12) and end (sessions 17 through 20) of treatment. The CCRT method starts with selecting a minimum of seven relationship episodes (REs) within the narrative material. REs are relatively discrete episodes in which a person speaks about relationships with others. The CCRT method then maps three dimensions of people's allying with others: the subjective wishes with which one enters interpersonal relations (W), one's own personal appraisal of how the other interacts and respond to these wishes (RO) and the characteristic reactions of the self to this other (RS). These components were rated separately by the first and fourth author using the Standard Categories (Edition 2) provided by the CCRT manual, which includes 35 Ws, 30 ROs, and 31 RSs. Via the Consensual Qualitative Research Method for case studies (CQR-c; Jackson, Chui, & Hill, 2011), in which consensus through a series of meetings is achieved, we systematized our research process. Consensus on the frequency of each component was achieved through detailed discussion and the final frequency with which each category occurred across the REs was computed to provide the dominant CCRT.

We applied the *Penn Adherence/Competence Scale for SE Dynamic Psychotherapy* (PACS-SE, Barber & Crits-Christoph, 1996) to assess the frequency of different therapeutic techniques. The scale consists of 9 items assessing general techniques (e.g., 'The therapist encourages the patient to explore the personal meaning of an event or feeling'), 9 items

assessing supportive techniques (e.g., 'The therapist conveys a sense of respect, understanding and acceptance to the patient.'), and 27 items assessing expressive interventions (e.g., 'The therapist focuses attention on similarities among the patient's past and present relationships'). All therapist interventions – except 'mhm', which was considered a neutral intervention – were rated as general, supportive or expressive by the first and second author, independent from each other. Through consecutive meetings, consensus was achieved (Jackson et al., 2011) and the frequencies per technique were computed for every session.

Results

Initial Complaints and Outcome Assessment

When Amy entered therapy, she worked a blue-collar temp-job, which did not line up with her university degree. She lived in a small one-room apartment and was recently engaged to her boyfriend. She felt she suffered from insecurity and instability in relationships, which she would like to address before getting married. She believed that her lack of self-confidence in interactions stemmed from her troubled childhood, especially the physical and psychological abuse perpetrated by her father, who died 4 years prior to the start of treatment. She acknowledged that there were certain aspects of her past that she had not fully worked through, which she believed necessary in order to sustain healthy relationships.

At the beginning of treatment, Amy had a BDI-II score of 30, indicating severe depressive complaints (Beck et al., 1996). Her post-treatment BDI-II score of 2 suggests that depressive symptoms are minimal (Beck et al., 1996). Amy's IIP-32 score of 57 at the beginning of treatment indicates that interpersonal problems are above average (Horowitz et al., 2000). A detailed evaluation indicates that Amy has above average difficulty with issues of being cold/distant and non-assertiveness and significant difficulty with issues of being domineering/controlling, self-sacrificing and intrusive/needy (Horowitz et al., 2000). According to her scores at the end of treatment, all these issues are sufficiently resolved (IIP-32 = 8). Amy has a very high SCL-90-R total score at the beginning of treatment (SCL-90-R = 188) and an average score at the end of treatment (SCL-90-R = 118; Derogatis, 1992). The declining trend in self-reported scores on the outcome measures reaches significance when assessed via the RCI (BDI-II: RCI= -5.74, $p < .05$; IIP-32: RCI = -10.01, $p < .05$; SCL-90-R: RCI = -4.59, $p < .05$). Despite narrative diagnostic information on longitudinal and multiple exposure to childhood maltreatment, Amy's scores on the ZIL do not reach the cut-off score of 52 (Hovens et al., 2002) to meet the diagnosis of single-incident PTSD, both at the beginning of treatment (ZIL = 44) and at post-treatment (ZIL = 30).

During the post-therapy CCI interview, Amy explains in her own words the changes she experienced after therapy. She no longer feels as if she is becoming mad or crazy. She expresses the contention that it is okay to have doubts and think or feel conflicting thoughts or feelings and that she must no longer hide from her uncertainties. This change stems from the realization that choices do not automatically result in severe consequences or a bad outcome. This altered viewpoint is also accompanied with some alterations in interpersonal relationships. By being more open in interactions, Amy learned that others open up more easily as well and that other people have their own peculiarities and uncertainties. This results in feeling less disconnected from others and having more honest and close relationships. On the other hand, she learned that her relationship with her boyfriend and close family members were less profitable and even noxious and damaging, which resulted in taking a distance from them. Albeit painful and trying, Amy explains that standing up for herself and being more assertive and self-confident felt liberating and improved her overall well-being. Near the end of treatment, Amy lost her job. Notwithstanding the associated financial insecurity, also here she felt liberated to pursue a career compatible with her interests and capacities.

A follow-up assessment two years after treatment termination shows that the demonstrated changes lasted (BDI-II = 8, IIP-32 == 13, SCL-90-R = 121). Amy also reports that she has a new satisfying relationship and found a very rewarding and gratifying job.

CCRT Analysis

Table 1 provides information regarding the dominant CCRT for phase 1 (sessions 1 through 4), phase 2 (sessions 9 through 12) and phase 3 (sessions 17 through 20).

In the first phase, Amy talks about past relationships as well as current interactions. There are two REs concerning interactions with her father. These interactions are characterized by him being angry, aggressive, controlling and overall wrong (RO ‘are bad’), causing her feeling mostly angry, but also helpless, anxious and ashamed and wishing to take over his dominant power position (W ‘to oppose others’, ‘to have control over others’).

Table 1
The dominant wish (W), response other (RO) and response self (RS) throughout therapy

	#	W	RO	RS
Phase 1	12	to be open (6)/ to not be hurt (5) to be understood (4)/ to be accepted (4)/ to have control over others (4)/ to be respected (3)/ to oppose others (3)/ to be opened up to (2)/ to have self-control (2)/ to achieve (2)	Negative are not understanding (7)/ are controlling (6)/ are rejecting (5) don't respect me (3)/ are bad (3) are distant (2)/ are out of control (2)/ are angry (2)	Negative am not open (9)/ feel anxious (7)/ am controlling (5)/ feel ashamed (5)/ feel angry (4)/ don't understand (3)/ am helpless (3)/ am uncertain (3)/ feel disappointed (3)/ oppose others (2) Positive am helpful (2)
Phase 2	8	to be accepted (5)/ to be respected (5)/ to be understood (4)/ to be open (4)/ to feel good about myself (3)/ to be helped (2)/ to be independent (2)/ to be my own person (2)/ to be stable (2)/ to assert myself (2)	Negative are distant (5)/ are rejecting (4)/ are not understanding (3)/ are controlling (3)/ don't respect me (2)/ are unhelpful (2)/ are independent (2)/ are angry (2) Positive are understanding (2)/ respect me (2)/ are open (2)	Negative feel angry (3)/ oppose others (2)/ am helpless (2)/ am uncertain (2)/ feel anxious (2) Positive am open (5)/ understand (2)/ feel respected (2)/ am independent (2)/ feel self-confident (2)/ feel comfortable (2)/ feel happy (2)
Phase 3	13	to be understood (6)/ to be accepted (6)/ to be my own person (6)/ to feel good about myself (5)/ to assert myself (5)/ to be respected (4)/ to be independent (3)/ to be open (2)/ to be helped (2)/ to have control over others (2)	Negative are rejecting (7)/ are unhelpful (5)/ are not understanding (4)/ oppose me (4)/ are controlling (3)/ are bad (3)/ are angry (3)/ don't respect me (2)/ are out of control (2) Positive are open (3)/ are understanding (2)/ respect me (2)/ are cooperative (2)	Negative feel angry (6)/ oppose others (3)/ am helpless (3)/ feel disappointed (3)/ am controlling (2)/ am uncertain (2) Positive understand (4)/ am independent (4)/ feel self-confident (3)/ feel accepted (2)/ feel respected (2)/ feel happy (2)

Note. #: amount of REs, W: the dominant wish, RO: response other, RS: response self, (x) amount of REs in which the CCRT component occurs.

Amy: *He had the absolute power position* (RO 'controlling'). *I never was able to truly express myself* (W 'to be open') *out of fear* (RS 'anxious') *for the consequences. I could never express my emotions. One time, I threw my schoolbag through my room because I came home from school angry. He immediately stormed up the stairs. He told me I was insane* (RO 'critical') *and then he knocked a hole in the wall with his fist* (RO 'are angry'), *which didn't prove his point about my behavior really* (RO 'are bad'). *I felt so much anger* (RS 'angry') *and also a bit embarrassed* (RS 'ashamed'). *And I could not express those feelings in any way* (RS 'am not open'). (session 3)

In relation to her mother, the wish to be empathized with (W 'to be understood'), to be treated fairly (W 'to be respected') and 'to be opened up to' prevailed. In two REs, Amy makes explicit how her mother frustrated her wishes by not being there for her (RO 'are distant', 'are unhelpful'; *e.g., 'she just let it happen'*) and was rather out of control (i.e., unreliable and not dependable).

Also in current interactions, the dominant CCRT of Amy can be described as the wish to be able to express her feelings, ambitions and desires freely (W 'to be open', 'to be understood'). Others are, however, perceived as inconsiderate, critical and disapproving (RO 'are not understanding', 'rejecting') and aggressively dominating (RO 'are controlling'), which causes Amy to keep silent (RS 'am not open') and feeling anxious about expressing herself, ashamed about her opinions and angry towards others. Moreover, to protect herself (W 'to not be hurt'), she manipulates certain situations (RS 'am controlling') in order to still have things her own way (W 'to have control over others').

Amy: *I have a strong need to express my thoughts* (W 'to be open'). *The reactions from others are often not that great. People always say I'm overthinking or they find the things I think about a bit strange* (RO 'are rejecting'). *And then I try to express my thoughts and feelings in a way that they would sound logical for other people to the point where it's not really what I feel anymore* (RS 'am not open', 'am controlling'). *I fear to come across as stupid and I often feel embarrassed* (RS 'anxious', 'ashamed'). *Those are terrible moments, when people are not understanding what I'm trying to say* (W 'to be understood', RO 'are not understanding'). *I truly fear that when I would really be genuine, people would think I'm crazy* (W 'to be accepted'). *To avoid that, I monitor everything closely* (W 'to have control over others', RS 'am controlling'). (session 4)

As Table 1 illustrates, the wishes do not particularly change in the second phase. Contradictory to the first phase, however, Amy does no longer express the wish to protect herself (W 'to not be hurt'). In interactions, she now communicates openly (RS 'am open')

albeit others remain mostly unresponsive (RO 'are distant') and inconsiderate (RO 'are not understanding'). In this phase, there were four current REs concerning Amy's boyfriend, three current REs concerning her mother and one current RE concerning her girlfriends. The episodes concerning her boyfriend mainly center on situations in which he is doing things or making decisions (RO 'controlling') without consulting her (RO 'don't respect me'). In all instances in which she talks about her boyfriend, she expresses the wish to be respected and to be accepted *(e.g., 'I just want the acknowledgement that my feelings are normal.').* She experiences him as not understanding *(e.g., 'I think he underestimates what this means to me.'*) and rejecting *(e.g., 'He finds the things I say a bit crazy.')*. She feels helpless *(e.g., 'I feel as if things are just happening and I just let them pass.')* and uncertain *(e.g., 'I don't know if this is the right thing for me to do.')*. There is one occasion where she felt understood and respected *(e.g., 'Now he realizes and he has suggested himself that we could postpone it if I don't feel comfortable with it.')*. However, on another occasion, he frustrates her wish to be understood:

Amy: *We were talking and I really articulated that I have not been feeling well lately* (RS 'am open'). *And I wanted him to know* (W 'to be understood') *because I notice that he is often totally stunned and I realize that I maybe wasn't telling him everything or that I was belittling things* (RS 'understand'). *So, I was talking about those things I was struggling with and then he said: 'It's not because you're in therapy now that you have to wallow in it.'*(RO 'are not understanding', 'are rejecting'). *I was a bit angry about that* (RS 'am angry'). *I entered therapy because I know I suppress things and because I no longer want to do that anymore* (W 'to be open', 'to feel good about myself').(session 9)

In relation to her mother, Amy expresses she openly communicated how her needs to be nurtured and protected were frustrated in the past, to which her mother remained unresponsive and rejecting *(e.g., 'she didn't want to express herself.')*. Amy conveys a sense of understanding that she must accept she cannot mold her mother in a certain way, but that in order to assert herself and to feel good about herself, she still has the opportunity to go against the oppression of her mother and to self-confidently express her thoughts and feelings *(e.g., 'She could say that I'm crazy or whatever, but I won't let that get to me anymore.')*

Contrasting her experience with her boyfriend and her mother, Amy elaborates on a sensitive conversation she had with her girlfriends:

Amy: *I said that I didn't feel well and that I didn't know what I want anymore and that I have felt very guilty about that and that trying to hide all that made things worse* (RS 'am open') *and the reactions were very positive* (RO 'are understanding', RS 'feel accepted', 'feel respected'). *I noticed that when I'm genuine to people who also genuinely care about me* (RO

'respect me'), *there won't be any severe consequences.* (session 12)

At the final stage of therapy, Amy talks about her interactions with several others, including her by that time ex-boyfriend (6 REs), family members of her ex-boyfriend (2 REs), work relationships (3 REs) and her own family members (2 REs). Next to the wish to be understood and accepted, wishes to feel good about herself, to not conform (W 'to be my own person') and to compel recognition (W 'to assert myself') gain importance *(e.g., 'I aspire to not excuse myself for everything and for the things I want.').* Others' responses are mostly apprehended in a negative way, since others are perceived as mainly rejecting *(e.g., 'he was accusing me')*, unhelpful *(e.g., 'he was not there the way I needed him to be')*, opposing and not understanding *(e.g., 'they don't take it seriously').* Although these negative reactions still generate feelings of anger, helplessness, disappointment and uncertainty, Amy takes an overall more positive stance in these interactions. She now understands how these negative interactions unfold and takes a more independent and self-confident stance towards the disdaining attitude of others *(e.g., 'It's important to me and that should be enough.')*

Therapeutic Alliance and Therapy Process

Amy's scores on the WAI subscales, measured after the fourth therapy session (on a scale of 1 to 5, task scale = 4, goal scale = 3, bond scale = 3), suggest that feelings of mutual trust and consensus on treatment objectives were established early in treatment (Stinckens et al., 2009). The scores on the WAI subscales, measured after the last therapy session (task scale = 3.75, goal scale = 4, bond scale = 4.25) suggest that the therapeutic alliance was good up until the end of treatment.

By and large, Amy reports positively about the therapeutic relationship during the peri- and post-CCI interviews. She focusses attention on three specific aspects she found helpful during her therapy process. First, Amy considers the therapist's neutral stance very liberating:

Amy: *I had anticipated the therapist pointing an accusing finger like 'I see you do this, that's bad'. Beforehand, I expected to feel judged, but that was entirely not the case.* Amy: *I could focus on myself and my feelings without being anxious to hurt someone and being very careful choosing my words. Elsewhere, I always worried how a message would come across. Now, I didn't feel that way because my therapist was neutral. […] Being able to talk to someone without it being thrown back in my face felt good. I finally had the feeling of being able to communicate openly. That was very helpful.*

Second, Amy states that being able to steer the direction of the conversation herself contributed to an organic and pleasant flow of the interactions:

Amy: *It was not an interrogation. I thought that was nice because I could really take*

control. And she encouraged that. She also said: 'If there is anything you're not comfortable with and if you don't want to talk about it, you shouldn't.' I think that's great because I would push myself too far and that would probably have caused more damage.

Third, the therapist's empowering demeanour allowed Amy to open up about difficult topics and provided means to comprehend her own story more clearly:

Amy: *Her way of approaching things corresponded to my needs. I was really uncertain about things and she was really reassuring and empowering actually. That I mustn't let people run over me, that I'm worthy of being self-confident, that I may well trust on my own emotions. I feel lucky because we had a real connection and we agreed about what I needed.*

Therapist Interventions

Table 2 shows the total distribution of supportive, expressive and general interventions throughout therapy. Over 20 sessions, there were a total of 1,107 interventions (M = 55, SD =18). On average, there were more general (M = 39, SD = 14) than expressive (M = 17, SD = 6) and supportive (M = 9, SD = 5) techniques per session, respectively. General techniques were mainly used at the beginning (e.g., greeting each other) and end (e.g., making a new appointment) of each session. Other general techniques encompassed expressions of misunderstanding (e.g., 'Can you repeat that?'), small repetitions of words to encourage further speech and neutral questions to elaborate on a certain topic.

Figure 1 shows the evolution in the amount of supportive and expressive techniques per session. Expressive techniques were more frequent nearly all sessions, except for the first session in which there was an equal amount of supportive and expressive interventions, and at a later stage in therapy (Th12, Th18), in which the amount of supportive techniques was higher. The fact that the therapeutic alliance was readily established can help explain the preponderance of expressive interventions. An in-depth exploration provides further means to understand these finding, as well as some other interesting observations.

Table 2

The frequency of supportive, expressive and other interventions per session

Session	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	
Supportive	21 (18)	8 (21)	9 (14)	9 (15)	5 (10)	3 (7)	1 (2)	4 (6)	10 (22)	6 (14)	13 (29)	9 (26)	12 (22)	5 (11)	10 (20)	9 (13)	6 (14)	20 (28)	10 (15)	15 (26)	185 (17)
Expressive	21 (18)	10 (27)	19 (31)	19 (33)	6 (12)	16 (36)	12 (25)	28 (44)	20 (44)	17 (40)	14 (31)	8 (23)	28 (52)	12 (26)	22 (43)	18 (25)	14 (32)	16 (23)	19 (29)	17 (30)	336 (30)
Other	74 (63)	19 (51)	34 (55)	30 (52)	38 (78)	25 (57)	35 (73)	32 (50)	15 (33)	19 (45)	18 (40)	18 (51)	14 (26)	30 (64)	19 (37)	45 (63)	24 (55)	35 (49)	37 (56)	25 (44)	586 (53)
Total	116	37	62	58	49	44	48	64	45	42	45	35	54	47	51	72	44	71	66	57	1107

Note. (xx): percentage of total interventions that session.

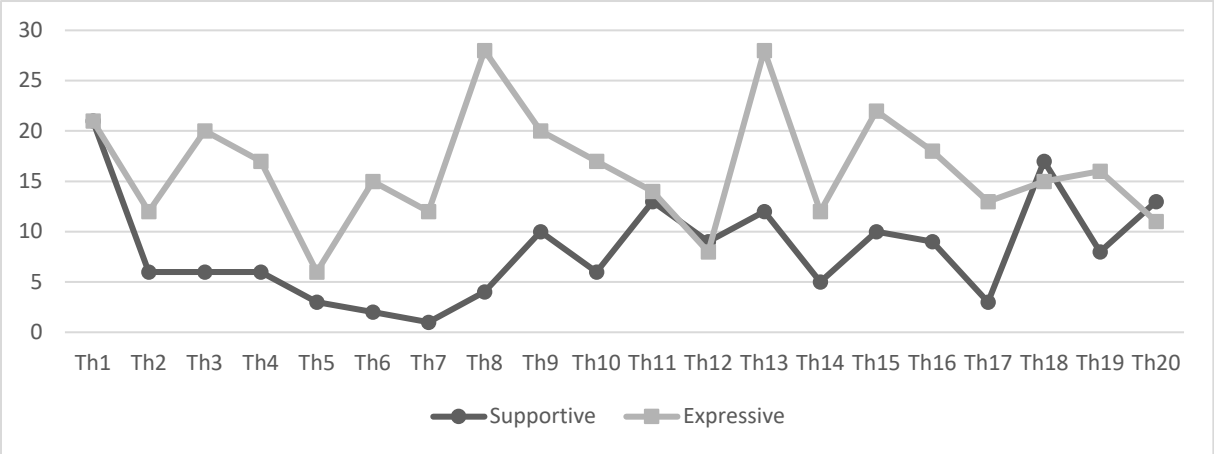


Figure 1: Evolution of the frequency of supportive and expressive interventions using the PACS-SE.

We found that in the beginning of treatment (sessions 1 through 3), expressive techniques were used throughout the entire session, whereas supportive techniques were stacked. In these sessions, expressive techniques mostly concern questions in order to gather data about Amy's central relationship problems or CCRT components.

Amy: *My father had the absolute power. I never really could express myself because I feared the consequences.* Therapist: *Yes. You say that even the smallest expression of your emotions had, especially with your father, repercussions. Now, you have a tough time making decisions… because every choice implies a consequence. I don't want to jump to conclusions, but there's a certain resemblance there.* (session 2)

What we see here is that the expressive interventions are already focused on clarifying Amy's position in interactions and giving feedback about how certain CCRT components transpire across situations and are related to past relationships. The supportive techniques mostly express a supportive and hopeful attitude about therapy. From session 4 onwards, supportive techniques are used in closer proximity to the expressive interventions and convey a sense of understanding, acceptance, respect and recognition.

Amy: *When I'm emotional, I'm afraid to listen to myself. I always felt I was acting crazy at those moments. And I shut them down immediately, but I don't know any more if that's a good thing or a bad thing. And that's why I'm panicking, that's why I'm afraid. I feel as if I don't understand myself anymore and that confuses me so much.* Therapist: *[…]* (expressive) *And that confuses you because you're not used to listen to that. It's much easier when we can say 'white' or 'black'. And that has worked for a very long time. Now it becomes more complex and everything you tried to hide is resurfacing, which forces you to listen. And that's something*

you're not used to do and that's scary and it panics you. (supportive) *But you don't have to be afraid. That's something that can come about step by step. It's overwhelming, of course, and you must tell when it's too overwhelming.* (expressive) *You notice you have the tendency of turning away when you completely doubt yourself and undermine yourself and say to yourself 'what I'm feeling or thinking is not true' and 'is this me?'* (supportive) *Yes, that's you!* Amy: *This is so recognizable on so many specific levels. It's strange because I believe I think more in shades of grey… about other things. […]* (session 4)

This example illustrates how including supportive phrases allows the therapist to clarify Amy's stance in relationships in a way that facilitates further elaboration and working through her CCRT. In the following sessions a variety of themes, such as sexuality (session 6), recurrent dreams (session 7) and work (session 8), are elaborated via general techniques by which the therapist does not steer the dialog in a certain direction. Expressive interventions are implemented to interpret the content of the conversation and to make connections with Amy's general CCRT. Other sessions were more clearly focused on exploring certain specific relationships. Sessions 8 through 12 mainly concentrate on Amy's general position in relationship to her mother, her sisters, and her boyfriend. In these sessions, expressive interventions mainly target a more thorough understanding and working through the CCRT. With supportive interventions at the beginning and end of the sessions, the therapist conveys a sense of liking for the patient. Other supportive interventions are spread across the sessions and can be characterized as little encouragements and ways of recognizing and supporting small changes.

From session 13 to session 17, Amy starts to report on very specific interactions in which there is a notable change in the way she positions herself in these situations, i.e., she notices a change in her RS. Expressive techniques focus on understanding the – unchanged – position of the other party (RO) and via supportive techniques the therapist recognizes Amy's own changed position. In these sessions, the therapist also explicitly returns to the more general CCRT in order to demarcate the evolution in Amy's own stance.

Therapist: (supportive) *It seems to me that what's going on lately is that you start to see things more clearly. You actually always did.* (expressive) *You have always been the eye-opener and you were the one to say 'something's not right' and your sisters keep their eyes shut. They disappear in oblivion.* (session 16)

There were more supportive interventions in session 18 than expressive interventions. Here, we observed another pattern in the way different techniques are interconnected:

Amy: *I will have to look into things to see what's manageable and realistic. I'll work it out step by step.* Therapist: *My hat's off to you! You're so right. It's remarkable how you now focus on your dreams. It seems to me you knew about these things all along, but now there's room for them. There has been an evolution in your relationships. They don't slow you down anymore. You are true to yourself and you follow your own path.*

Here, the therapist shows a supportive stance towards what Amy is saying and then makes the connection with the observed changes in the CCRT. In the last session, supportive techniques are prevalently used to support marked changes. Expressive techniques are more frequently used since the session centres around some specific situations, which the therapist links to broader interpersonal dynamics and the observed changes in Amy's CCRT.

Discussion

Research over the past decades has established sufficient support for the clinical observation that childhood trauma is associated with interpersonal difficulties. However, much is yet to be learned about the specific nature of interpersonal features associated with prolonged and repeated exposure to traumatic events.

Quantitative self-report measures confirmed the presence of interpersonal difficulties at the beginning of treatment. Based on the IIP-32, Amy suffered with issues of being cold/distant and non-assertive on the one hand, and with issues of being intrusive/needy and domineering/controlling on the other. This corresponds with the results of our qualitative analysis of the CCRT components at the beginning of treatment. The CCRT framework provides further means to understand how Amy's interpersonal difficulties are embedded within the context of the underlying, dominant interpersonal dynamics. We saw that Amy's aspiration to be able to express herself freely was frustrated by others' critical and rejecting reactions. In order to protect herself, Amy remained silent or she purposefully altered her tongue in light of anticipated responses of others. These observations bear resemblance to the seemingly contrasting findings in the field that childhood trauma can result in the tendency to oppose others as well as to strongly attach (e.g., Cook et al., 2004). The lack of assertiveness and being overly controlling in relationships by means of manipulation resembles a familiar borderline dynamic (e.g., APA, 2000). This relational pattern has been less described in the childhood trauma literature. Drawing from attachment theory, we can assume that this typical interaction pattern also stems from the conflictual nature of her relationship with primary caregivers (e.g., Gleiser et al., 2008). We have seen that her mother was unavailable and could

not be depended upon to satisfy Amy's need for closeness and nurturance. In relation to her father, Amy also wanted to express herself, but she learned not to do so as this would lead to retaliation. This pattern repeated itself in adult relationships, because Amy anticipated negative consequences whenever she would express herself openly, and therefore, she resorted to other means.

Notwithstanding Amy connected her interpersonal difficulties to her upbringing at the beginning of treatment, she never fully recognized the influence of these primary relations. She primarily connected the interpersonal discomfort with the physical and psychological terror perpetrated by her father. Throughout therapy, she learned to understand how the anticipation of negative reactions from others and her own reactions were colored by the relationship with her father, whom would always react in a very negative fashion, which she tried to avoid by keeping silent. In the treatment, these issues were regularly explored via expressive interventions by which the therapist highlighted similarities between past and current relationships as well as repeatedly referred to Amy's relationship with her father in order to facilitate working through. As treatment progressed, Amy also started to explore the detrimental influence of her mother's negligence, which she never thought to be so influential. In fact, the focus of therapy progressively shifted towards understanding the dynamics between her mother and her, both in the past as well as in their current relationship. Working through this conflictual relationship led Amy to understand that she cannot alter the negative responses of certain others, such as her mother, and finally led her to the decision to take a distance from those people who would continue to disrespect and disregard her. She experienced her own opinion and feelings as righteous and felt self-confident to pursue a more independent stance.

The final aim of this study was to examine the process of change. In the literature, it has been stated that special attention should be given to the initial distrust of the patient and the installation of a safe and durable therapeutic relationship (e.g., Herman, 1992; Pearlman & Courtois, 2005). Both quantitative and qualitative analyses showed that in Amy's case, a good therapeutic relationship was readily installed. This observation requires further remarks. It is important to understand the underlying reasoning in stressing the importance of issues of trust in therapy. It is assumed that basic distrust is a core issue for people with a history of childhood trauma. People have learned not to trust their primary caregivers, which transpires later in life in a general distrust concerning all others (Pearlman & Courtois, 2005). In Amy's case, however, distrusting others was not on the forefront; it was merely a distrust of self and a lack of self-confidence that would more accurately describe Amy's initial stance in therapy. Albeit

the overt openness shown towards the therapist in early sessions, the rational stance and the inaccessible and precarious emotional presence in the therapeutic relationship signals a repetition of a specific trust-related relationship pattern in the therapeutic context. In other words, Amy's general tendency to enter interactions with the anticipation to be labelled crazy also transpired in the therapy, especially in using utterances such as 'this is going to sound weird' or 'what I'm about to say is ridiculous'. The therapist drew Amy's attention to the presence of these core interpersonal patterns in the transference by isolating and questioning these phrases, thereby allowing Amy to examine the repetition of her interpersonal difficulties in the treatment context. Further, by being neutral, acknowledging and empowering, the therapist provided a new relational experience and a safe environment in which Amy could explore and work through these issues, without having to fear criticism or rejection.

It is possible that Amy is an exceptional case and that distrust does play a more central role in the majority of patients with a childhood trauma background. However, our results warrant to consider the possibility that trust should not be considered categorical, either present or absent, but rather dimensional, meaning that the degree of trust can differ from patient to patient and appear in the treatment situation in different guises and, thus, should be determined and considered for every individual patient. As a more general guideline, we could add the importance of identifying (other) core interpersonal patterns, since a repetition of those patterns could potentially hamper the installation of the therapeutic alliance and the therapeutic process in general. Moreover, insight into the dominant interpersonal dynamics provides opportunities to create different relational experiences for the patient and to further address them in therapy. To allow more firm conclusions on these topics, there is a definite need for more research.

Above, we linked the readily established therapeutic alliance to the observation that – contrary to our expectation – expressive techniques were more numerous than supportive interventions at the beginning of treatment. The benevolent attitude Amy addresses, namely that the therapist is neutral, acknowledging and empowering, however, corresponds with a supportive attitude, rather than with an expressive stance. We can explain this from our observations in several ways. First, expressive techniques can be delivered in a supportive way. On multiple occasions, we have seen that expressive and supportive interventions were used in close connection to each other, in which expressive interventions were 'packed' in or accompanied by supportive interventions. Second, it is possible that the therapist applied a general supportive demeanour, for instance, through non-verbal gestures. We noticed, for example, that the therapist changed her tone of voice when delivering more affect-laden

interpretations. At those occasions, she also often explicitly used Amy's name, which could serve the purpose of minimizing the hierarchical distance between them and deliver a more personal message. Also, the therapist and patient often joined in laughter, which shows a more overall appreciation and understanding. It is conceivable that other physical gestures and facial expressions, which cannot be captured on audiotape, confide a supportive attitude. Third, and perhaps most importantly, independently from the interventions used, Amy experiences the therapist as supportive. As Gleiser et al. (2008) point out, the therapeutic context is not only defined "by therapist factors (i.e., what the therapist gives), but also by patient's experience (i.e., what the patient receives)" (p. 350). Especially important for Amy was the experience of an atmosphere in which she could express herself freely without having to fear negative consequences. Albeit the general importance of such a therapeutic environment, it is possible that for other patients other core issues play a more vital role and that those issues require a different therapeutic stance. As discussed above, in Amy's case, distrusting others was not on the forefront. Rather, Amy showcased a self-doubting response to the childhood paternal emotional abuse and maternal emotional neglect. In relation to that, the main reason to enter therapy was the difficulties she experienced in interpersonal relationships. Childhood trauma has, however, been associated with a broad range of other complaints, such as affect dysregulation, dissociation, somatization and personality disruptions, such as borderline personality disorder (e.g., Herman, 1992). It is reasonable to assume that whereas the treatment of Amy consisted of a short-term treatment with an emphasis on validation and empowerment, the treatment with clients who presents as more severely dysregulated will require a longer treatment and a stronger focus on containing and modulating the emotional dysregulation and other disruptions. Therefore, there is a definite need to study the interpersonal dynamics and process of change in cases with fewer internal resources and more severe characterological dysfunctions.

To have a full appreciation of the context in which our results need to be understood, it is important to address that we drew our data from a larger research project in which the presence of depressive symptoms was the main diagnostic criterium to be able to participate. Amy did receive the diagnosis of MDD and also on the basis of self-report measures, it is clear that depressive complaints are apparent. Amy did not receive a diagnosis of PTSD. Moreover, self-report measures indicate that she did not suffer from typical symptoms, such as numbing, avoidance and hyperarousal. For this study, diagnostic criteria were not included in our case selection procedure. At the beginning of therapy, Amy strongly associates her complaints to

her traumatic past. This suggests that people with a childhood trauma background do not necessarily suffer from typical PTSD symptoms. Rather, they are often found to suffer more from and seek help for secondary symptoms, such as depression or interpersonal difficulties (van der Kolk et al., 2005). This observation opens up the discussion whether or not distinct diagnostic categories are necessary in the assessment of patients with a childhood trauma background (e.g., Cloitre, Garvert, Weiss, Carlson, & Bryant, 2014; Resick et al., 2012). Our findings do recommend a thorough assessment procedure for patients with a history of childhood trauma in order to enable a full comprehension of the clinical picture.

On the basis of repeated observations with different quantitative and qualitative measures, we were able to provide a detailed analysis of the interpersonal dynamics in the case of Amy. Our results suggest a strong interconnection between dominant interpersonal patterns and the therapy process. By being neutral, acknowledging and empowering, the therapist provided a safe environment in which Amy could explore and work through interpersonal issues, without having to fear criticism or rejection. This new relational experience allowed her to express herself more openly and self-confidently outside the therapy room as well.

We contend that this study provides sufficient grounds to conclude that a thorough understanding of the nature of dominant interpersonal patterns in childhood trauma-related suffering is of pivotal importance to formulate clinical guidelines. As we have argued that interpersonal features must always be understood within the broader narrative of the individual patient, further longitudinal case study research and process studies are warranted to broaden our understanding of the dynamics of interpersonal features in childhood trauma.

References

American Psychological Association (2000). *Diagnostic and Statistical Manual of Mental Disorders,* Fourth Edition Text Revision. Washington, DC: Author.

Barber, J. P., & Crits-Christoph, P. (1996). Development of a Therapist Adherence/Competence Scale for Supportive-Expressive Dynamic Psychotherapy: A Preliminary Report. *Psychotherapy Research, 6*(2), 81-94.

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Manual for the Beck Depression Inventory-II.* San Antonio, TX: The Psychological Corporation.

Chance, S. E., Bakeman, R., Kaslow, N. J., Farber, E., & Burge-Callaway, K. (2000). Core conflictual relationship themes in patients diagnosed with borderline personality disorder who attempted, or who did not attempt, suicide. *Psychotherapy Research, 10*(3), 337-355.

Cloitre, M., Garvert, D. W., Weiss, B., Carlson, E. B., & Bryant, R. A. (2014). Distinguishing PTSD, Complex PTSD, and Borderline Personality Disorder: A latent class analysis. *European Journal of Psychotraumatology, 5*: 10.3402/ejpt.v5.25097.

Cook, J. M., Riggs, D. S., Thompson, R., Coyne, J. C., & Sheikh, J. I. (2004). Posttraumatic Stress Disorder and Current Relationship Functioning Among World War II Ex-Prisoners of War. *Journal of Family Psychology*, *18*(1), 36-45.

Derogatis, L. R. (1992). *SCL-90-R: Administration, Scoring and Procedures Manual* (2nd ed.). Towson, MD: Clinical Psychometric Research Inc.

Drapeau, M., & Perry, J. C. (2009). The Core Conflictual Relationship Themes (CCRT) in Borderline Personality Disorder. *Journal of Personality Disorders*, *23*(4), 425-431.

Elliott, R., Slatick, E., & Urman, M. (2001). Qualitative change process research on psychotherapy: Alternative strategies. *Psychologische Beiträge, 43,* 69-111.

First, M. B., Gibbon, M., Spitzer, R. L., Williams, J. B. W., & Benjamin, L. S. (1997). *Structured Clinical Interview for DSM-IV Axis II Personality Disorders, (SCID- II).* Washington, DC.: American Psychiatric Press, Inc.

First, M. B., Spitzer, R. L., Gibbon, M., & Williams, J. B. W. (2002). *Structured Clinical Interview for DSM-IV-TR Axis I Disorders, Research Version, Patient Edition, (SCID-I/P).* New York, NY: Biometrics Research, New York State Psychiatric Institute.

Ford, J. F., Courtois, C. A., Steele, K., van der Hart, O., & Nijenhuis, E. R. S. (2005).

Treatment of Complex Posttraumatic Self-Dysregulation. *Journal of Traumatic Stress, 18*(5), 437-447.

Gleiser, K., Ford, J. D., & Fosha, D. (2008). Contrasting exposure and experiential therapies for complex posttraumatic stress disorder. *Psychotherapy, 45*(3), 340-360.

Herman, J. L. (1992). *Trauma and Recovery.* New York, NY: Basic Books.

Herman, J. L., Perry, J. C., & van der Kolk, B. A. (1989). Childhood trauma in borderline personality disorder. *American Journal of Psychiatry, 146*(4), 490-495.

Hodgdon, H., Kinniburgh, K, Gabowitz, D., Blaustein, M. E., & Spinazzola, J. (2013). Development and Implementation of Trauma-Informed Programming in Youth Residential Treatment Centers Using the ARC Framework. *Journal of Family Violence, 28,* 679-692.

Horowitz, L. M., Alden, L. E., Wiggins, J. S., & Pincus, A. L. (2000*). Inventory of Interpersonal Problems.* London: The Psychological Corporation.

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the working alliance inventory. *Journal of Counselling Psychology, 36,* 223-233.

Hovens, J. E., Bramsen, I., & van der Ploeg, H. M. (2009). *Zelfinventarisatielijst posttraumatische stressstoornis.* Amsterdam: Pearson Assessment and Information BV.

Jackson, J. L., Chui, H. T., & Hill, C. E. (2011). The Modification of Consensual Qualitative Research for Case Study Research: An Introdution to CQR-C. In C. E. Hill (Ed.), *Consensual Qualitative Research: Practical Resources for Investigating Social Science Phenomena* (pp. 285-303). Washington, DC: American Psychological Association.

Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59*(1), 12-19.

Kisiel, C., Fehrenbach, T., Stolbach, B., Briggs, E. C., Layne, C. M., … & Spinazzola, J. (2014a). Examining Child Sexual Abuse in Relation to Complex Patterns of Trauma Exposure: Findings from the National Child Traumatic Stress Network. *Psychological Trauma: Theory, Research, Practice, and Policy, 6*(1), 29-39.

Leichsenring, F., & Schauenburg, H. (2014). Empirically supported methods of short-term psychodynamic therapy in depression: Towards an evidence-based unified protocol. *Journal of Affective Disorders, 169,* 128-143.

Luborsky, L. (1984). *Principles of psychoanalytic psychotherapy: A manual for supportive-expressive treatment.* New York, NY: Basic Books.

Luborsky, L., & Crits-Christoph, P. (1998). *Understanding Tranference: The Core Conflictual Relationship Theme* (2nd Ed.). Washington, DC: American Pscyhological Association.

Meganck, R., Desmet, M., Bockting, C., Inslegers, R., Truijens, F., … & Vanheule, S. (2017). The Ghent Psychotherapy Study (GPS) on the differential efficacy of supportive-expressive and cognitive behavioral interventions in dependent and self-critical depressive patients: Study protocol for a randomized controlled trial. *Trials,* 18, 126.

Newman, E., Riggs, D. S., & Roth, S. (1997). Thematic Resolution, PTSD, and Complex PTSD: The Relationship Between Meaning and Trauma-Related Diagnoses. *Journal of Traumatic Stress, 10*(2), 197-213.

Pearlman, L. A., & Courtois, C. A. (2005). Clinical Applications of the Attachment Framework: Relational Treatment of Complex Trauma. *Journal of Traumatic Stress, 18*(5), 449-459.

Resick, P. A., Bovin, M. J., Calloway, A. L., Dick, A. M., King, M. W., … & Wolf, E. J. (2012a). A critical evaluation of the complex PTSD literature: implications for DSM-5. *Journal of Traumatic Stress, 25*(3), 241-51.

Stiles, W. B. (2013). The Variables Problem and Progress in Psychotherapy Research. *Psychotherapy, 50*(1), 33-41.

Toomela, A. (2007). History of Methodology in Psychology: Starting Point, Not the Goal. *Integrative Psychological and Behavioral Science, 41,* 75-82.

van der Kolk, B. A., Roth, S., Pelcovitz, D., Sunday, S., & Spinazzola, J. (2005). Disorders of Extreme Stress: The Empirical Foundation of a Complex Adaptation to Trauma. *Journal of Traumatic Stress, 18*(5), 389-399.

Van Nieuwenhove, K., & Meganck, R. (2017). Interpersonal Features in Complex Trauma Etiology, Consequences, and Treatment: A Literature Review. *Journal of Aggression, Maltreatment, & Trauma,* DOI: 10.1080/10926771.2017.1405316

Wampold, B. E. (2007). Psychotherapy: The humanistic (and effective) treatment. *The American psychologist, 62*(8), 855-873.

Westen, D. (2006). *The Clinical Diagnostic Interview.* Atlanta, GA: Emory University.

5

THE INFLUENCE OF INTERPERSONAL PATTERNS ON THE THERAPY PROCESS IN A CASE OF CHILDHOOD TRAUMA. [14]

Research concerning the nature of interpersonal difficulties related to childhood trauma and their influence on the therapeutic process is scarce. We investigated interpersonal patterns at the start of treatment, changes in interpersonal patterns as treatment progressed, and the change process in a mixed-methods single case study of a supportive-expressive psychodynamic psychotherapy with a 33-year-old female with a history of childhood trauma. The patient showed a pervasive inability to open up towards others throughout the entire treatment, which is closely associated with others' actual or anticipated rejection, disrespect and disinterest. Excessive use of expressive interventions, which target interpersonal change, initially led to a worsening of the patient's condition. Via supportive and general interventions, symptom stabilization was achieved. The findings of this study suggest a thorough understanding of dominant interpersonal patterns is necessary to recognize their influence on the therapy process.

[14] This chapter is based on: Van Nieuwenhove, K., Meganck R., Acke, E., Cornelis, S., & Desmet, M. The Influence of Interpersonal Patterns on the Therapy Process in a Case of Childhood Trauma. (unpublished manuscript)

Introduction

People with a history of complex trauma (i.e., being exposed to prolonged and repeated interpersonal traumatic events) suffer from a wide variety of symptoms, including interpersonal difficulties (e.g., Herman, 1992; van der Kolk et al., 2005; Van Nieuwenhove & Meganck, 2017). These interpersonal problems are often related to a lack of trust in others and the world (e.g., Hodgdon, Kinniburgh, Gabowitz, Blaustein, & Spinazzola, 2013) as a result of childhood experiences in which primary caregivers were unreliable and unpredictable (e.g., Pressley & Spinazzola, 2015). Drawing from attachment theories, this insecure basis gives rise to certain deeply engrained interpersonal dynamics, such as a fundamental distrust, which are translated to interpersonal relations later in life, including the relationship with a therapist (Gleiser et al., 2008; Pearlman & Courtois, 2005).

Following this idea, several researchers propose a more tailored treatment approach focusing primarily on the formation of a safe therapeutic relationship, symptom stabilization and the acquisition of social and interpersonal competencies (e.g., Cloitre et al., 2011; Cloitre et al., 2012; Ford, Courtois, Steele, van der Hart, & Nijenhuis, 2005; Herman, 1992). After more than three decades of research in this area, however, the necessity of the implementation of such an initial stabilization phase remains highly controversial.

Several researchers have found support for the inclusion of a stabilization phase (e.g., Cloitre et al., 2010; Gleiser, Ford, & Fosha, 2008; Jepsen, Langeland, & Heir, 2013; Zorzella, Muller, & Classen, 2014). In a more recent study, Classen, Muller, Field, Clark, and Stern (2017), for instance, studied the effects of what they called an intensive ‘stage 1’ treatment program in a sample of 54 treatment-seeking women with a history of chronic trauma. Their results indicate that these women strongly benefitted from this stabilization oriented treatment program as they significantly improved on a wide array of measures, including PTSD symptoms, interpersonal problems and attachment difficulties.

On the other hand, there are studies that contest the idea of employing a stabilization phase in treatment (e.g., De Jongh et al., 2016; Resick et al., 2012a; Resick, Wolf, Wiltsey Stirman, & Bovin, 2012b). Wagenmans, Van Minnen, Sleijpen, and De Jongh (2018) challenged the idea that first-line trauma-focused psychotherapy without a stabilization phase would not be beneficial or even detrimental for people with a complex trauma history. In a sample of 165 patients with a varying trauma background, they found no support for discernible outcomes between patients with or without a history of sexual abuse after a treatment program consisting of prolonged exposure and EMDR without a stabilization phase.

Van Nieuwenhove and Meganck (2017) refer to the impasse in the complex trauma research field regarding the necessity of a stabilization phase as a Sisyphean struggle, which will not likely be resolved by approaching it with classical methods, such as cross-sectional comparison studies and dismantling studies. Conclusions about whether or not a stabilization phase is mandatory cannot be deduced from these typical effectiveness studies because they only allow general causal statements (i.e., the specific treatment produces changes) and not statements about the mechanisms underlying the changes (Kazdin, 2007). For example, Wagenmans et al. (2018) only assessed PTSD symptoms post treatment. Therefore, it cannot be concluded as of yet that a stabilization phase would not be warranted to manage other related difficulties, such as interpersonal problems and affect-dysregulation (e.g., Briere & Jordan, 2009; Dorrepaal et al., 2014; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). Moreover, it is possible that in their treatment programs, Wagenmans et al. (2018) did incorporate mechanisms that targeted – albeit unsolicited – those features which are considered crucial for stabilization. In other words, it is difficult if not impossible to exclude attention for a safe relationship, symptom stabilization and interpersonal issues from any psychotherapy (Wampold, 2007). Likewise, the fact that stabilization-focused treatment produces therapeutic gains does not by definition mean that the intended treatment targets, such as a safe therapeutic relationship, are in themselves the (only) mechanisms through which change comes about. Thus, stabilization-based treatments and more traditional trauma-focused treatments might produce changes through certain factors they have in common; or changes in both treatment modalities might stem from different therapy processes. All in all, the current state of research in the field does not allow any firm conclusions about mechanisms of change. Consequently, a more thorough investigation of therapy processes is necessary to make advancements (Kazdin, 2007; 2009). Moreover, to arrive at a more comprehensive understanding, it is necessary to study some of the core assumptions underlying the need for initial stabilization, such as if and how dysfunctional interpersonal patterns influence early therapeutic encounters, how therapeutic interventions can foster or hamper the establishment of a safe working alliance, and which therapeutic techniques are necessary to accomplish therapeutic change. More generally, several researchers have put forward the need to further investigate interpersonal features associated with exposure to chronic trauma (e.g., Briere & Jordan, 2009; Ford, Connor, & Hawke, 2008; Tarocchi, Aschieri, Fantini, & Smith, 2013; Van Nieuwenhove & Meganck, 2017) .

In order to refine theory and enhance our understanding of these basic mechanisms (Levitt et al., 2018; Stiles, 2013), we aim at an in-depth investigation of the nature of interpersonal patterns and how these patterns change throughout the course of therapy in a systematic mixed-method single case study of a woman with a background of childhood trauma. We opted for a case study approach because it allows an in-depth scrutiny of the unfolding of interpersonal dynamics in a treatment context, therefore also allowing to study their influence on the therapy process. Moreover, it allows to investigate the process of change in-depth by systematically monitoring the therapeutic relationship and therapist interventions and mapping possible shifts throughout treatment (Fishman & Messer, 2013; Stiles, 2013).

Specifically, we will study interpersonal features and processes in a manualized supportive-expressive psychodynamic treatment. Supportive-expressive psychodynamic therapy explicitly targets interpersonal dynamics, both through supportive and expressive techniques, and therefore provides an adequate framework to study interpersonal features in complex trauma and to investigate the process of change in-depth. Concisely, supportive interventions aim to foster the therapeutic relationship and include interventions which express the therapist's engagement in treatment to help the patient and to provide an empathic and safe atmosphere. Expressive interventions, on the other hand, include clarifications and interpretations to recognize, understand and work through core interpersonal issues, which are generally considered to be directly associated with symptoms and therefore warrant change (Luborsky, 1986; Luyten & Blatt, 2012). The manual of Luborsky also includes specific guidelines for working with more severely distressed patients to strengthen the therapeutic alliance by applying a greater amount of supportive interventions. As therapy progresses, and the relationship is safe enough to tolerate expressiveness, more expressive interventions can be introduced (Luborsky, 1986).

In summary, this study's first aim is to investigate the nature of interpersonal relationship problems in childhood trauma. Second, we will study the way early interpersonal patterns change throughout treatment. Third and finally, we will examine this process of change via a systematic study of the therapeutic alliance and the therapist interventions.

Method

Participants

Client. Pam, a Caucasian female, was 33 years old the moment she entered therapy. She has a history of childhood physical and psychological abuse perpetrated by her mother, while her

father remained a passive witness. According to DSM-IV criteria (APA, 2000), Pam received the diagnosis of recurrent seasonal Major Depressive Disorder (MDD), agoraphobia and Body Dysmorphic Disorder. She has been taking antidepressant and anti-epileptic medication for some decades and has been hospitalized for three months because of suicidal ideations three years prior to treatment. In order to guarantee confidentiality, we used a pseudonym. Moreover, all information that would lead to the identification of the patient has been removed or anonymized. Ethics committee approval was granted by the Ghent University Hospital (B670201523446) (Meganck et al., 2017).

Therapist. The therapist is a Caucasian female, who was 32 years old and had 8 years of clinical experience when therapy started. She is formally trained in Psychoanalytic Therapy and received an additional training in Short Term Psychodynamic Psychotherapy (STPP, Leichsenring & Schauenburg, 2014; Luborsky, 1984). The therapy consisted of 20 weekly sessions of STPP. Session duration ranged between 35 and 68 minutes (M = 51.24 minutes).

Case Selection. We drew our data from the Ghent Psychotherapy Study (GPS, Meganck et al., 2017), a Randomized Controlled Trial in which patients either receive 16 to 20 sessions of Cognitive Behavioral Therapy (CBT) or STPP for the treatment of MDD. Only the measures used in this study are mentioned (for a full description, see Meganck et al., 2017). We selected the case of Pam, without knowledge of outcome, using two criteria. The first requirement was the presence of a complex traumatic background (i.e., repeated and prolonged interpersonal traumatic events) as reported in the Clinical Diagnostic Interview (CDI, Westen, 2006). During the CDI, Pam describes having had a poor upbringing with a very 'tyrannical' mother, whom would be very controlling (e.g., regular room inspection not allowing any secrets), demanding (e.g., cleaning and cooking) and punishing (e.g., physical abuse, psychological games). The second requirement was that Pam received STPP to ensure treatment focuses on interpersonal themes. As our research objectives mainly require rich information on interpersonal dynamics, we did not set any further (diagnostic) requirements.

Measures

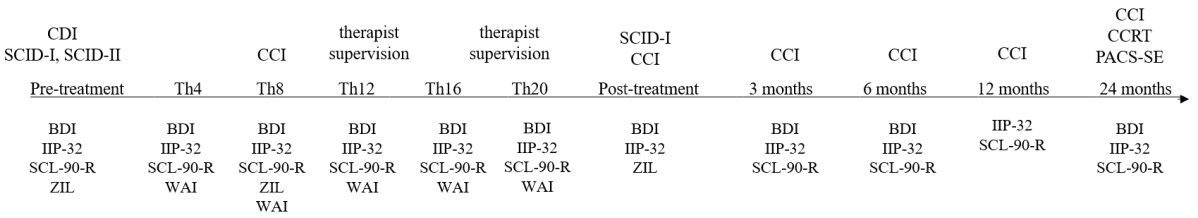
Interview and Qualitative Measures. *The Clinical Diagnostic Interview* (CDI, Westen, 2006) is a semi-structured narrative-based interview that assesses a broad range of intra- and interpersonal characteristics. *The Structured Clinical Interview for DSM-IV* (SCID) is a structured interview to determine DSM-IV axis I disorders (SCID-I, First, Spitzer, Gibbon, & Williams, 2002) and DSM-IV axis II personality disorders (SCID-II, First, Gibbon, Spitzer,

Williams, & Benjamin, 1997). The *Client Change Interview* (CCI, Elliott, Slatick, & Urman, 2001) is a semi-structured interview assessing the experience of the therapeutic process and therapeutic change. In the context of the GPS, the therapist joined in bi-weekly group *supervision*, in which she discussed the case of Pam two times. All interviews, therapy sessions – with the exception of session 13 where the audiotape failed – and supervision sessions, were audiotaped and transcribed using pre-set standards.

Quantitative Measures. *The Beck Depression Inventory* (BDI-II, Beck, Steer, & Brown, 1996) is a 21-item self-report questionnaire used to assess depression severity. *The Self-rating Inventory for Posttraumatic Stress Disorder* (ZIL, Hovens, Bramsen, & van der Ploeg, 2000) is a 22-item self-report questionnaire used to assess symptoms related to PTSD. *The Inventory of Interpersonal Problems* (IIP-32, Horowitz, Alden, Wiggins, & Pincus, 2000) is a 32 items self-report questionnaire used to assess interpersonal functioning on eight scales (i.e., domineering, vindictive, cold/distant, socially inhibited, nonassertive, overly accommodating, self-sacrificing, and intrusive). The *Symptom Checklist* (SCL-90-R, Derogatis, 1992) is a 90-items self-report questionnaire administered to assess psychical and physical symptoms on nine dimensions (i.e., somatization, obsessive-compulsive, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism). The *Working Alliance Inventory-Short Revised* (WAI-SR, Horvath & Greenberg, 1989) is a 12-item self-report questionnaire to assess the quality of the therapeutic relationship on three scales (i.e., task scale, goal scale, and bond scale).

Procedures

We executed an *integrative mixed-methods design* (Levitt et al., 2018) and applied principles of *Consensual Qualitative Research for case studies* (CQR-c, Jackson, Chui, and Hill, 2011), in which consensus and triangulation are essential, to systematically examine interpersonal features and processes. Specifically, we used triangulation of both quantitative and qualitative measures (self-report questionnaires, interviews, therapy sessions), methods (outcome assessment, qualitative analysis, standardized coding systems) and researchers (consensus procedures, audits). See Figure 1 for a comprehensive overview of when different measures were administrated.



Note. Due to missing values, the total scores for the SCL-90-R at post-treatment and the BDI-II at 12-month follow-up could not be calculated. CDI: Clinical Diagnostic Interview; SCID-I: Structured Clinical interview for DSM-IV axis-I disorders; SCID-II: Structured Clinical Interview for DSM-IV personality disorders; CCI: Clinical Change Interview; CCRT: Core Conflictual Relationship Theme method; PACS-SE: Penn Adherence/Competence Scale for Supportive-Expressive Dynamic Psychotherapy; BDI: Beck Depression Inventory; IIP-32: Inventory of Interpersonal Problems; SCL-90-R: Symptom Checklist; ZIL: Self-rating Inventory for Posttraumatic Stress Disorder; WAI: Working Alliance Inventory.

Figure 1. Quantitative self-report (lower half) and interview and qualitative measures (upper half) throughout the research and therapy process

The *Core Conflictual Relationship Theme method* (CCRT, Luborsky & Crits-Christoph, 1998) is a manualized procedure to map dominant interpersonal patterns in narrative material derived from transcribed therapy sessions and consists of two broad steps. First, relationship episodes (REs) are selected within the narrative material, i.e., excerpts in which an interpersonal exchange is described. Second, these REs are coded to map the dominant wish (W), the (anticipated) response of the other person involved (RO) and the person's own reaction (RS), using standard categories (Edition 2) provided by the CCRT manual (Luborsky & Crits-Christoph, 1998), which includes 35 Ws, 30 ROs and 31 RSs. The CCRT method was conducted by the first and fourth author on narratives derived from the transcribed therapy sessions at the beginning (sessions 1 through 4), middle (sessions 9 through 12) and end (sessions 17 through 20) of treatment. Consensus on the frequency of each component was achieved through detailed discussion and the final frequency with which each category occurred across the REs was computed to provide the dominant CCRTs.

The *Penn Adherence/Competence Scale for Supportive-Expressive Dynamic Psychotherapy* (PACS-SE, Barber & Crits-Christoph, 1996) is a 45-item rating-scale to assess the frequency of different therapeutic techniques. The scale consists of 9 items assessing general techniques, which can be broadly defined as neutral questions or comments to facilitate patient's speech, 9 items assessing supportive techniques, such as positive appraisals and an empathic conveyance of understanding and acceptance, and 27 items assessing expressive

interventions, including questions to gain information on interpersonal dynamics and interpretations or statements to focus attention on or give feedback about core interpersonal patterns. All therapist interventions – except 'mhm', which was considered a neutral intervention – were rated as general, supportive or expressive by the first and third author, independent from each other. Through consecutive meetings, consensus was achieved and the frequencies per technique were computed for every session.

Results

CCRT Analysis

Table 1 shows the dominant CCRT components for phase 1 (sessions 1 through 4), phase 2 (sessions 9 through 12) and phase 3 (sessions 17 through 20). For each phase, we will describe the most prominent CCRT components and illustrate them with excerpts from the REs derived from the corresponding therapy sessions.

In the first phase, all REs center around the wish to avoid conflict in relation to others. Especially in relation to her parents (3 REs), Pam experiences a lot of criticism (RO 'are rejecting'). Despite from her wanting to break free from them (W 'to not be responsible or obligated') and her strong wish to be recognized in her own choices (W 'to assert myself', 'to be respected'), she says nothing (RS 'am not open') and passively undergoes (RS 'am dependent') their intimidation and domination (RO 'are controlling') out of fear (RS 'am anxious') and to protect herself (W 'to not be hurt', 'to avoid conflict').

> P: They just show up unannounced and walk inside without asking if it suits me or not (RO 'are controlling'). I don't speak up (RS 'am not open') when something bothers me. If my parents show up, then I do not dare to say (RS 'am anxious') that it does not work out well for me at that moment. I'm so annoyed by it (RS 'am angry'). I feel like a slave (RS 'dependent'). I usually provide them with coffee and they stay for like a half an hour to an hour. And then, they say all sorts of negative things, sometimes pure criticism (RO 'are rejecting'), for instance that it is not clean enough. I don't react. If they ask a question, I answer and that's that. I don't go into discussion with them (W 'to avoid conflict'). I do not set any limits. I would want to (W 'to assert myself'), but towards my parents, I just can't do it (RS 'am helpless').

This pattern is also clearly shown in relation to others in her life, both in terms of her relationship with her husband (2 REs) and in work-related contacts (4 REs). The next RE

Table 1

The dominant wish (W), response other (RO) and response self (RS) throughout therapy

	#	W	RO	RS
Phase 1	9	to avoid conflict (9)/ to not be responsible or obligated (4)/ to assert myself (4)/ to be respected (3)/ to be helped (3)/ to not be hurt (3)/ to be accepted (2)/ to be my own person (2)/ to be loved (2)	are rejecting (8)/ are controlling (5)/ are not understanding (3)/ dislike me (3)/ are distant (3)/ are bad (3)/ don't respect me (2)/ are not trustworthy (2)/ are unhelpful (2)/ hurt me (2)/ oppose me (2)/ are angry (2)	am not open (9)/ feel anxious (7)/ am dependent (6)/ feel angry (6)/ dislike others (3)/ am helpless (3)/ am out of control (2)/feel depressed (2)/ feel guilty (2)
Phase 2	12	to avoid conflict (10)/to be respected (6)/ to be accepted (5)/ to be open (3)/ to be loved (3)/ to be liked (2)/ to not be hurt (2)/ to not be responsible or obligated (2)	don't respect me (5)/ are rejecting (5)/ are not understanding (4)/ are not trustworthy (4)/ are distant (4)/ are strong (3)/ are controlling (2)	am not open (10)/ am helpless (5)/ am uncertain (5)/ feel angry (5)/ feel anxious (5)/ am dependent (4)/ feel disappointed (4)/ feel unloved (3)
Phase 3	12	to be respected (8)/ to have trust (8)/ to be accepted (6)/ to be liked (6)/ to be understood (4)/ to be opened up to (4)/ to be open (4)/ to be helped (3)/ to not be hurt (3)/ to be loved (2)	are rejecting (8)/ are controlling (7)/ don't respect me (5)/ are distant (5)/ are strong (5)/ are not understanding (4)/ are not trustworthy (4)/ are strict (4)/ are unhelpful (3)/ are accepting (2)/ respect me (2)	am not open (8)/ feel disappointed (8)/ oppose others (5)/ am dependent (5)/ am helpless (4)/ don't understand (3)/ dislike others (3)/ feel self-confident (3)/ am uncertain (3)/ feel angry (3)/ am self-controlled (2)/ feel unloved (2)/ feel anxious (2)

Note. #: amount of REs, W: the dominant wish, RO: response other, RS: response self, (x) amount of REs in which the CCRT component occurs.

concerning her husband illustrates how she does not open up because of the anticipated reaction, rather than his actual reaction:

> P: If I think about it, I know that I don't have to be afraid (RS 'feel anxious') for questions he might ask. He means well. But still, the idea that there might come questions or reproaches, such as 'you don't do anything around the house' (RO 'are rejecting'), makes me not talk about it (RS 'am not open').

Between sessions 9 through 12, the dominant CCRT components do not particularly change. At large, this can be explained by the fact that seven REs concern interactions with her parents, which show a very rigid pattern. However, it seems that another layer of her core interpersonal issues got unraveled in this phase. Table 1 shows that in the negative reaction of others, next to the critical and controlling demeaner (RO 'are rejecting', 'are controlling'), more emphasis is placed on the fact that people don't value her or treat her fairly (RO 'don't respect me'), are unsympathetic and inconsiderate (RO 'are not understanding') and unresponsive or unavailable (RO 'are distant'). In the same respect, the wish to be affirmed (W 'to be accepted'), to be important to others (RO 'to be respected') and others to show an interest in her (W 'to be liked') prevail. Parallel to the first phase, we see similarities in the relation between Pam and her parents (7 REs) and her husband (2 REs):

> P: My parents don't ask (RO 'are distant'), so I keep silent (RS 'am not open'). I have the idea that it just does not interest them (RO 'don't respect me', 'dislike me'). They don't ask and I'm not going to talk spontaneously about how that was for me (W 'to be respected', 'to be liked'). It seems as if they don't care, so… yeah.
>
> P: I think my husband knows by now that my parents are a tricky issue for me, but how and what exactly, he does not know. He does not often ask anything about it, so… (RO 'are distant', 'are not understanding').

In this phase, Pam does express the wish to be able to be more open towards others, especially her sister (2 REs) (e.g. 'I would like to be able to open up to people that are close to me.'). However, she experiences a strong ambivalence (RS 'am uncertain') and inability to do so (RS 'am helpless'), which she links to a very specific situation in which she tried to reveal her home situation to people she thought she could trust (1 RE):

> P: In the past, I tried to talk about the situation at home (W 'to be open', 'to be understood', 'to be helped') and it just blew up in my face. I told a teacher once and he contacted my parents and they just denied everything. Also, I went to the general practitioner and he asked my parents and they said it was not true. If no one believes you (RO 'don't trust me'), you just can't change that (RS 'am helpless', RO 'are

strong'). If no one believes you anymore, you don't have any trust in the world anymore (RO 'are not trustworthy').

At the end of therapy, in line with the first two phases, the reactions of others are perceived or anticipated in a negative way (e.g. RO 'are rejecting', 'don't respect me', 'are controlling'). In this phase, Pam mainly talks about interactions with people she perceives as having an authoritarian position (e.g., parents, doctors, bosses). She discloses how she would always remain silent (RS 'am not open') and passively submit to their superiority (RS 'am dependent', RO 'are strong', RO 'are controlling') whilst feeling disappointed (RS 'feel disappointed') about their negligence (RO 'are not understanding', 'don't respect me', 'are distant') and denunciation (RO 'are rejecting', 'are not trustworthy'). In this phase, the wishes show a notable shift. She emphasizes wanting others to be sincerely interested (W 'to be respected', 'to have trust', 'to be liked') in who she really is (W 'to be accepted', 'to be understood'). Moreover, she wants to be able to have genuine conversations (W 'to be opened up to', 'to be open'). Whereas before, her wishes were formulated in terms of wanting to avoid the negative anticipated reactions of others, she now seems to articulate her own desire, stemming from what she misses in relation to others.

Therapeutic Alliance

Pam's scores on the WAI-SR subscales, measured after the fourth therapy session (on a scale of 1 to 5, task scale = 4.5, goal scale = 4, bond scale = 4.25), suggest that feelings of mutual trust and consensus on treatment objectives were established early in treatment (Stinckens et al., 2009). These scores show a slight decrease towards session 12 (task scale = 4, goal scale = 3.25, bond scale: 3.75) and remain stable or increase again towards the end of treatment (task scale = 4, goal scale = 3.5, bond scale = 4.5). On the whole, these scores suggest that a good therapeutic relationship was formed at the start of treatment, which remained quite stable throughout the entire therapy process (Stinckens et al., 2009).

In the CCI after session 8, Pam indicates that she experiences the therapy process as 'positive'. She describes her therapist as a professional and friendly person. She recounts that she said to the therapist that she was not that talkative and that the therapist responded that she did just fine. She feels that she can be more open in the therapy room. However, when Pam experiences difficulties to come up with topics to talk, she finds it comforting that the therapist herself steers the conversation by asking questions.

After treatment termination, Pam recounts the therapist felt familiar and safe. If she would ever consider to go back to therapy, she would return to her because of the therapist's

professional attitude, the fact that she asked the right questions and their good connection. In the follow-up CCIs, Pam does not elaborate much on her experience of the therapy process. She can only say that, looking back, she was very pleased of having been in therapy and she would definitely go back if needed.

Therapist Interventions

Table 2 shows the total distribution of supportive, expressive and general interventions throughout therapy. Over 19 sessions (session 13 not included) there were a total of 2,495 interventions (M = 119, SD = 22). On average, there were more general (M = 69, SD = 18) than expressive (M = 36, SD = 16) and supportive (M = 26, SD = 10) techniques per session, respectively.

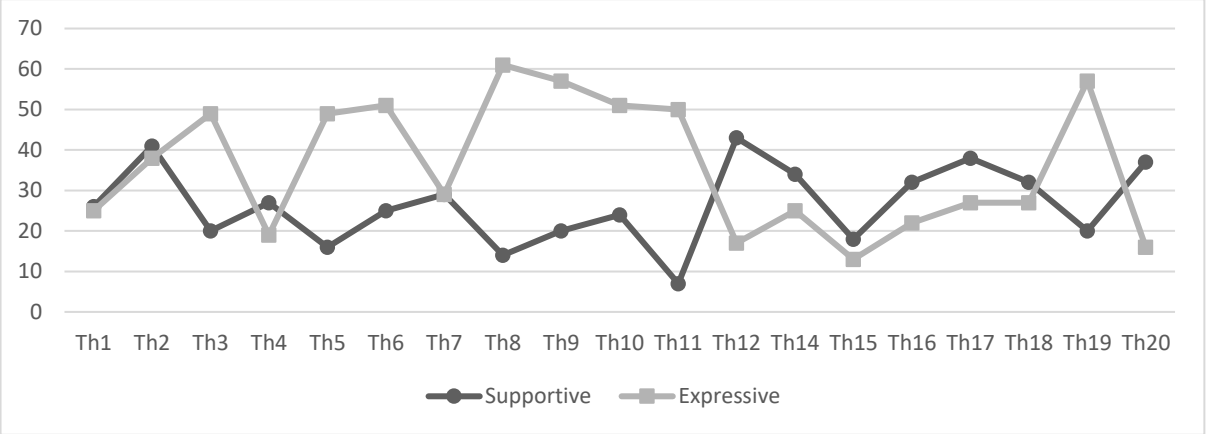


Figure 2: supportive and expressive interventions throughout the treatment

Figure 2 shows the evolution in the amount of supportive and expressive techniques per session. In the first two sessions, supportive techniques were used slightly more than expressive techniques. Between sessions 3 and 11, expressive techniques were used notably more than supportive techniques, whereas between sessions 12 and 18 the opposite is true. The end of treatment shows a peak in expressive interventions in session 19 and a higher rate of supportive interventions in session 20. Based on the literature, we would have expected that the ratio between supportive and expressive interventions remained the same after the initial phase, especially because, according to the WAI-SR scores, the therapeutic alliance seemed to be easily established and did not suffer abrupt ruptures. The erratic sequence of supportive and expressive techniques shows that the formation of the therapeutic relationship is clearly more complex and therefore necessitates a more in-depth investigation of the therapy process.

Table 2

The frequency of supportive, expressive and general interventions per session

	Duration	General	Supportive	Expressive	Total
Th1	55’33	94 (65)	26 (18)	25 (17)	145
Th2	46’22	60 (43)	41 (29)	38 (27)	139
Th3	55’35	82 (54)	20 (13)	49 (32)	151
Th4	41’54	52 (53)	27 (28)	19 (19)	98
Th5	59’12	111 (63)	16 (9)	49 (28)	176
Th6	49’00	83 (52)	25 (16)	51 (32)	159
Th7	50’26	62 (52)	29 (24)	29 (24)	120
Th8	49’42	47 (39)	14 (11)	61 (50)	122
Th9	57’41	52 (40)	20 (16)	57 (44)	129
Th10	67’43	88 (54)	24 (15)	51 (31)	163
Th11	52’40	74 (56)	7 (5)	50 (38)	131
Th12	42’05	42 (41)	43 (42)	17 (17)	102
Th14	51’00	68 (54)	34 (27)	25 (20)	127
Th15	49’00	76 (71)	18 (17)	13 (12)	107
Th16	50’35	69 (56)	32 (26)	22 (18)	123
Th17	49’59	69 (51)	38 (28)	27 (20)	134
Th18	53’43	78 (57)	32 (23)	27 (20)	137
Th19	56’22	61 (44)	20 (14)	57 (41)	138
Th20	34’59	41 (44)	37 (39)	16 (17)	94
Total		503 (20)	683 (27)	1309 (52)	2495

Note. (xx): percentage of total interventions.

First of all, it is remarkable that there are, on average, 119 interventions each session, which comes down to more than 2 interventions every minute. This means that the interventions follow each other in rapid succession. Most of these interventions are general interventions, with a percentage of 39 to 71 of all interventions, in which the therapist repeats small phrases or asks neutral questions to allow Pam to elaborate on a certain situation or feeling. Pam does not spontaneously talk in great length about anything, whether or not it concerns intimate or difficult topics, requiring a more active stance from the therapist. An excerpt from session 5, in which the largest amount of general techniques were used, illustrates this. The situation concerns the impact Pam’s diagnosis of epilepsy has on her life.

P: Even if you don’t want it, it controls your life. You always take it into account.

T: Yes. Can you tell me some more about that? Can you give me an example?

P: Yes. Going to bed in time, not too much alcohol, going home from a party on time. Euhm, driving. I drive to work, but that’s it.

T: Is that something, are you allowed to drive?

P: Yes, that’s a grey area.

T: Because there is doubt about if people, euhm.

P: Yes, but in our neighbourhood, you cannot get around without a care. Then you don't get anywhere.

As treatment progresses, the amount and content of general techniques remain stable with only a slight decreasing trend, which implies that Pam remained rather reticent to talk spontaneously up until the end of therapy.

In the first two sessions, supportive techniques are marginally more prevalent and are used throughout the entire session. At the end of these sessions, supportive techniques are more stacked and convey a commitment from the therapist to work together.

T: I want to express clearly that I find it really important that you talk and that *we* explore *together* what is going on and what is important to you. […] *We* will take our time to figure things out *together*. Gradually, you will notice how that works and if you have any questions or if something is unclear, please notify me. We see each other weekly, is that doable?

Expressive techniques incline between sessions 1 and 3 and mostly concern questions to gather information about Pam's relationships, especially with regards to her not being able to open up and the very tense relationship with her mother, which are issues Pam herself often introduces.

P: I have never understood and I guess I never will……. And I don't know if I even want to know.

T: How do you mean?

P: I have been asked before if I didn't want to know why my mother reacts the way she does, but frankly, I really don't need to gain insight in those people. No.

T: As if gaining an understanding would be equal to wiping things out.

P: Yes.

T: Do you have the idea that your story would disappear?

P: No… What happened in the past stays and... I don't need. No, I just don't need to specialize myself in my mother's behaviour.

T: Some people say okay, I want to understand because I don't want to end up with the idea that she didn't love me, that it had to do with something else.

P: … Yeah, I don't know what to think of it.

T: You really don't have a clue as to why she was so cold towards you?

P: … … … I don't know if she has always been this way or if my sister and I had to do something with it… … That, I don't know… ….

T: And your sister, does she asks such questions?

P: I don't know.

T: You don't talk about that?

P: No, we don't talk about that.

What we see here is that the therapist keeps insisting, despite Pam's very short and dismissive answers. Expressive interventions remain high up until session 12, with the exception of session 4 and session 7. In these sessions, expressive interventions are less prevalent because the therapy sessions mainly focus on Pam receiving a negative evaluation on her job (session 4) and losing her job (session 7). The therapist uses supportive techniques to convey an empathic understanding towards her (e.g. 'I notice it is hard on you.'; 'I'm really sorry for you.') and working together towards achieving her goals (e.g. 'Work is important to you, but the pressure now seems really high, especially considering you are still recovering. Let us address this issue to the extent possible, but let us also think about a plan B, so as to lower the pressure a bit.'). Expressive interventions during these sessions continue to focus on Pam's main interpersonal difficulty, namely being unable to open up to others. Interventions specifically aim at elaborating this issue. The intervention 'Did you talk to anyone about that?', for instance, appears multiple times in all sessions and are always followed by naysay. Therapy sessions 6 is an exemption within this regard:

T: You say 'they still try to control me.' It strikes me that you don't let anyone control you, very persistently.

P: Yes. Maybe I'm too controlling. That is perhaps the sore point.

T: I'm thinking about you not informing anyone about the epilepsy. It sounds as if you don't want anyone to influence or control your decisions.

P: Yes, that might be.

T: Or do you see it differently?

P: No, what you say is right … … … I want to be my own boss.

T: Yes, that is something I heard you say a couple of times, but it also seems – how do I say this – a lonely position.

P: Yes, that is the down side. Maybe that is why I'm so unhappy, because I'm lonely.

T: Are you lonely?

P: I think so.

T: You don't share a lot with people.

P: I always see dangers on the road. I've been hurt by people I confided in too many times and they used that against me.

Here, Pam recognizes and marks some delicate interpersonal core issues. In session 8, which is the sessions with the highest amount of expressive interventions, she further elaborates on not being able to open up to others. She now expresses a wish to change that.

P: It is always tough to let other people in. I want to change that with regards to my sister and start to confide in her more. Last Saturday, I had the chance to say I no longer have a job, but then I just don't say that.

T: You remember what stopped you? How would she have reacted?

P: I was just waiting for the right moment and then I dropped her off and I hadn't said it … … … I wanted to. I can't imagine she would have a fierce reaction.

T: Speaking up is important. If you stop talking, it has an effect.

P: Yes, that is starting to dawn on me.

T: You stopped talking at a very young age at home, but at a sudden point also outside something stopped.

P: Yes, in a variety of ways my speech has flattened. To just call on someone or say something about myself. That does not run smoothly. To learn that a bit, my sister might be the most convenient person to take the first steps.

T: You think you should learn that now?

P: Yes, I think so. I think it is time to change.

Up until session 11, the expressive interventions continue to explore, elaborate and try to work through these issues of trust and being unable to open up, with a special emphasis on understanding not only Pam's position in relationships, but also her mother's. Sessions 9 and 11 were followed by epileptic insults, which Pam linked to the intensified stress she experienced in these therapy sessions. After session 11, the therapist received an email from Pam in which she expressed doubt about continuing therapy and not wanting to bother the therapist given the epileptic insults took place near the therapy room. Before session 12, the therapist voiced her concerns about this case in an intensive supervision session. She wondered about whether or not it was her own desire to let Pam work through issues concerning her childhood traumas and the relationship with her mother and if the therapy should take another turn in order to help Pam to feel better rather than worse. The conclusion of the supervision session was that the therapist perhaps should not insist on elaborating these difficult issues, especially when Pam would show bodily signs of stress. Moreover, it was proposed that the therapist could work together with her patient to find words for what her body was trying to say. From session 12 onwards, we see that supportive interventions rise exponentially.

T: I think it is really important that you can speak with someone. I understand how hard it is for you to open up about the past. Perhaps we should not avoid it completely because, in any way, you and your history are interconnected, but perhaps we should take things a bit more slowly. Opening up can only happen in a safe environment. Now, from my part, I'm going to state it very clearly that I believe it is important that you talk and that the things you say here are very important, but I want to ask you if that's all right with you too.

With these supportive interventions, the therapist emphasizes having heard Pam's message and that she recognizes the profound impact therapy has on her. She encourages Pam to continue treatment whilst also allowing her agency in treatment and showing respect for her boundaries and decisions. In the following sessions, we also see a shift in the themes that are discussed. Issues of bodily symptoms and difficulties in current relationships are now more on the forefront. Moreover, the therapist often steers the conversation away from the more intimate topics when she or Pam recognize an increase in stress reactions to more safe issues, such as day-to-day schedules and more long-term plans. Next to that, it is noticeable that when intimate topics are discussed, the therapist is less persevering and more cautious in delivering certain messages, by building an expressive message on a supportive foundation.

T: Tension makes the body cramp, a tension that arises from a fear, an anxious feeling… and to what that is connected, perhaps we can go into that… We can take our time to do that.

P: Yes. I know that when my parents come, I panic. That is pure stress. But I don't believe that I'm very tense once they are inside. Although, maybe. I don't really know … … …

T: Do you sometimes relax your body?

P: Not really. When I go to bed, then perhaps.

T: Well, that's something we should not shy away from. Also here, when you talk. If I notice something, is it okay I say something about it or is that inappropriate?

P: No, that's okay. I can't do much about it anyway.

T: Yes, of course you can't. That's also not what's at stake here, but I think we should consider it, because your body also speaks and whether or not we immediately know what it says, it does bring forward that it is a certain theme that is hard on you. Over time, we'll figure out why that is or what it is connected to. What I do see now is that it is not easy on you and we should take into account that your body gets to endure a lot. (session 14)

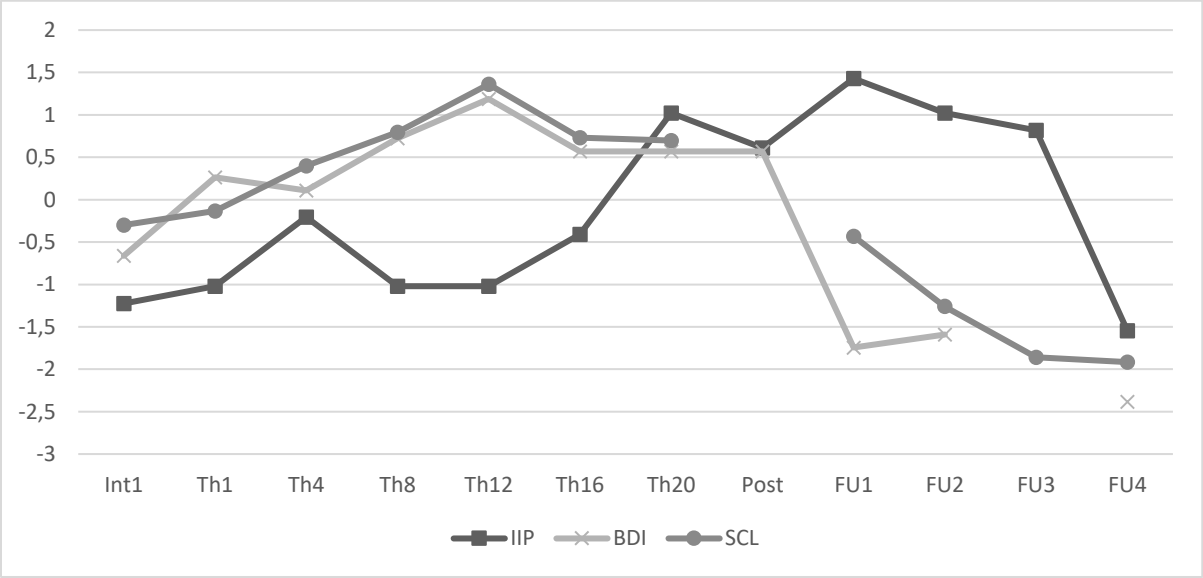
In the last four sessions, the therapist inquires several times about whether or not Pam would want to continue treatment after the assigned 20 sessions in the context of the GPS study and what she would like to talk about in those last sessions. In session 18, Pam indicates that her depressive symptoms are lessening and that she is still in doubt about whether or not to continue treatment afterwards.

> T: On the one hand, I am very pragmatic. If you would have a job and you have structure and you feel good about your body, that would mean a lot to you. You put a lot of energy in that and, at this moment, it is a safe way for you to handle things. That's the pragmatic part and it is good you handle things your way. On the other hand, there is also the part of your youth and the way your relationship with your parents is built, how that influences other relationships, how you get stuck there and how you are confronted with questions about who you are and how others think of you. […] Those are the two sides. On the one hand issues about your work situation and your body image and on the other hand the relationship with your parents and how that affects your current life. Do you still have questions about that part?

Here, the therapist supports the progress Pam made over the course of therapy. On the other hand, she draws attention to the deeper-rooted destabilizing influence the relationship with her parents might have. Pam recognizes what the therapist is saying and indicates that while speaking up in treatment feels *no longer* unsafe, she still experiences troubles outside the therapy room. However, because she feels better now, she does not know if she wants to explore things further. In session 19, however, there was significant work done concerning the relationship with her parents. Here, we see that Pam could enunciate important questions about her upbringing, whereas at the beginning of treatment she was very reluctant to do so. Notwithstanding the idea that this could be the starting point of further working through, session 20 takes a radically different turn. Pam enters the session with great news: she was selected for a job and was very excited because of the satisfying work environment and challenging job content. The therapist echoes Pam's enthusiasm and confirms that having a job and daily structure were important themes throughout the sessions. She repeats the question about whether Pam would like to continue working around the subject of her parents or if she would rather close the subject down. Pam indicates that questions about that topic specifically surface during but not outside their sessions and suggests she would reconsider the offer to come back if questions would arise outside the therapy room as well. The therapist suggest they leave it at that and ends with firmly expressing her commitment to continue their work in the future if and when a new request for therapy would arise.

Symptoms and Outcome Assessment

At the beginning of treatment, Pam had a BDI-II score of 36, indicating severe depressive complaints (Beck et al., 1996). Her IIP-32 score of 57 indicates that interpersonal problems are above average. Her scores on the subscales of the IIP suggest significant difficulties with being 'socially inhibited', 'non-assertive' and 'overly accommodating' and above average difficulties with being 'cold/distant' and 'self-sacrificing' (Horowitz et al., 2000). Her SCL-90-R score of 231 indicate overall very high symptom burden (Derogatis, 1992).



Note. IIP: Inventory of Interpersonal Problems; BDI: Beck Depression Inventory; SCL-90-R: Symptom Checklist.

Figure 3: Evolution in outcome measures (z-scores)

As figure 3 illustrates, Pam's scores on the outcome measures continue to increase as treatment progresses and remain high at the end of treatment with scores that suggest severe depression (BDI-II = 44, Beck et al., 1996), significant interpersonal difficulties (IIP-32 = 68, Horowitz et al., 2000) and an overall very high symptom burden (SCL-90-R=261, Derogatis, 1992). At the end of treatment, her scores on the IIP-32 subscales 'socially inhibited' and 'non-assertive' are above average and her scores on the subscales 'cold/distant', 'overly accommodating' and 'self-sacrificing' suggest significant difficulties in these areas (Horowitz et al., 2000). When assessed with the RCI, the increasing trend indicates a clinically significant deterioration on the SCL-90-R (RCI = 1.966, >1.96, p <.05) and no change on the BDI-II (RCI = 1.678, p. >.05) and the IIP-32 (RCI=1.647, p. >.05). Taking the cut-off of 52 into account (Hovens et al., 2009), Pam's scores on the ZIL indicate that she was suffering from symptoms

related to PTSD both before (ZIL=59), during (as measured before session 8, ZIL=70) and after (ZIL=61) treatment, despite not meeting the basic criteria for the SCID-diagnosis of PTSD. After treatment termination, Pam's scores on the outcome measures show a decreasing trend and two years after treatment ended clinical significant improvement was achieved on the BDI-II (RCI = -4.61, <-1.96, $p < .05$) and her ZIL-score of 46 dropped below the cut-off of 52 (Hovens et al., 2009).

Albeit the pre-post scores suggest therapy failure, the qualitative analysis from the CCIs warrants some nuance. In the CCI after session 8, Pam indicated that the therapy confronted her with certain issues, such as loneliness, which she was not conscious about before and now saw as important matters to work on. Albeit she did not indicate a deterioration of her situation, this might explain the rising trend in the outcome measures to some extent.

At the end of treatment, Pam noticed a remarkable change in her sentiment and vigour, which has not been captured in the self-report questionnaires and said: "I feel worse on paper than I actually do." Also, the SCID-I, which was conducted by an independent researcher after treatment termination, revealed no indications of MDD. Pam did report a worsening of interpersonal issues during the post CCI interview. Especially in relation to her mother, she described how therapy would let the hatred towards her resurface which made encounters with her mother specifically cumbersome. Talking in-depth about her childhood memories made her feel worse and in the middle of therapy, when she also had several epileptic insults, she felt at her lowest point yet. At that point, the therapist decided to take things more slowly, which she found helpful. Pam stated that, although she still had a few goals she did not yet achieve, such as being more open to her sister and her husband, she would not continue further treatment. She concluded that, all in all, she felt much better since she entered therapy and when needed, she would contact the therapist again.

After three months, Pam indicated her symptoms decreased further, which is in accordance with her scores on the SCL-90-R and BDI-II. Differently from what we might expect from her score on the IIP-32, she claimed that, as time went by, the relationship with her mother had stabilized again. She noted that she would still expect the worst from others, in and outside her family relations, but that these issues did not require therapeutic attention.

Six months after treatment termination, Pam stated she no longer experienced depressive complaints and felt happy with how things were going for her. The expected winter blues stayed out and she completely stopped her antidepressant medication. She noticed that she was still quite introvert in social interactions, but she had good hopes that this would

continue to improve in the future. She would still get disappointed when her parents did not show interest in her, but she had come to accept that they will not change.

Another six months later, Pam reported having stopped all medication and feeling happy and vital. She was offered a permanent position in the company she worked for and had lost 30 kilos after having gastric bypass surgery. Also at home, everything ran smoothly. Having filled in the questionnaires, she did observe she was still quite uncertain and had a worst-case scenario attitude, but all in all this did not prevent her from feeling good.

Also two years after treatment termination, Pam reported remaining issues of negative thinking and distrust in social encounters. She maintained the idea that those difficulties were inherent to her person and were not likely to change. Nonetheless, she felt much better. She felt more self-confident and energetic. She decided to decline the permanent position in her previous work environment and found a more satisfying job, and had now lost over 50 kilos. She ascribed the progress in her self-esteem and overall well-being to the treatment she followed two years ago and the tools she got out of it to proceed further in life.

Discussion

The first and second aim of this study was to investigate the nature of interpersonal difficulties at the beginning and throughout treatment, respectively. We found that Pam experienced a strong inability to open up, which could be traced back to the relationship with her parents, whom were always very critical towards her. This resulted in the feared anticipation of rejection in later relationships, both at the level of love and work, which made her strive to avoid such confrontations by keeping silent. As treatment progressed, we additionally learned that the parental disdain also involved a lack of valuing her and being interested in her, which she also encountered in her adult relationships. At the end of treatment, Pam more actively articulated the need that others would take a genuine interest in her and to be able to communicate openly with people who are close to her.

Pam's core interpersonal pattern shows a resemblance to what in the literature is referred to as an oscillating trend between wanting and working towards being close to others and remaining distant (e.g., Cook et al., 2004), an interpersonal pattern that would stem from the paradoxical situation in which significant others are both the source of nurturance and a source of threat (e.g., Zilberstein & Messer, 2010). Although Pam communicates the wish to be close to others, as articulated in the wish to be liked and to be respected, she does not show any action towards achieving those goals. Instead, she rather persistently upholds a passive/dependent and silent demeanour because she anticipates disappointment when others fail to meet her needs.

Moreover, Pam does not articulate the wish to be distant from others as such. She rather expresses a wish to avoid conflict and not to be hurt, i.e., to not be confronted with the anticipated criticism and rejection. It is our contention that the wish to avoid conflict actually has nothing to do with favouring distance, but that also here, the underlying wish is to be genuinely close to others.

The negative (anticipated) reactions from others and Pam herself do not change over time, which is also reflected in the stagnating IIP-32 scores. However, Pam was able to communicate her desire to have close relations more openly as treatment progressed, which might allow another perspective on her relationship with others. The lack of change in the perceived reactions of others and her own interpersonal behaviour shows how difficult deeply engrained interpersonal patterns are to transform (e.g., Pearlman & Courtois, 2005; Zorzella et al., 2014) and that short-term treatment might not suffice to achieve such a challenging, yet desired treatment objective. Nevertheless, the enquiry of the follow-up quantitative self-report data and qualitative interviews suggests that the treatment did commence a process of working through, of which the therapeutic effects were only visible as time progressed (Leichsenring & Schauenburg, 2014).

The third and final aim of this study was to investigate the therapy process, by mapping the therapeutic relationship and therapist interventions. Our case study provides some insights into the connections between (variations in) symptom severity and the treatment process. We saw that Pam initially reported a worsening of her depressive symptoms and she suffered more epileptic insults, which she strongly linked to rising levels of stress both outside (e.g., impending unemployment) and inside the therapy room. The therapist used a large amount of expressive interventions, specifically aimed at exploring the interpersonal traumatic experiences Pam had throughout her life. Before discussing the case in supervision, she kept insisting on analysing these matters through her questions, notwithstanding Pam's reluctant stance, which was obvious from her short and resistant (e.g., 'I don't know.') answers to the therapist's questions. This phase in the therapy process – which lasted up until session 11 – bears resemblance to treatment modalities that straightforwardly focus on the traumatic content (e.g., Wagenmans et al., 2008). After supervision, the therapist applied a different strategy, by focusing more on current difficulties and applying more supportive interventions. Pam responded well to these changes in focus, which was demonstrated by symptom improvement. However, as Pam also admitted on several occasions, there were some unresolved issues, such as being unable to trust others, having the tendency to always think negatively, and having low self-esteem, which could easily be traced back to Pam's traumatic experiences. As we have

seen, the therapist alluded to the possibility of working through these difficulties in continued treatment. She did not force this on Pam, but rather informed her, communicated her commitment and willingness to continue their work together, and left the choice up to her. Pam did not take up this proposal, but always kept the possibility in mind if these or other issues would impede her daily functioning.

These observations show the importance of allowing patients agency in their own therapy process (Lawson et al., 2013) and that a therapy consisting predominantly of supportive interventions can facilitate substantial therapeutic effects as such (e.g., Gleiser et al., 2008). It might not always be necessary to apply a large amount of supportive interventions at the beginning or throughout treatment (e.g., Van Nieuwenhove, Meganck, Cornelis, & Desmet, 2018). Nevertheless, signs of distress might indicate the need for more supportiveness (Luborsky, 1986). We conclude from this that it is important that therapists are aware of the impact their interventions have on their patients and that they should reappraise their approach if necessary (Stiles, 1998). Supervision can help clinicians to address these issues (Pearlman & Courtois, 2005; Ford, Chapman, Conner, & Cruise, 2012).

Given Pam's levels of distress, more supportive techniques were favoured, which is in line with treatment modalities focusing on stabilization (e.g., Classen et al., 2017; Jepsen et al., 2013). However, the results of the WAI-SR did not support the underlying reasoning behind the need for stabilization, namely that a trusting relationship in the therapy would be difficult to establish. This might imply that no special consideration should be given to building and sustaining a safe therapeutic relationship in this case. However, based on our qualitative analysis, we deem it necessary to consider alternative explanations. From our results of the CCRT analysis, we learned that Pam views others as untrustworthy and critical, which causes her to be rigidly introverted, apprehensive and cautious in interactions. From developmental and attachment theories, we would expect these issues to resonate in the treatment context (Ebert & Dyck, 2004; Pearlman & Courtois, 2005). The results based on the WAI-SR suggest this did not occur. However, we could detect several instances in which the dominant CCRT components did transpire in the therapeutic dialogue.

Pam, for instance, stressed the professionalism of the therapist. In one of the sessions, she said that talking in therapy was safer and easier because the therapist was in no position to pass down information to her parents. This remarkable comment suggests that it was the therapist confidentiality obligations that prohibited a repetition of what she would normally expect. It thus seems that Pam's remark roots from the same dominant patterns that structure her interpersonal interactions. Although Pam *knows* she is safe on the basis of the professional

duties of the therapist, a fundamental *feeling* of trust or a sustainable and intrinsic sense of the therapeutic context as a safe environment seems lacking. This also transpires in the fact that she was not able to communicate to the therapist that she was experiencing a lot of distress related to the therapy sessions. Also here, she was unable to open up. After having several epileptic insults, she finally sent an email to the therapist with the specific message that she did not want to bother the therapist any further. Also here, she did not fully express what she needed from or missed in the therapy. These observations show the perseverance of dominant interactional patterns (Luborsky, 1986), how their repetitive nature affects the therapeutic encounters (Ebert & Dyck, 2004; Gleiser et al., 2008), but also how Pam remains unaware of the influence her core relational patterns have on her stance in therapy. This raises the question whether the WAI-SR is able to capture the underlying dynamics in the therapeutic relationship. It appears that Pam filled in the WAI-SR based on her rational knowledge about the therapeutic setting, yet that her answers were not indicative for her inner experiences. This suggests that the WAI-SR scores should not be taken at face value and should always be considered within the broader narrative of the patient (Desmet, 2018; Truijens, 2017).

In the first phase of therapy, the therapist also appeared unable to make a fair estimation of Pam's condition. By reviewing her case in supervision, however, she recognized the deteriorating effect the therapy produced (Dimidijian & Hollon, 2010; Hatfield, McCullough, Frantz, & Krieger, 2010). This stimulated a fundamental change in the therapeutic bond. Following the supervision session, the therapist noticed Pam's distress and acknowledged it explicitly in therapy. Further, she started using more supportive techniques by which she conveyed her commitment and a genuine interest. Moreover, the therapist proved not to be critical or authoritarian in any way. She commended Pam for expressing herself in treatment and did not reprimand her or gave advise about the choices she made. She merely took notice or asked neutral questions to explore what grounds Pam's choices were based on. Finally, Pam commented that, whereas opening up to others remained troublesome, speaking up in therapy no longer felt unsafe. All these considerations suggest that the therapist constituted a different other for Pam and provided a new relational experience (e.g., Lawson et al., 2015) in which, eventually, she could open up more safely.

The use of supportive interventions will definitely have played an important role in creating a safe atmosphere. However, Pam's case also shows that general interventions might serve the same purpose. Specifically interesting here is Pam's remark that the therapist asked the right questions, which is quite different from people in her environment, whom would not ask any questions at all. Against this background, the large amount of general interventions

appear to have had another function in the treatment process than merely keeping the conversation going. That is, by asking (neutral) questions, the therapist conveyed a genuine interest in Pam, which contributed to the creation of a new relational experience. What we deduce from this is that treatment interventions, and treatment strategies more generally, must always be considered in the context and the effects they produce in a particular case (Stiles, 2013). This further shows the importance of challenging habitual therapy practices and considering alternative views on the treatment process, especially, but not exclusively, when the therapy process is stagnating or produces negative effects.

There were some remarkable discrepancies between the different qualitative and quantitative measures, which require some further comments. First, Pam did not receive a diagnosis of PTSD, as assessed during the pre-treatment interviews, whereas her ZIL-score suggest she suffers from typical PTSD symptoms, such as hyperarousal and avoidance. The ZIL only assesses symptom severity and not traumatic antecedents. When asked for traumatic experiences during the PTSD module of the SCID-I interview, Pam did not mention her childhood experiences, nor other traumatic experiences that caused continued suffering. Therefore, this module was terminated without exploring the occurrence of typical PTSD symptoms. We put forward several possible explanations. First, the SCID-I interview mainly assesses recent, acute and single-incident traumatic events. This can explain why Pam failed to mention the exposure to past and chronic childhood traumatic experiences which are not easily recognized as separate events for the individual's experience. A second possible explanation is that Pam avoided to talk about her upbringing in-depth or that, at that moment in time, she did not connect her suffering to the traumatic relationship with her parents. In the literature, it has been widely acknowledged that the psychological consequences connected to traumatic experiences can be very diverse and that co-morbid conditions, such as depressive symptoms, can be communicated more explicitly when seeking treatment (e.g., Van der Kolk et al., 2005). This shows the importance of more clinically oriented intake procedures, such as the inclusion of the CDI.

It should also be noted that there is an important inconsistency between the self-report outcome questionnaire scores and Pam's narrative concerning therapy outcome. Whereas the outcome measures suggest no improvement or even deterioration, the structured and semi-structured interview material indicate otherwise and suggest depressive symptoms have significantly declined. These irregularities show the importance of triangulation (Jackson et al., 2011) and complementing quantitative findings with narrative information (Desmet, 2018).

Next to the methodological limitations regarding the interpretability of certain self-

report outcome and process measures, we need to address the restrictions associated with single-case research, especially with regards to the generalizability and transferability to other cases (Levitt et al., 2018). As our aim was to deepen our understanding of interpersonal features in complex trauma (i.e., enriching, Stiles, 2013), we selected a case based on criteria that invoke rich information on the matter. In retrospect, however, Pam can also be considered a critical case (Patton, 2002), on account of the intricate interconnections between Pam's core interpersonal patterns and the formation of the therapeutic relationship, which was demonstrated by the erratic sequence of supportive and expressive interventions. Our results necessitated to refine and extent certain theoretical assumptions (i.e., theory-building, Stiles, 2013) and provided some interesting insights with regards to the influence of core interpersonal patterns on the therapy process. What we distilled from Pam's case is that therapists should be aware that patients' dominant interpersonal schemes slip into the therapeutic relationship, sometimes in very subtle ways. Therefore, sufficient attention should also be paid to the discrepancies between what patients rationally acknowledge about the therapeutic framework and the underlying impulses which might unconsciously affect the therapeutic relationship. If it turns out that a constitutive feeling of trust is lacking or has not yet been appropriately established, then, the therapist should adjust his or her therapeutic approach accordingly (e.g., via additional supportive techniques) and search for ways to allow for a new relational experience for the patient.

These preliminary conclusions compel more research into the effects of dominant interpersonal patterns on the formation of the therapeutic relationship and the therapeutic process. Pam specifically refused to continue working through her core interpersonal issues. Her case shows that this might not always be necessary in order to achieve therapeutic gains. However, it would be interesting to study therapeutic processes in which these issues are further addressed and to examine the interconnections between this undertaking and changes in interpersonal dynamics, including the relationship with the therapist. Therefore, there is a definite need for more case study and process research to further investigate therapy processes and mechanisms of change.

References

American Psychological Association (2000). *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition Text Revision. Washington, DC: Author.

Barber, J. P., & Crits-Christoph, P. (1996). Development of a Therapist Adherence/Competence Scale for Supportive-Expressive Dynamic Psychotherapy: A Preliminary Report. *Psychotherapy Research, 6*(2), 81-94.

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Manual for the Beck Depression Inventory-II.* San Antonio, TX: The Psychological Corporation.

Briere, J., & Jordan, C. E. (2009). Childhood maltreatment, intervening variables, and adult psychological difficulties in women: An overview. *Trauma, Violence & Abuse, 10*(4),375–388.

Classen, C. C., Muller, R. T., Field, N. P., Clark, C. S., & Stern, E. M. (2017). A naturalistic study of a brief treatment program for survivors of complex trauma. *Journal of Trauma & Dissociation, 18*(5), 720-734.

Cloitre, M., Courtois, C. A., Charuvastra, A., Carapezza, R., Stolback, B. C., & Green, B. L. (2011). Treatment of complex trauma: Results of the ISTSS Expert Clinician Survey on *Best Practices. Journal of Traumatic Stress*, 24, 615–627.

Cloitre, M., Courtois, C. A., Ford, J. D., Green, B. L., Alexander, P., Briere, J., … Van der Hart, O. (2012). *The ISTSS expert consensus treatment guidelines for complex PTSD in adults.* Retrieved from https://www.istss.org/ISTSS_Main/media/Documents/ISTSS-Expert-Consensus-Guidelines-for-Complex-PTSD-Updated-060315.pdf.

Cloitre, M., Stovall-McClough, K. C., Nooner, K., Zorbas, P., Cherry, S., Jackson, C. L., . . . Petkova, E. (2010). Treatment of PTSD related to childhood abuse: A randomized controlled trial. The American Journal of Psychiatry, 167(8), 915–924.

De Jongh, A., Resick, P. A., Zoellner, L. A., van Minnen, A., Lee, C. W., Monson, C. M., . . . & Bicanic, I. A. (2016). Critical analysis of the current treatment guidelines for complex PTSD in adults. *Depression and Anxiety, 33*(5), 359-369.

Desmet, M. (2018). *The pursuit of objectivity in psychology*. Borgerhoff en Lomberigts: Gent.

Derogatis, L. R. (1992). *SCL-90-R: Administration, Scoring and Procedures Manual* (2nd ed.). Towson, MD: Clinical Psychometric Research Inc.

Dimidijian, S., & Hollon, S. D. (2010). How would we know if psychotherapy were harmful? *The American Psychologist, 65*(1), 21-33.

Dorrepaal, E., Thomaes, K., Hoogendoorn, A. W., Veltman, D. J., Draijer, N., & van Balkom, A. J. L. M. (2014). Evidence-based treatment for adult women with child abuse-related complex PTSD: A quantitative review. *European Journal of Psychotraumatology, 5*. doi:10.3402/ejpt.v5.23613

Elliott, R., Slatick, E., & Urman, M. (2001). Qualitative change process research on psychotherapy: Alternative strategies. *Psychologische Beiträge, 43,* 69-111.

First, M. B., Gibbon, M., Spitzer, R. L., Williams, J. B. W., & Benjamin, L. S. (1997). *Structured Clinical Interview for DSM-IV Axis II Personality Disorders, (SCID- II).* Washington, DC.: American Psychiatric Press, Inc.

First, M. B., Spitzer, R. L., Gibbon, M., & Williams, J. B. W. (2002). *Structured Clinical Interview for DSM-IV-TR Axis I Disorders, Research Version, Patient Edition, (SCID-I/P).* New York, NY: Biometrics Research, New York State Psychiatric Institute.

Fishman, D. B., & Messer, S. B. (2013). Pragmatic case studies as a source of unity in applied psychology. *Review of General Psychology, 17*, 156–161.

Ford, J. D., Connor, D. F., & Hawke, J. (2008). Complex trauma among psychiatrically impaired children: A cross-sectional, chart-review study. The Journal of Clinical Psychiatry, 70(8), 1155–1163.

Ford, J. F., Courtois, C. A., Steele, K., van der Hart, O., & Nijenhuis, E. R. S. (2005). Treatment of Complex Posttraumatic Self-Dysregulation. *Journal of Traumatic Stress, 18*(5), 437-447.

Gleiser, K., Ford, J. D., & Fosha, D. (2008). Contrasting exposure and experiential therapies for complex posttraumatic stress disorder. *Psychotherapy, 45*(3), 340-360.

Hatfield, D., McCullough, L., Frantz, S. H., & Krieger, K. (2010). Do we know when our clients get worse? An investigation of therapists' ability to detect negative client change. *Clinical Psychology and Psychotherapy, 17*(1), 25-32.

Herman, J. L. (1992). *Trauma and Recovery.* New York, NY: Basic Books.

Hodgdon, H., Kinniburgh, K, Gabowitz, D., Blaustein, M. E., & Spinazzola, J. (2013). Development and Implementation of Trauma-Informed Programming in Youth Residential Treatment Centers Using the ARC Framework. *Journal of Family Violence, 28,* 679-692.

Horowitz, L. M., Alden, L. E., Wiggins, J. S., & Pincus, A. L. (2000*). Inventory of Interpersonal Problems*. London: The Psychological Corporation.

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the working alliance inventory. *Journal of Counselling Psychology, 36,* 223-233.

Hovens, J. E., Bramsen, I., & van der Ploeg, H. M. (2009). *Zelfinventarisatielijst posttraumatische stressstoornis.* Amsterdam: Pearson Assessment and Information BV.

Jackson, J. L., Chui, H. T., & Hill, C. E. (2011). The Modification of Consensual Qualitative Research for Case Study Research: An Introdution to CQR-C. In C. E. Hill (Ed.), *Consensual Qualitative Research: Practical Resources for Investigating Social Science Phenomena* (pp. 285-303). Washington, DC: American Psychological Association.

Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59*(1), 12-19.

Jepsen, E. K. K., Langeland, W., & Heir, T. (2013). Impact of dissociation and interpersonal functioning on inpatient treatment for early sexually abused adults. European Journal of Psychotraumatology, 4. doi:10.3402/ejpt.v4i0.22825

Kazdin, A. E. (2007). Mediators and mechanisms of change in psychotherapy research. *Annual Review of Clinical Psychology, 3,* 1-27.

Kazdin, A. E. (2009). Understanding how and why psychotherapy leads to change. *Psychotherapy Research, 19*(4-5), 418-428.

Leichsenring, F., & Schauenburg, H. (2014). Empirically supported methods of short-term psychodynamic therapy in depression: Towards an evidence-based unified protocol. *Journal of Affective Disorders, 169,* 128-143.

Levitt, H. M., Bamberg, M., Creswell, J. W., Frost, D. M., Josselson, R., Suárez-Orozco, C. (2018). Journal article reporting standards for qualitative primary, qualitative meta-analytic, and mixed methods research in psychology: The APA Publications and Communications Board task force report. *The American Psychologist, 73*(1), 26-46.

Luborsky, L. (1984). *Principles of psychoanalytic psychotherapy: A manual for supportive-expressive treatment.* New York, NY: Basic Books.

Luborsky, L., & Crits-Christoph, P. (1998). *Understanding Transference: The Core Conflictual Relationship Theme* (2nd Ed.). Washington, DC: American Psychological Association.

Luyten, P., & Blatt, S. J. (2012). Psychodynamic treatment of depression. *The Psychiatric Clinics of North America, 35*(1), 111-129.

Meganck, R., Desmet, M., Bockting, C., Inslegers, R., Truijens, F., … & Vanheule, S. (2017). The Ghent Psychotherapy Study (GPS) on the differential efficacy of

supportive-expressive and cognitive behavioral interventions in dependent and self-critical depressive patients: Study protocol for a randomized controlled trial. *Trials*, 18, 126.

Patton, M. Q. (2002). Qualitative designs and data collection. In *Qualitative research and evaluation methods* 3rd ed., (pp. 228-247). London, England: Sage.

Pearlman, L. A., & Courtois, C. A. (2005). Clinical Applications of the Attachment Framework: Relational Treatment of Complex Trauma. *Journal of Traumatic Stress, 18*(5), 449-459.

Pressley, J., & Spinazzola, J. (2015). Beyond survival: Application of a complex trauma treatment model in the Cristian context. Journal of Psychology & Theology, 43(1), 8–22.

Resick, P. A., Bovin, M. J., Calloway, A. L., Dick, A. M., King, M. W., … & Wolf, E. J. (2012a). A critical evaluation of the complex PTSD literature: implications for DSM-5. *Journal of Traumatic Stress, 25*(3), 241-51.

Resick, P. A., Wolf, E., Wiltsey Stirman, S., & Bovin, M. J. (2012b). Advocacy through science: Reply to comments on Resick et al. (2012). *Journal of Traumatic Stress, 25*(3), 260–63.

Stiles, W. B. (1998). Responsiveness in Psychotherapy. *Clinical psychology: science and practice, 5*(4), 439-458.

Stiles, W. B. (2013). The Variables Problem and Progress in Psychotherapy Research. *Psychotherapy, 50*(1), 33-41.

Tarocchi, A., Aschieri, F., Fantini, F., & Smith, J. D. (2013). Therapeutic assessment of complex trauma: A single-case time-series study. Clinical Case Studies, 12(3), 228–245.

Truijens, F. (2017). Do the numbers speak for themselves? A critical analysis of procedural objectivity in psychotherapeutic efficacy research. (Matteo Colombo, R. Gervais, & J. Sprenger, Eds.)*SYNTHESE*, *194*(12), 4721–4740.

van der Kolk, B. A., Roth, S., Pelcovitz, D., Sunday, S., & Spinazzola, J. (2005). Disorders of Extreme Stress: The Empirical Foundation of a Complex Adaptation to Trauma. *Journal of Traumatic Stress, 18*(5), 389-399.

Van Nieuwenhove, K., & Meganck, R. (2017). Interpersonal Features in Complex Trauma Etiology, Consequences, and Treatment: A Literature Review. *Journal of Aggression, Maltreatment, & Trauma,* DOI: 10.1080/10926771.2017.1405316

Van Nieuwenhove, K., Meganck R., Cornelis, S., & Desmet, M. (2018). Core conflictual

relationship patterns in complex trauma: A signle-case study. *Psychodynamic Practice*, DOI:10.1080/14753634.2018.1498801

Verhaeghe, P., & Vanheule, S. (2005). Actual neurosis and PTSD: The impact of the other. *Psychoanalytic Psychology, 22*(4), 493–507.

Wampold, B. E. (2007). Psychotherapy: The humanistic (and effective) treatment. *The American psychologist, 62*(8), 855-873.

Wagemans, A., Van Minnen, A., Sleijpen, M., & De Jongh, A. (2018). The impact of childhood sexual abuse on the outcome of intensive trauma-focused treatment for PTSD. *European Journal of Psychotraumatology, 9*(1): 1430962.

Westen, D. (2006). *The Clinical Diagnostic Interview.* Atlanta, GA: Emory University.

Zorzella, K. P., Muller, R. T., & Classen, C. C. (2014). Trauma group therapy: The role of attachment and therapeutic alliance. *International Journal of Group Psychotherapy, 64*(1), 24–47.

6

GENERAL DISCUSSION

In this chapter, we discuss the main findings of this dissertation by means of a cross-case comparison using principles of qualitative meta-synthesis (e.g., Iwakabe & Gazzola, 2009). We outline our key conclusions and recommendations with regards to the nature and change of dominant interpersonal patterns in complex trauma, the formation of the therapeutic relationship and therapist interventions. Further, we sketch the context to which our findings apply, address the limitations of our study and provide several avenues for further research.

This dissertation focused on interpersonal dynamics in complex trauma and complex trauma treatment. In chapter 1, we started out from a psychoanalytic/psychodynamic frame of reference, from which we emphasized the importance of considering the relation between subject and Other in order to understand how certain events get a traumatic character and why some people are unable to process these events (e.g., Bistoen, 2016). Instead of understanding the development of symptoms as a logical consequence of the confrontation with certain experiences, we argued that the Symbolic-Imaginary framework, the starting point for the subject to construct meaning, is essential to understand how people deal with adverse circumstances (Chiriaco, 2012; Verhaeghe & Vanheule, 2005). Therefore, it is necessary to examine the relationship between subject and the Other, because (the formation of) the Symbolic-Imaginary frame is contingent on this relationship. We used the Core Conflictual Relationship Theme (CCRT, Luborsky & Crits-Christoph, 1998) as a framework to operationalize the way subjects perceive themselves, others, and the world, and how they give meaning to what happens in their lives.

In chapter 2, we argued that the available literature up until now only provides a static examination of interpersonal difficulties experienced by patients with a complex trauma background and yields inconsistent findings with regards to dominant interpersonal patterns. Therefore, we stated that a more thorough investigation of the structural component of the CCRT is necessary in order to advance in the field. Further, we argued that more qualitative, case-study research is necessary in order to get to a fuller understanding of the structure of the CCRT in complex trauma. Therefore, we studied the CCRT components throughout therapy in the cases of James, Amy and Pam, as discussed in chapter 3, chapter 4, and chapter 5, respectively.

Next to the structure component of the CCRT, we aimed to examine the process of change by 1) investigating the formation of the therapeutic relationship in-depth, and 2) studying which interventions are used to address interpersonal difficulties in treatment. The importance of studying the therapeutic relationship stemmed from the general accepted proposition that a safe therapeutic alliance is difficult to establish with patients with a complex trauma history because of their overall difficulty in trusting others (e.g., Cloitre, Stavall-McClough, Miranda, & Chemtob, 2004; Pearlman & Courtois, 2005). In chapter 2, we discussed how the compromised ability to trust the therapist complicates the revision and reworking of interpersonal difficulties in treatment (e.g., Lawson, Davis, & Brandon, 2013; Pressley & Spinazzola, 2015), thereby warranting additional and explicit attention to the formation of a safe therapeutic relationship early in treatment (e.g., Ford, Courtois, Steele, van

der Hart, & Nijenhuis, 2005; Gleiser et al., 2008). As we have noted in chapter 2, the formation of the therapeutic relationship with patients with a complex trauma background has hardly ever been studied. We argued that especially more qualitative, longitudinal process studies are necessary in order to get to a more comprehensive understanding of (the establishment of) a good therapeutic relationship (e.g., Gleiser, Ford, & Fosha, 2008; Lawson & Quinn, 2013). Therefore, we examined the therapeutic relationship and therapist interventions in the case of Amy and Pam via a mixed-method approach. Albeit we did not systematically investigate the therapeutic relationship in James' case, from our qualitative analysis, we could relate some interesting findings to his case as well.

In this chapter, we provide a cross-case comparison to integrate and discuss the main findings derived from the three separate cases, using principles of qualitative meta-synthesis (e.g., Iwakabe, 2005; Iwakabe & Gazzola, 2009). Via comparing and contrasting the findings from the individual cases, it is possible to provide a synthesis through which new insights may arise, beyond the level of the single case, thereby expanding our knowledge on interpersonal features associated with complex trauma (e.g., Walsh & Downe, 2005). The analytic process of a meta-synthesis of single-case studies consists of identifying commonalities and dissimilarities between cases and provides alternative interpretations by identifying underlying mechanisms that might explain the convergent and divergent findings (Iwakabe & Gazzola, 2009).

The Structural Component of the CCRT in Complex Trauma

To integrate our findings with regards to the nature and change of the CCRT components, we aggregated the findings of the three cases per phase (beginning, middle, and end of therapy). Table 1 provides an overview of the accumulated results. In what follows, we discuss several interesting observations derived from the comparison of the individual cases.

The Nature of the CCRT

At the beginning of treatment, the wish (W) 'to be respected' and 'to not be hurt' prevailed in all three cases. Others (RO) were perceived as 'rejecting', 'not understanding', 'disrespectful' and 'distant', rendering our subjects (RS) feeling 'angry'. Luborsky and Crits-Christoph (1998) make a distinction between positive and negative ROs and RSs. It is clear that in all three cases, the reactions from others, as well as their own reactions, are perceived in a negative way. Furthermore, the reactions from our subjects are not only negatively connotated, but also demonstrate a passive position and a lack of agency (e.g., 'am not open', 'am dependent', 'am helpless'). In this context, it is important to note that the anger our subjects felt was not expressed towards others. Moreover, the helpful attitude that both James and Pam

Table 1

The main CCRT components over three cases at the beginning, middle and end of treatment.

	#	W	RO	RS
Phase 1	3-30	to be respected (3-12)/ to not be hurt (3-10)/ to be loved (2-6)/ to be helped (2-5)/ to be accepted (2-4)	are rejecting (3-21)/ are not understanding (3-13)/ are distant (3-11)/ don't respect me (3-7)/ are controlling (2-11)/ are bad (2-6)/ are not trustworthy (2-5)/ are angry (2-4)	feel angry (3-12)/ am not open (2-18)/ feel anxious (2-14)/ am dependent (2-11)/ feel disappointed (2-10)/ feel depressed (2-6)/ am helpless (2-6)/ am helpful (2-4)
Phase 2	3-30	to be respected (3-19)/ to be accepted (2-10)/ to be open (2-7)/ to be liked (2-6)/ to be understood (2-6)	*respect me* (2-9)/ are distant (2-9) are rejecting (2-9)/ are not understanding (2-7)/ don't respect me (2-7)/ are not trustworthy (2-6)/ *are open* (2-5)/ are controlling(2-5)/ *are understanding* (2-4)	am uncertain (3-11)/ *feel respected* (2-8)/ *feel comfortable* (2-8)/ *am open* (2-8)/ feel angry (2-8)/ feel disappointed (2-7)/ feel anxious (2-7)/ am helpless (2-7)/ *feel happy* (2-6)/ *am independent* (2-6)
Phase 3	3-35	to be respected (3-22)/ to be accepted (2-12)/ to be understood (2-10)/ to assert myself (2-9)/ to be liked (2-8)/ to be opened up to (2-6)/ to be open (2-6)/ to have control over others (2-5)/ to be helped (2-5)	don't respect me (3-11)/ *respect me* (3-8)/ are rejecting (2-15)/ are controlling (2-10)/ *are open* (2-8)/ are unhelpful (2-8)/ are not understanding (2-8)/ oppose me (2-7)/ *are understanding* (2-6)/ are bad (2-5)/ *are accepting* (2-5)/ *are cooperative* (2-5)/ are out of control (2-4)	feel disappointed (3-14)/ feel angry (3-12)/ *feel self-confident* (3-11)/ oppose others (2-8)/ am helpless (2-7)/ *feel respected* (2-6)/ *am self-controlled* (2-5)/ am uncertain (2-5)/ *feel accepted* (2-4)/ am controlling (2-4)/ *feel happy* (2-4)

Note. Phase 1 = beginning of treatment; Phase 2 = middle of treatment; Phase 3 = end of treatment; # = number of cases – number of Relationship Episodes; W = Wish; RO = Response of Other; RS = Response of Self; (x-y) = number of cases – number of Relationship Episodes; *italic* = positive RO or RS.

expressed can be seen as passive or dependent reactions because their behaviour does not correspond with what they longed for in relation to others (W 'to be respected', 'to be loved', 'to be helped'), but rather shows a submissive compliance in order to protect themselves (W 'to not get hurt', 'to avoid conflict') in the face of the anticipated 'rejection' and 'disrespect'.

On the level of the dominant wish, our results correspond with studies demonstrating the prevalence of the wish 'to be close and accepted' (Okey, McWhirther, & Delaney, 2000) or 'to be loved and understood' (Chance, Bakeman, Kaslow, Farber, & Burge-Callaway, 2000). The contrasting wish 'to oppose others', 'hurt others' or 'control others' (e.g., Drapeau & Perry, 2009; Frueh, Turner, Beidel, & Cahill, 2001) could only explicitly be observed in Amy's case. However, as we have seen in chapter 4, these wishes were strongly interconnected with the wish 'to not be hurt'. Our results suggest that certain wishes, such as 'to oppose others', 'to control others', 'to not be hurt', 'to avoid conflict', are actually subordinate to the wishes 'to be loved', 'to be respected' and 'to be accepted' and are formulated only because the subjects anticipate these latter wishes to be frustrated by others' reactions of ignorance (RO 'are not understanding', 'are distant') and contempt (RO 'are rejecting', 'don't respect me'). The wish to be close to others, to be loved, to be respected or to be accepted basically boils down to the desire for recognition, which has been put forward by Lacan as the fundament of human desire (Lacan, 1973/1998; Schrans, 2018) [15]. It begs the question whether the wish for recognition is a unique component of the interpersonal dynamics associated with complex trauma or just a basic feature of being human. Further, in the broader field of studies concerning interpersonal patterns related to psychopathology, it has been found that the most common wish is to be close to others and to be accepted in several patient groups (e.g., Wilczek, Weinryb, Barber, & Gustavsson, 2010).

Regarding the dominant (perceived) response of others, we found strong support for the prevalent perception of others being 'rejecting' (Okey et al., 2000; Chance et al., 2000)[16]. The perception of others as 'controlling' (Drapeau & Perry, 2009; Shafran, Shahar, Berant, & Gilboa-Schetman, 2016) appeared explicitly in the cases of Amy and Pam, whereas in James' case it appeared more implicitly in his submissive reaction (RS 'am dependent') towards others. We further found support for the perception of others as malignant (RO 'are bad', 'are angry',

[15] From an attachment perspective, this observation also converges with Bowbly's postulation that it is the fundamental human condition to need proximity and that the underlying wish to be close to others might be expected in all cases (Waldinger et al., 2003).

[16] Note that the perception of others as rejecting has also been found as a dominant CCRT component in patients with major depressive disorder (e.g., Barber, Luborsky, Crits-Christoph, & Diguer, 1995; Wilczek et al., 2010). We discuss the implications of the commonalities between the CCRT components in our cases and other patient groups in the section 'strengths, limitations and suggestions for further research'.

e.g., Arntz, 1994; Tummala-Narra, Kallivayalil, Singer, & Andreini, 2012) and the prevalence of mistrust (RO 'are not trustworthy', e.g., Ebert & Dyck, 2004; Ma & Li, 2014). Whereas in the literature, feelings of mistrust are put forward as the core characteristic feature of complex trauma (e.g., Hodgdon, Kinniburgh, Gabowitz, Blaustein, & Spinazzola, 2013; Pearlman & Courtois, 2005), our subjects hardly refer to lack of trust in an explicit way. As the broader contexts and narratives of James, Amy, and Pam indicate, this does not mean that feelings of distrust are not implicitly present. Our findings show that a lack of trust not always manifests as the perception that others 'are not trustworthy' and warrant to also take others' 'misunderstanding', 'distance', and 'disrespect' into consideration, as these components explicitly accrued in all three cases.

Finally, with regards to the patients' own reaction, we found support for feelings of 'depression', 'disappointment' (Chance et al., 2000; Okey et al., 2000), 'anxiety' and 'helplessness' (e.g., Ebert & Dyck, 2004; Tummala-Narra et al., 2012) and the tendency to keep silent (RS 'am not open', e.g., Cook, Riggs, Thompson, Coyne, & Sheikh, 2004; Godbout, Sabourin, & Lussier, 2009). On the basis of the literature, we would also have expected feelings of shame, guilt, and self-blame to be dominant (e.g., Allen, Huntoon, & Evans, 1999; Cloitre, Garvert, Brewin, Bryant, & Maercker, 2013). However, we only found minor indications of the prevalence of these components as 'feeling guilty' and 'feeling ashamed' only accrued in the case of Pam and Amy, respectively. What stood out in our results, was the feelings of 'anger' towards others. Whereas in the literature, this has been described as active hostility and aggressive behaviour (e.g., Cloitre et al., 2009; Frueh et al., 2001), again, our results suggest that the patients' anger was not expressed overtly. Within the broader perspective of our findings, the inhibition of anger feelings can be understood as a defence strategy because expressing anger might 'threaten the very hand that feeds' (Blatt, 2004), whereas refraining from anger might aid the pursuit for nurturance.

All in all, our results correspond partly with the interpersonal consequences associated with complex trauma described in the literature. The rich nature of our studies, taking into account the broader narrative and context of the patients, allows a more in-depth and rich understanding of the development and dynamic structure of the observed interpersonal patterns and provides a means to comprehend the sometimes contradictory findings. The narratives of our three cases reveal a history of childhood maltreatment, both in terms of physical and psychological abuse. When James was a child, he (passively) obeyed his father's demands, notwithstanding his interior anger and disappointment, out of fear for retaliation. Amy also feared her fathers' anger outbursts and avoided them by not expressing her (anger) emotions.

Finally, Pam tried to avoid the feared conflicts with her parents, especially her mother, by retaining a passive stance and keeping silent. What stands out in all three cases, is how they *feared* their parent(s) and *tried to avoid confrontation* by taking up a *passive position* towards them and showing a *reluctance to express themselves*. Both James, Amy, and Pam stated they were *feeling* angry at the time of the abuse, but in no way were able to *express* this anger.

In chapter 1, we discussed the importance of the relationship between subject and primary caregivers, because the Symbolic-Imaginary framework is attained via their dynamic interrelations (e.g., Verhaeghe, 2004). In the same vein, drawing from attachment theory, in chapter 2, we worked out how a secure attachment provides the subject with a supportive basis, whereas an insecure attachment does not provide a safe template to deal with others and the world. In fact, the adverse circumstances in which the subject is brought up, force him/her to create schemes to understand and adapt to the dysfunctional situation (e.g., DePrince, Chu, & Pineda, 2011). Further, these schemes form a deeply-engrained internal working model, which colours the subject's further relationships (e.g., Walsh, Fortier, & DiLillo, 2010). James, for instance, submissively obeyed the anger provoking demands of his girlfriend out of fear for rejection, while strongly aspiring a loving and close relationship. Amy, for her part, strongly wished to be able to express her desires and emotions freely, but prevented herself from doing so out of fear to receive critical and rejecting reactions. Pam then, in her adult love and work relationships, did not open up, despite wanting to assert herself, because she wanted to protect herself from the anticipated criticism of others. A general pattern we can distil from these subjects' singular narratives, is the *inability to express desires and emotions* to *avoid anticipated negative, rejecting reactions* from others. We thus see a clear resemblance between the reaction patterns in childhood and adulthood. This provides support for the assertion that childhood adverse experiences lead to certain relational patterns which influence and manifest themselves in adult relationships (e.g., Gleiser et al., 2008).

In this context, a typical pattern that is described in the literature is the tendency of patients to oscillate between wanting to be close to others and isolating from others (e.g., Amos, Segal, & Cantor, 2015; Zilberstein & Messer, 2010). This pattern would stem from the paradoxical situation in which parents are both the source of threat and the source of nurturance, leading to isolating and clinging behaviour, respectively. We could not observe this trend in either of our cases; yet we did find certain resemblances between our subjects' dominant interpersonal patterns and the typical behavioural pattern described in the literature.

In accordance with the literature, James, Amy, and Pam described one of their parents as the aggressor and recounted isolating behaviour in order to prevent or avoid the threat.

Strikingly, all three cases described the other parent as remaining faint and unable to provide nurturance or soothing, which attests to unmet dependency needs (Steele, Van der Hart, & Nijenhuis, 2001). The dominant wishes 'to be respected', 'to be loved', 'to be helped' and 'to be accepted' can be understood as stemming from this privation of interpersonal care. Importantly, neither of our subjects explicitly expressed the wish 'to be distant from others'. Amy and Pam did convey a desire to 'avoid conflict' or 'to not be hurt', but we have seen that these wishes are rather subordinate to the more inherent wish for nurturance.

We observed quite diverse reactions of our subjects, which did not fully correspond to the oscillating pattern described in the literature. James, for instance, did show overt clinging and dependent behaviour towards others (RS 'am dependent', 'am helpful'), but showed no indications of overt distancing behaviour. In fact, the anticipated rejection of others coerced him to help them. Amy and Pam, on the other hand, more proactively distanced themselves from their aggressors, but showed no signs of trying to get close to them. To not be confronted with the anticipated criticism and rejection from others, Pam persistently sustained a silent demeanour. Next to that, Amy sometimes consciously manipulated her reactions in light of the anticipated response.

All in all, our findings show that the relationship between exposure to complex trauma and the (interpersonal) consequences is neither universal (i.e., a one-to-one relationship with identical reactions in every case) nor absolute relativistic (i.e., the relationship between event and reaction depends on too many context-specific variables to extract certain patterns across cases). Instead, the relationship between the exposure to traumatic events and traumatic reactions can be understood via the principle of *universalism without uniformity* (Soenens, Vansteenkiste, & Van Petegem, 2015), meaning that, notwithstanding every person has a unique response to the exposure of childhood adversities, certain patterns recur across cases. Within this regard, it is interesting to note that our cases were most similar with regards to the negative (perceived) response of others, which frustrated their overall wish for closeness. In this context, more important than the tendency to stay close to others or to keep distance, is the tendency to *avoid* the negative responses of others, be it by either actually keeping distance or by resorting to submissive compliance. In other words, they are all passively subjected to the other without any agency to pursue their own desires. This has important implications for therapy, as it is with this preoccupation to manage the response of others that the subject enters therapy.

Changes in the CCRT throughout Treatment

In chapters 4 and 5, we stressed the importance of identifying core interpersonal patterns, because a repetition of those patterns could potentially threaten the therapeutic process. We argued that insight into the dominant interpersonal dynamics provides opportunities to create different relational experiences for the patient and to further address interpersonal difficulties in treatment. In all three cases, we have seen that in providing another response, the therapist created an opening for change.

In the case of James, we noted that the therapist asserted acceptance and understanding, and showed an overt interest in what James had to say. This was in strong contrast with the restraint James experienced in other relationships. Moreover, James did not have to fear retaliatory actions from the therapist as the latter conveyed a neutral and unprejudiced stance, providing a safe environment. As a consequence, James did not have to resort to his usual conduct in order to avoid negative reactions and was able to open up about sensitive issues.

In Amy's case, we have seen that Amy entered treatment with the same anticipation of being labelled crazy she has in other relationships. In contrast to what she would expect from others, the therapist exerted a neutral, acknowledging and empowering attitude. As a result, Amy did not have to fear criticism or rejection, thereby she did not have to avoid these reactions by purposefully adjusting her own conduct, and was able to explore and work through her interpersonal issues.

Lastly, Pam showed to be very introverted and cautious at the beginning of treatment, in accordance with her general tendency to avoid someone betraying her trust. It was only when the therapist actively communicated her genuine interest and appreciation, and restrained from any authoritarian whim, that Pam was able to open up more safely.

We will discuss the impact of the dominant interpersonal patterns on the therapeutic process into more detail below, but for now we want to stress the importance of creating an environment in which patients no longer have to fear or anticipate negative reactions and, therefore, no longer have to avoid the negative response as they typically would. By providing such a safe environment, another mode of responding becomes possible.

The main CCRT components in the middle and end of treatment give an indication of what that other mode of responding might be, in terms of dominant wishes, responses of others and responses of self. As table 1 illustrates, the wish 'to be respected' remains dominant in all three cases in the middle of treatment. Likewise, the wishes 'to be accepted' and 'to be liked' (in phase 1 'to be loved') prevail. What stands out is that the wish 'to not be hurt', which was

present in all three cases in phase 1, is no longer on the forefront and is only mentioned twice by Pam. Next to that, we see that the wish 'to be open' also emerged in Pam's case. An overall tendency seems to be that our subjects articulate their desire no longer (James and Amy) or less (Pam) in a passive voice, meaning they no longer formulate what they aspire from relationships in a negative way ('I don't want to...'), but rather express their desires in an active way ('I want to...').

With regards to the response of others and the response of self, we also see a notable shift. Whereas in phase 1, there were, in general, only negative ROs; in phase 2, there are also positive ROs with the exception for Pam's case. Especially the ROs 'respect me' and 'are understanding' stand out in the cases of James and Amy because these responses satisfy the wish 'to be respected' and 'to be understood'. In accordance, James and Amy express positive RSs, such as 'feel respected', 'feel comfortable' and 'am open', whereas in Pam's case, there are only negative RSs. It thus seems that the perceived response of others and the way that response endorses the main wish strongly influences the way the subjects view and position themselves in relationships. This could imply that they are still rather subject to the response of the other. This is perhaps most clearly illustrated in James' case. We saw that James was surprised by the positive and encouraging reactions of others with regards to his recent suicide attempt and that their positive reactions made him feel 'loved' and 'respected'. The relationship episodes concerning his ex-girlfriend, however, show that a negative reaction from her part still provoked a negative response in James.

Finally, in phase 2, we see that the RS 'am uncertain' is the most prevalent and occurs in all three cases. In Pam's case, ambivalence ensued when she described the wish to be more open towards others. Amy articulated uncertainty with regards to continuing her relationship. James, on his part, felt torn between feelings of love and anger with regards to his ex-girlfriend Rebecca and whether or not to move forward in relation to his friend Holly. It thus seems that, notwithstanding the influential nature of the others' responses described above, our subjects take a more active position and begin to interrogate and question their position vis-à-vis important others in their lives. We could assume that this is part of the process of change that is ensuing.

At the end of treatment, table 1 illustrates that the dominant wish 'to be respected' holds out in all three cases. This corresponds with the overall tendency in therapy that wishes do not particularly change (Luborsky & Crits-Christoph, 1998; Wiseman & Tishby, 2017). However, the trend we observed in phase 2, namely that the wishes were being formulated in a more active voice, sustained until the end of treatment as evidenced by the wishes 'to assert myself', 'to be

open', and 'to have control over others'. Distinctive here is that there is a wide variety of possible positive and negative responses of others and self in all three cases. James, Amy and Pam recount situations in which others were either perceived as 'disrespectful' or 'respectful'. So, in all cases, in some instances, their main wish 'to be respected' was fulfilled. Interestingly, this pattern does not seem to automatically correspond with 'feeling respected', especially in Pam's case in which this RS was not accounted for. Correspondingly, the negative responses of others did not always provoke a negative reaction in our subjects anymore. James, for instance, upheld a positive position, regardless of whether others initially were perceived as uncooperative. Similarly, Amy embraced the continued negativity of others and continued to stand up for herself, notwithstanding sometimes feeling helpless or uncertain. Overall, the available ROs and RSs suggest very diverse interactional patterns between our subjects and important others. Therefore, we cannot formulate a characteristic structure of the CCRT at the end of treatment. We do not necessarily see this as a bad thing, because this suggests that our subjects are no longer trapped in a fixed template of interacting with others. In this context, we also want to highlight the fact that all subjects expressed more self-confidence in relationships. This observation conveys the impression that at the end of treatment James, Amy and Pam were able to take a more active and dynamic stance with a sense of agency and control in their relationships. Despite outcome was not unequivocally positive, it thus appears that change in the CCRT components was established in all three cases.[17]

The Process Component of the CCRT throughout treatment

The Formation of the Therapeutic Relationship

To integrate our findings with regards to the process of change, we systematically compared the quantitative and qualitative data of the cases of James, Amy, and Pam. The most curious and unexpected observation was that in all three cases the therapeutic relationship seemed to be readily established. In Amy's and Pam's cases, the quantitative analysis of the therapeutic relationship, via the Working Alliance Inventory (WAI, Horvath & Greenberg, 1989), suggested that feelings of mutual trust (bond scale) and consensus on treatment objectives (goal scale) and ways to accomplish them (task scale) were achieved early in treatment. Correspondingly, both Amy and Pam commented rather positively on their

[17] Whereas Amy and James showed significant improvement throughout the course of therapy, Pam's outcome scores suggested a worsening of her overall condition. Despite the minor changes we could observe in the CCRT components in the case of Pam and the improvements after treatment termination, it is interesting to note that the perseverance of CCRT components throughout treatment has been associated with negative outcome in the literature (e.g., Wilczek et al., 2010).

relationship vis-à-vis the therapist in the Client Change Interviews (CCI, Elliott, Slatick, & Urman, 2001). Pam, for instance, recounted that the therapist was friendly and professional and Amy praised the therapist's neutrality, acknowledgment and empowerment. However, in both cases, we have seen that these results should not be taken at face value. Especially in Pam's case, we saw that a fundamental feeling of trust was lacking at the beginning of treatment. This was evinced by the fact that Pam relied on the professional confidentiality of her therapist to ensure discretion and did not dare to communicate her distress in treatment. We linked this lack of fundamental trust to Pam's general stance in relationships, i.e., her CCRT at the beginning of treatment, in which she would be quiet and apprehensive in interactions because she would expect others to be unreliable and deceitful. Perhaps to a lesser extent, this also accrued in the case of Amy. We have seen that Amy feared being labelled crazy whenever she would express herself openly. This pattern repeated itself in treatment via a more rational presence and preparing the therapist that what was about to come out of her mouth might sound crazy. These observations correspond to the idea that certain elements of the therapeutic relationship cannot be accessed or assessed via self-report measures because of certain underlying dynamics that are unconsciously influencing the exchanges between patient and therapist (e.g., Waldinger et al., 2003).

As we have already alluded above, core interpersonal dynamics are repeated in the exchange between patient and therapist. The core interpersonal patterns implicitly manifest themselves in treatment and therefore automatically impact the therapeutic relationship. Because Pam and Amy unconsciously expected a certain negative reaction from their therapists, they were not able to express themselves openly at the beginning of treatment. In other words, the therapeutic environment was not inherently seen as a safe environment, notwithstanding the objective qualification of the therapeutic relationship as satisfactory. In this way, we found confirmation for the idea that building a trusting relationship with patients with a complex trauma background might be a precarious task (e.g., Ebert & Dyck, 2004). However, contrary to the literature in which it appears that the lack of trust is manifested rather overtly in treatment and resolutely warrants attention to the formation of the therapeutic alliance (e.g., Pearlman & Courtois, 2005), our results indicate that it is not always clear and that issues of trust might remain obscure. Therefore, we postulate that therapists should always be wary of the nature of the therapeutic relationship. In this, it is not only a matter of checking the overt qualities of the relationship, but, more importantly, to be aware of the dynamics underlying the interpersonal exchange.

No straightforward recommendations can be made in order to guarantee a sustainable therapeutic relationship because these underlying dynamics differ from person to person and should be reviewed case by case. Our CCRT results revealed some commonalities over cases, which allow a more general rule of thumb, namely to avoid getting caught up in a repetition of the CCRT by providing a different response and thereby constituting a different other for the patient. As our results showed, our subjects anticipated others to be 'rejecting', 'not understanding', 'distant', and 'disrespectful', which, of course, warrants the general recommendation of providing warmth and acceptance in treatment (e.g., Wampold, 2007). As Lawson et al. (2013) indicate, however, these non-specific therapist factors do not suffice, as the determining factor is the patient's perception of the therapist's genuineness and authenticity (see also Gleiser et al., 2008). To illustrate, Pam readily described her therapist as a friendly person, showcasing that the non-specific therapist factors were in place. Nevertheless, as outlined above, this certainly was insufficient for the formation of a safe environment. At the end of treatment, Pam declared that the therapist felt familiar and safe, which demonstrates a more fundamental connection between them. In chapter 5, we connected this change to the therapist's decision to change her treatment to a more supportive approach in order to create a better fit with Pam's needs. This was also explicitly cited by Amy when she mentioned that her therapist's "way of approaching things corresponded to [her] needs." Amy stressed the importance of her therapist's neutrality, reassurance and empowerment, which also might be considered non-specific therapist factors. She demonstrated the importance of her therapist's neutrality in situations where she would normally expect an accusing finger, whereas she commented the therapist's reassuring and empowering statements on very particular instances in which Amy felt uncertain about herself. This suggests that the therapist tailored her therapeutic approach on the basis of her knowledge about Amy's interpersonal sensitivities, thus adapting her interventions quite specifically to Amy's case. These findings illustrate the importance of therapists' responsiveness in treatment, which means that therapists are attentive to patients' (changing) needs and resources and appropriately adapt their interventions accordingly (Stiles, 1998). This does not only apply to the overt speech and behaviour of patients. Our findings show the importance of those dialectical moments in which the therapists conveyed a deeper understanding and attuned their interventions to the underlying dynamics or CCRT components that influence the therapeutic exchange. These interventions fostered a feeling of recognition in the patient, by which the therapists demonstrated to respond differently in comparison to significant others (Levitt, Pomerville, & Surace, 2016).

Therapist Interventions throughout Treatment

From the above, we can already deduce the importance of assessing and addressing the CCRT in treatment. We have seen that it is important to understand the operating interpersonal dynamics and how they materialize in treatment in order to be able to effectively address them in treatment. Our next objective was to study the process and mechanisms of change in the CCRT more in-depth. Specifically, we wanted to investigate how therapist interventions are used to address interpersonal issues in treatment. We formulated the expectation that the beginning of treatment would be dominated by supportive interventions, because these interventions focus on fostering the therapeutic relationship, which has ubiquitously been put forward as a pivotal first task in the treatment of patients with a complex trauma background (e.g., Cloitre et al., 2004; Ford et al., 2005). Then, when the therapeutic relationship is established, we would expect more expressive interventions, which focus on addressing and working through the CCRT. On the basis of our results with regards to the therapeutic alliance, which indicated that the therapeutic relationship was seemingly established quite easily, we could already suspect that our results would fail to meet our expectations. In our pilot study of James' case, in which we did not systematically examined the therapeutic interventions, we already observed that the therapist implemented expressive interventions from the outset, without any specific or special efforts to build the therapeutic relationship, for which the therapist could rely on the therapeutic situation in itself. In this context, the use of supportive techniques served the purpose of maintaining the already established relationship. Also in Pam and Amy's cases, in which the therapists' interventions were systematically studied, we could not find the expected sequence of supportive and expressive interventions. In Amy's case, we saw that expressive interventions were more frequent all sessions, with the exception for sessions 1, 12 and 18. On the other hand, in Pam's case, the sequence of supportive and expressive interventions showed a more erratic sequence, with alternatingly more supportive and expressive interventions throughout treatment. The therapeutic processes of Amy and Pam thus demonstrate very distinct treatment trajectories. Below, we discuss which conclusions can be drawn from the commonalities and dissimilarities between cases.

A first notable difference between the therapy processes of Amy and Pam is the amount of interventions used throughout the sessions. Pam's therapist used twice as much interventions per sessions (M = 119) in comparison to Amy's therapist (M = 55). In order to facilitate Pam's speech, the therapist mainly used a large amount of general interventions, including neutral questions and small reiterations. Amy's therapist also used a large amount of general

interventions by ways of encouraging further speech. Although general interventions were more prevalent in nearly all sessions in Amy's case as well, they seem to carry another weight in Pam's case. Notwithstanding possible therapist-specific factors, it was clear that Pam was not as talkative as Amy, which forced the therapist to take in a more active position.

Second, common in both cases is the general preponderance of expressive interventions with on average of 17 and 36 expressive interventions per session in Amy's and Pam's case, respectively. In the beginning of treatment, the two therapists used expressive interventions to gather information about their patients' interpersonal relations and the position of the different people involved. Further, in both cases, supportive interventions were stacked at the end of the first treatment sessions and were used to convey a commitment to their work together. These observations are in line with the guidelines for the beginning of treatment in the manual for supportive-expressive therapy (Luborsky, 1984). It thus appears that a history of complex trauma did not influence the therapists' approach at the beginning of treatment. It would, however, be interesting to compare our findings with the developments at the beginning of treatment with cases with no such trauma background. Next to that, there is a need to study cases that showcase more overt issues of trust and other severe symptomatologic or characterological disfunctions.

Third, in both cases we saw a shift in the purpose of the expressive interventions the therapists used. Whereas at the beginning of treatment, the expressive interventions were used to gather information about interpersonal issues, they were applied gradually more with the aim to work through the interpersonal difficulties. This was made possible by the fact that both Amy and Pam recognized and acknowledged their own position in relationships, i.e., they conveyed a sense of understanding concerning their CCRT, and both expressed a wish to make a change. However, there is a noticeable difference in the way Amy and Pam responded to these interventions. Amy was able to elaborate on her (RS) and significant others' (RO) general position in relationships and started to explore how these components influenced very specific interpersonal encounters. The therapist supported this working through via additional supportive interventions. Pam, on the other hand, was not able to safely explore and work through her interpersonal issues. Instead, we saw a deterioration of her depressive complaints and an increase in distress. Above, we explained that Pam did not experience the therapeutic situation as a context in which she could fundamentally feel safe. The large amounts of expressive interventions confronted her time and again with the interpersonal problems she experienced outside the therapy room, without having the tools to manage the thoughts and feelings accompanying these issues. What we noticed is that, at this instance in treatment, the

therapist only used a small amount of supportive techniques. Keeping Amy's treatment in mind, we could wonder whether the use of more supportive techniques might have prevented the negative effects Pam experienced. However, we have also seen that supportive techniques as such do not suffice to evoke a safe therapeutic relationship per se, since this depends on the patient's perception of the therapeutic situation. We saw that the treatment took a radical turn after the therapist discussed Pam's situation in group supervision. The therapist shifted her attention from the (trauma-related) interpersonal difficulties to issues Pam encountered in her everyday life, such as working towards a daily structure and dealing with bodily distress. Moreover, she used a greater amount of supportive interventions. Here, we could see that the therapist not only used supportive interventions to convey her genuine interest and honest commitment, but also – in parallel with Amy's case – to deliver expressive interventions in a more supportive way by stacking an expressive intervention on a supportive one. It thus seems that certain interpretations might be digested more easily when delivered with care and support. This becomes even more apparent when we take into consideration that Amy stressed the importance of her therapist's supportive attitude, notwithstanding the latter did not use a tangible amount of supportive interventions. In contrast, we noted several more general and non-verbal gestures (e.g., changes in tone of voice, laughter) that could add to the supportive atmosphere. Similarly, in Pam's case, we discussed the influence of the general interventions on Pam's perception on therapy. The neutral questions not only kept the conversation going, but also allowed Pam to feel listened to. In that way, the general interventions actually helped build up a safe environment. Amy and Pam's case thus show that the experience of a supportive environment can depend on very different things, regardless of the number of supportive interventions that specifically aim to foster such an environment. We conclude, similarly as before, that therapists should be attentive for the amount of support their patients *experience*, irrespective of the number of supportive interventions they use. More generally, we can put forward that for all treatment interventions one must consider the effect they produce in a particular case (Kazdin, 2009; Stiles, 1998, 2013). This does, however, not mean that there are no specific clinical implications to draw from our case studies. In what follows, we will discuss the importance of monitoring the treatment process, applying treatment strategies amenably, attending supervision, and allowing agency to patients in treatment.

Clinical Implications

Our first recommendation is strongly associated with our observation that therapists should be wary about the impact their interventions have on their patients. It has been suggested

in the literature that therapists are notoriously bad in estimating the effects of their interventions (Dimidijian & Hollon, 2010; Hatfield, McCullough, Frantz, & Krieger, 2010). In Pam's case, we saw a strong interconnection between symptom severity and the treatment process. The evolution in her symptoms followed a U-shaped curve. Symptoms worsened up until the middle of treatment, after which they steadily started to decline. We could connect this development in symptom burden to the amount of expressive and supportive interventions the therapist used throughout treatment. An excessive amount of expressive interventions were accompanied by a worsening of Pam's condition, whereas the mid-course correction with more supportive interventions went together with an improvement in symptom severity. Notwithstanding our results are formed on the basis of longitudinal observations, it is premature to draw any firm causal conclusions from this. However, our results do indicate the importance of tracking patients' complaints and symptomatic burden. Within this regard, it will not suffice to assess symptoms and other difficulties via self-report questionnaires. As we also have seen with regards to the results of the therapeutic alliance, as measured by the WAI, there might be a vast difference between the patient's conscious estimation of his/her condition and the underlying processes. Next to discussing cases in supervision (see third recommendation), case formulations offer a means to reflect about cases with all available sources of information taken into consideration. We discuss case formulations in more detail below.

Our second recommendation, which is closely related to the first, is to apply treatment strategies amenably and attuned to the patient's needs (e.g., Beutler, Someah, Kimpara, & Miller, 2016). Therapists should intervene with appropriate responsiveness, meaning that their interventions are accustomed to the patient's needs and resources (Stiles, 1998). This seems self-evident, but research has shown that therapists sometimes persistently hold on to their treatment regimens even when the patient does not respond in a foreseen or benevolent way (Castonguay, Boswell, Constantino, Goldfried, & Hill, 2010). As the different responses of Amy and Pam to expressive interventions show, this does not mean that the interventions themselves are faulty; yet that there is a mismatch between patient, therapist and treatment interventions. This point is particularly salient with regards to the strenuous discussion in the complex trauma literature with regards to appropriate treatment strategies. Throughout this dissertation, we have repeatedly referred to the disagreement in the field regarding whether or not a phase-based treatment approach is necessary in order to treat patients with a complex trauma background appropriately. Repeatedly, we have stated that this might not be an either/or decision and that we should take into account the mechanisms of change (Kazdin, 2009) to make any sound recommendations. In the case of Amy, we have noted that Amy responded

particularly well to expressive interventions, which lines up with treatment approaches that protest against the use of initial stabilization (e.g., Wagemans, Van Minnen, Sleijpen, & deJongh, 2008). In contrast, in Pam's case, we argued that a straightforward approach on traumatic contents was non-profitable and instead, her case warranted a supportive, stabilizing approach (e.g., Jepsen, Langeland, & Heir, 2011). In both cases, however, we readily articulated our reservations about such a dichotomous vantagepoint. Instead, we argued for a more dimensional or flexible approach in which for every individual patient the amounts and appropriateness of supportive versus expressive interventions have to be weighted and balanced in light of the broader context and narrative of the case. Moreover, therapy is a fluid situation and the interactions between therapist and patient change dynamically as a function of numerous factors inside (e.g., increased self-understanding of the patient, growing therapeutic alliance) and outside (e.g., social support, life events) the therapy (Polkinghorne, 1999). Therefore, there should be a continuous back-and-forth between monitoring the patient's overall condition and the practical customization of therapist interventions (Polkinghorne, 1999; Stiles, 1998).

Third, we want to stress the importance of discussing (difficult) patients in supervision. Studies have revealed that therapists are not always able to make a fair estimation of the (negative) effects therapy produces (e.g., Hatfield et al., 2010). Such an evaluation of the treatment process seems, however, necessary because it could determine whether a change in the treatment approach is recommended. The benefits of psychotherapy supervision have been widely acknowledged, not only for training psychologists; it is also often endorsed as a general prerequisite for the practice of psychotherapy (e.g., Dulsster & Vanheule, 2019; Luborsky, 1984). Also in the complex trauma literature, supervision has been put forward as a valuable way to recognize and understand therapists' actions and reactions in treatment (e.g., Pearlman & Courtois, 2005). This is further illustrated in Pam's case in which the therapist discussed the case of Pam in supervision and, accordingly, changed her treatment approach. Particularly interesting here was that the therapist asked herself whether it was her own desire, rather than Pam's, to work through the traumatic contents and explore the traumatic nature of Pam's relationship with her mother. In other words, the therapist questioned the universal treatment guideline in the trauma literature to focus on the traumatic contents (e.g., American Psychological Association, APA, 2017), but also the central focus of working through interpersonal difficulties in supportive-expressive psychodynamic therapy (e.g., Luborsky, 1984). Therefore, this question pertinently demonstrates the potential of being blindsided by theoretical convictions or clinical preferences (Castonguay et al., 2010). Next to that, the

outcome of the supervision shows how it can lead to new perspectives on the treatment process of a particular patient. In Pam's case, we saw that after the supervision, the therapist applied much more supportive techniques and shifted the focus of the treatment to the more pressing issues in Pam's daily life, which gave rise to an improvement in her overall condition and well-being.

Fourth, we want to comment on the importance of facilitating patients agency in treatment. In our studies, we have seen that allowing the patient agency was pivotal. For Amy, being able to steer the conversation contributed to feeling safe to set boundaries regarding what she felt comfortable with to talk about. In Pam's case, we have seen that the therapist eventually discontinued the tenacious focus on talking about Pam's traumatic history and, instead, let Pam decide whether or not to talk about those delicate issues. In parallel with the importance of supervision, allowing patients agency has been put forward as a more general guideline for good practice (Bohart & Tallman, 2010; Levitt et al., 2016). Moreover, in the trauma literature, special emphasis has been placed on giving agency to patients (e.g., Arntz, 1996: Herman, 1992; Verhaeghe, 2004) with regards to building a trusting relationship (e.g., Amos et al., 2012; Tummula-Narra et al., 2012). The underlying logic consists of the idea that (complex) trauma victims were repeatedly placed in a passive position by their aggressors, which undermined their sense of personal entitlement and agency (Brown, Kallivayalil, Mendelsohn, & Harvey, 2012). Note that with regards to the structure of the CCRT, we found that James, Pam and Amy maintained a passive position vis-à-vis others. In this context, it is important to prevent placing the patient again in a passive position. Instead, it is better to allow the patient control over the therapeutic situation in order to enhance their sense of agency (e.g., Herman, 1992) and to prevent them from feeling subjected to the control of someone else (e.g., Liotti, 2013). In other words, as a therapist, it is important to refrain from a position of control in order to prevent a repetition of the (traumatic) relational experiences the patient has sustained and to allow a new relational experience from which change can ensue.

This leads us to our last and perhaps most important clinical implication, which we have touched upon already a number of times and seems to encompass all of the above, namely to address interpersonal patterns in diagnosing and treating patients with a complex trauma background. It is important to have insight in the dominant interpersonal patterns because a repetition of these patterns hampers the installation of the therapeutic relationship. Moreover, understanding the nature of core interpersonal patterns is necessary in order to be able to create a new relational experience for patients. Finally, we have seen that this allows patients to safely and freely express themselves in treatment, by which opportunities are created to work through

interpersonal issues, to alleviate symptoms and to augment patients overall well-being.

In general, our results show that there is a strong interconnection between dominant interpersonal patterns and the process of change in the treatment of cases with a complex trauma background. We found that deeply engrained interpersonal patterns, which are formed in relation to primary caregivers, translated into severe difficulties in interpersonal functioning in later life. Further, we saw that a new relational experience, with a therapist that constituted another other for the patient, created opportunities to revise and rework these deeply engrained interpersonal patterns, which allowed our subjects to position themselves differently in relation to themselves, others, and the world. Next to these clinical implications, our observations provide insights into the impasses in the field with regards to the assessment and treatment of complex trauma, which we will discuss in the following paragraph. Next, we will discuss the strengths and limitations of our study and formulate suggestions for further research.

Case Formulations as a Way out of the Impasse

Throughout our research, we stumbled upon several issues with regards to the assessment and diagnosis of (complex) trauma. The most salient point being that there is a marked difference between the experience of certain (traumatizing) events and the (traumatic) consequences of undergoing such experiences. It is beyond a doubt that James, Amy and Pam encountered childhood physical and psychological abuse. In other words, they all have a history of complex trauma. Here, 'complex trauma' merely refers to the circumstances in which our subjects grew up. The concept of complex trauma, in itself, does not account for the consequences associated to the experience of complex trauma (Resick et al., 2012). In the literature, there are various views on how to capture the consequences associated with complex trauma. Two broad parties can be distinguished: those who claim that complex trauma leads to more severe expressions of PTSD (e.g., Teodorescu, Heir, Hauff, Wentzel-Larsen, & Lien, 2012) and those who propagate a distinct diagnostic category, such as complex PTSD or DESNOS, which also includes, amongst other things, affect-dysregulation and interpersonal difficulties (e.g., Cloitre et al., 2013; Elklit, Hyland, & Shevlin, 2014). Next to the confusion these different conceptions install in the therapeutic field, they surpass the underlying mechanisms between experience and consequences, which are necessary to understand the development of symptoms in the aftermath of being exposed to certain experiences.

In selecting our sample, the main inclusion criterion was that the subject had a history of complex trauma (i.e., the experience). When we look at the diagnostic assessment of our cases, we see that James was the only one who received the diagnosis of PTSD. He also met

the basic criteria of Dissociative Identity Disorder (DID). Pam, on her part, did report typical PTSD symptoms, such as hyperarousal, numbing, and avoidance, but failed to mention her upbringing when assessing for traumatic experiences. In contrast, Amy strongly connected her symptoms to her past, but suffered none of the 'typical' symptoms. Similar to Pam, she received the diagnosis of Major Depressive Disorder. In sum, there are few commonalities with regards to the symptoms experienced by James, Amy and Pam, although they clearly sustained similar experiences in their childhood (i.e., childhood abuse). Stated differently, our subjects all had a unique response to their experience of complex trauma (Harvey, 1996) and, as such, there is no such thing as 'a typical case' of complex trauma (van der Kolk, 2005). This implies that people can seek or enter treatment with very diverse psychological symptoms. Moreover, it has been found that people often seek help because of 'secondary' complaints or co-morbid conditions, such as depression or interpersonal difficulties, which not always can be directly connected to the traumatic past (e.g., van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005).

We acknowledge the importance of studying symptoms and difficulties related to complex trauma in order to increase our understanding of possible consequences on various domains. However, our observations show that it is not a question of whether or not distinct diagnostic categories should come in place in order to effectively assess the consequences related to a history of complex trauma. Instead, the question is how to gain insight into the patients' symptoms and complaints during the initial assessment phase to maximize adequate responsiveness in treatment (Stiles, 1998). On the basis of our findings, we would recommend a thorough assessment procedure for patients with a history of childhood trauma in order to enable a full comprehension of the clinical picture the patient presents with in treatment. Therefore, we strongly advocate for a *case formulation approach* (Vanheule, 2015) in which not only symptoms, but also the broader context, background, and interpersonal functioning of the patient are taken into account. A case formulation is defined as "a hypothesis about the causes, precipitants, and maintaining influences of a person's psychological, interpersonal and behavioural problems." (Eells, 2007, p.4). It includes information about symptoms, precipitating or predisposing stressors or life events and explanatory mechanisms for the development of symptoms (Eells, Kendjelic, & Lucas, 1998). In this way, a case formulation not only concerns information about the individual patient, but also provides theoretical reflections and includes research findings (e.g., Vanheule, 2015). As such, our results provide general themes and issues therapists should reflect about, whilst considering the particularities of the individual case.

In order to work out an informative and useful case formulation, next to having detailed information about the singular case, it is pivotal to have a more general knowledgebase in order to be able to formulate hypotheses about the mechanisms involved in the manifestation of symptoms (Polkinghorne, 1999). Using a psychodynamic/psychoanalytic frame of reference, in James' case, for instance, knowing he suffers from dissociative symptoms would not provide us with any tools to think about appropriate treatment strategies. When we frame the dissociative symptoms within the intersubjective structure, we understand that his dissociative symptoms served as a symptomatic solution for the internal conflict he experienced with regards to being unable to express his feelings of anger or frustration vis-à-vis others. This relational pattern stemmed from his traumatic youth in which he passively had to endure the whims of his father. Consequently, from this perspective, in order to alleviate his symptoms, treatment should be oriented at revising and reworking the dominant interpersonal patterns. In this way, case formulations allow to integrate scientific and theoretical knowledge into practice, which offers tools to understand the psychopathology of a singular case and subsequently can help shape treatment plans (Eells, 2007; Vanheule, 2015). In this context, it is important to stress that this implies that there are no generic solutions or one-size-fits-all treatment approaches that can be implemented for any particular case. Moreover, treatment strategies are and should be flux (Stiles, 1998) as therapists' knowledgebases are constantly changing through, amongst other things, new experiences, literature, supervision, conferences and clinical discussions (Polinkhorne, 1999). When used dynamically, a case formulation approach allows to adjust hypotheses in light of new material or information, which promotes flexibility and adequate responsiveness.

As such, case formulations can also offer a solution to the continuous discussions about the treatment of complex trauma-related suffering. Especially with regards to the debate of whether or not a stabilization phase is mandatory, because the amount of supportiveness or focus on building a safe environment can vary when considered on a case to case basis (cf. supra). Also here, a theoretical framework can provide a basis for deciding on appropriate levels of support. In chapter 1, we outlined two possible mechanisms to understand why patients are unable to process traumatic events. The first one explained how subjects were unable to transform and interpret the traumatic Real and to integrate it in the Symbolic-Imaginary structure because they lacked a sufficient amount of words and representations. This means that something went wrong in the early development years, in the relation between subject and Other, by which the Symbolic-Imaginary framework is formed. As such, it is recommended that the treatment focuses on the dynamical exchange between subject and Other, which implies

a stronger focus on the formation of a safe and supportive relationship (Kinet, 2016; Markey, 2006; Verhaeghe & Vanheule, 2005). To make this more tangible, we illustrate this with the case of Pam. In the Clinical Diagnostic Interview (Westen, 2006), Pam repeatedly claimed that she was 'not a talker', like her parents. Moreover, she indicated that she had great difficulty to identify and express her emotions because she had never learned to do so when she was young. These circumstances suggest that Pam has an inability to mentalize, which, in chapter 1, we defined as the capacity to interpret her own and others' feelings, thoughts and behaviours (e.g. Stein & Allen, 2007) and points to an actual-neurotic structure (Verhaeghe & Vanheule, 2005). From this, we could posit that the treatment should focus more on the process of signification, via the formation of the therapeutic relationship. Our results support this inclination as we have seen that Pam responded badly to an approach that directly targeted the traumatic contents and only showed improvement when the therapist resorted to more supportive interventions.

What Pam's case also shows, however, is that this precondition of having an inability to mentalize does not mean that there is no Symbolic-Imaginary frame at work which influences the way the subject positions him/herself in relationships. In fact, we could clearly distinguish how the relationship between Pam and her parents coloured her professional and romantic relationships later in life. However, in her case, it was not warranted to manifestly focus on these issues, precisely because Pam lacked the necessary symbolic tools to narrate and elaborate on these issues, which resonated in the immediate and Real effects on her body. Furthermore, Pam terminated treatment without working through her traumatic upbringing and the consequent interpersonal difficulties in adulthood. Nevertheless, Pam was content and had no desire to explore further how her upbringing had left its marks. This shows that a therapy consisting predominantly of supportive interventions can produce substantial therapeutic effects (e.g., Gleiser et al., 2008; Jepsen et al., 2011), which puts in question the general guideline of having to narrate and work through traumatic events in treatment (APA, 2017). Our results strongly indicate against such a one-treatment-fits-all approach. Again, a case-based approach, combining theory, research, and practice, can help decide on appropriate treatment strategies, without having to succumb to ready-made treatment protocols.

Strengths, Limitations and Suggestions for further Research

The greatest strength of this dissertation is our systematic case study research design and it's potential to bridge the gap between research and practice (Van Nieuwenhove & Notaerts, in press). It has been found that therapists do not often use findings from psychotherapy research to reflect on their clinical practice because it does not provide the

information that facilitates and inspires their clinical work (e.g., Abma et al., 2010). On the other hand, research shows that when treatments are presented in a narrative structure and the readers are able to follow the treatment process critically, clinicians integrate the information more quickly in their knowledgebase (e.g., Dattilio, 2006; Polkinghorne, 2005). Notwithstanding treatment should always be considered within the context of the particular case, therapists can draw from their expanded knowledgebase to make more effective clinical decisions (Edwards et al., 2004) and to be more attentive and responsive to the needs and resources of their own patients (Stiles, 1998). In this way, our case study research can stimulate clinicians to integrate scientific and theoretical knowledge into practice, which offers tools to understand the psychopathology of their patients and subsequently can help shape treatment plans (Eells, 2007; Vanheule, 2015).[18]

Via triangulation of researchers, resources and methods, and the use of consensus procedures (Jackson, Chui, & Hill, 2011), we aimed to safeguard the validity and reliability of our findings. Case studies with a mixed-method design provide a wealth of information. However, we also found several discrepant findings between our qualitative and quantitative measures. For instance, in Pam's case, we saw a clear discrepancy between self-report outcome questionnaires and her subjective accounts concerning her well-being throughout the treatment process. Further, both in Pam and Amy's case, we distinguished between the objective appraisal of the therapeutic relationship via the WAI and the underlying interpersonal dynamics which (unconsciously) affect the relationship. In discussing these discrepancies, our cases have provided us with some critical insights (Stiles, 2013) to understand interpersonal patterns in complex trauma and how they influence the therapeutic process. Moreover, these findings are indicative of the limitations inherent in an exclusive reliance on quantitative measures in the context of psychotherapy research and practice.

Although we were able to discuss numerous interesting findings and formulate several theoretical and clinical implications, there are also some limitations to address. A major drawback of our design has to do with our sample and our case selection procedure. We selected our cases using only two criteria, namely 1) the presence of a complex traumatic background defined as prolonged and repeated interpersonal maltreatment, and 2) treatment focuses on interpersonal issues. These criteria allowed us to study interpersonal patterns and their influence

[18] The Single Case Archive (www.singlecasearchive.com; Desmet et al., 2013) is a case database that consists of a unique collection of single case studies. The archive contains case studies from several theoretical orientations and each of these case studies are inventoried on the basis of various descriptive patient, therapist, and therapy characteristics, which facilitates the search for clinically relevant case studies.

on the therapeutic process in-depth. However, our case selection procedure might have skewed our findings in several ways.

First, although our results confirmed that patients have quite dissimilar reactions, in terms of symptomatic burden in the aftermath of complex trauma (e.g., van der Kolk, 2005), our sample is relatively homogeneous in terms of symptom severity. Complex trauma has often been associated with more severe personality disruptions, such as borderline personality disorder and manifest affect-regulation problems (e.g., Cloitre et al., 2004; Ford & Courtois, 2014; Herman, 1992). Whereas James entered treatment with dissociative complaints, neither Amy, nor Pam suffered from any severe characterological disfunctions. Further, issues of trust might be more overtly and explicitly prevalent in those cases with more severe symptomatic and characterological disfunctions. This implies that, in treatment, more explicit attention might be necessary to form a stable and safe therapeutic relationship. Therefore, there is a definite need to study the formation of the therapeutic relationship further in cases with fewer internal resources and more severe characterological disfunctions.

Second, in James case, his dissociative symptoms could be readily traced back to the interpersonal sphere, which allowed us to study the function of the dissociative symptoms in interpersonal relations as well as the alleviation of his symptoms via working through his interpersonal issues. However, it is reasonable to assume that in other cases, dissociative symptoms are more obscure, which might contraindicate the immediate exploration of the interpersonal difficulties associated with the dissociative complaints and warrant a more vigilant approach. Also here, it would be interesting to compare our findings with other cases in which dissociative complains are present.

Third, while our three cases presented with different diagnostic profiles, they were all able to associate their suffering to the troubled relationship with their primary caregivers without great difficulty. However, as is also clearly established in the trauma literature, people often struggle to connect the dots (van der Kolk et al., 2005; Van Nieuwenhove, 2018). When patients enter treatment with vague or unclear complaints or symptoms, without any reference to their (traumatic) background, this surely impedes the assessment procedure and, consequently, influences the treatment process.

Fourth, we drew our sample from larger psychotherapy research projects (i.e., Single Case Studies, SCS, and the Ghent Psychotherapy Study, GPS, Meganck et al., 2017) conducted at the department of Psychoanalysis and Clinical Consulting. In a way, our cases form a convenience sample (Patton, 2002), because, in these projects, the presence of complex trauma was not a determining or central factor. In contrast, in the GPS study, patients had to meet the

criteria for Major Depression Disorder, in order to participate in the study. Next to that, we only assessed for the presence of traumatic antecedents and symptoms in the PTSD module in the SCID-I and via the Self-rating Inventory for Posttraumatic Stress Disorder (ZIL, Hovens, Bramsen, & van der Ploeg, 2000). We did not include a specific instrument to assess complex trauma-related pathology. Currently, there is only one diagnostic instrument available for the assessment of complex trauma-related disorders, namely the Structured Interview for Disorders of Extreme Stress (SIDES, Pelcovitz et al., 1997). However, the psychometric qualities of this instrument have been widely debated (DeJongh et al., 2016; Resick et al., 2012). Nevertheless, it might be possible that we have missed some important aspects related to complex trauma-related symptomatology.

A fifth limitation concerns the use of standardized coding methods. We applied the CCRT method (Luborsky & Crits-Christoph, 1998) and the PACS-SE (Barber & Crits-Christoph, 1996) to examine dominant interpersonal patterns and therapist interventions, respectively. The general problem with the CCRT is its difficulty to discriminate between different types of patient samples. In our research, this might be even more cumbersome, because all three patients also suffered from depressive symptoms, which in the literature has been associated with roughly the same CCRT components we distilled in our cases (Luborsky & Crits-Christoph, 1998; Wilczek et al., 2010). Nevertheless, our studies provide an in-depth understanding of the underlying mechanisms of these CCRT components and how they are interlaced with the broader context and traumatic background of our cases. Yet, further research is necessary to investigate these mechanisms in other patient groups (for instance, cases with depressive complaints without a complex trauma background). Further, it would be interesting to take into consideration other factors, such as personality styles. The CCRT components in the cases of James, Amy, and Pam bear certain resemblances with the characteristics of an anaclitic personality style, as described by Blatt (2004), including dependency, a lack of assertiveness and passive obedience. However, early adversity can also be associated with an introjective personality style, which is characterized by a focus on self-definition, independency, autonomy and achievements (Blatt, 2004; Pagura, Cox, Sareen, & Enns, 2006). It would be interesting to study whether CCRT components differ according to personality styles and how these different interpersonal patterns influence the therapeutic process (Blatt, 2004; Meganck et al., 2017).

Finally, psychoanalytic constructs have the notorious reputation of being difficult to translate to research (Luyten, Blatt, & Corveleyn, 2006). This applies to more general constructs and mechanisms as well, such as the therapeutic relationship and therapist interventions. There

is no straightforward transition possible from a theoretical knowledgebase to research and vice versa. By using standardized methods, certain information unavoidably gets lost in translation. By complementing our findings with narrative information (Desmet, 2018), we tried to compensate for this inevitable restriction.

In sum, our main concern when selecting our sample was to ensure rich information (Patton, 2002) on interpersonal dynamics in complex trauma. However, considering the limitations connected to our case selection procedure, it is important to note that our results can only be understood and interpreted within the boundaries of the larger research projects, and more specifically, in the contexts and narratives of our cases. These limitations are inherent to case study research (Fishman & Messer, 2013; Levitt et al., 2018). This means that we cannot formulate general principles that are applicable to all cases with a complex trauma history. Nonetheless, we wish to strongly emphasize the merits of case study research, as it not only allows in-depth scrutiny and provides interesting insights regarding the phenomenon under study (i.e., enriching, Stiles, 2013), it also allows to refine and extend our knowledge (i.e., theory-building, Stiles, 2013). In that way, next to the clinical implications following from our research, our findings also provided various suggestions for further research.

Conclusion

On the basis of our systematic literature review (chapter 2), we argued that interpersonal patterns form a common thread in the etiology, consequences and treatment of complex trauma. We reasoned that deep-rooted interpersonal patterns, which are formed concomitant to the exposure to prolonged and repeated interpersonal maltreatment, created the breeding ground for later interpersonal difficulties. We further postulated that these issues would transpire in the treatment as well and that treatment should take up the task to address and rework these deeply engrained interpersonal patterns. Because of the repetition of dominant interpersonal problems in the treatment context, such as a lack of trust, the first focus of treatment should lie on the formation of the therapeutic relationship.

Overall, the accumulated findings of our case studies support these suppositions. We found that during developmental years, our subjects *feared* their abusive caregiver(s), from whom they *longed to be nurtured*, but felt they had to *try to avoid* confrontation via *passive* behaviours, such as the inclination to *not express* their emotions. In adulthood, this pattern repeated itself as the *inability to express desires and emotions* in order to *avoid anticipated negative, rejecting reactions* from others. Patients showed a variety of avoidant behaviours, from overtly distancing themselves or keeping silent, to contradictorily subjecting themselves

by submissively helping others or telling people what they want to hear. So, the underlying interpersonal dynamics are quite comparable, whereas the overt expression of these dynamics in practice can vary a great deal.

Subjects enter treatment with the same anticipation they have in other, formal or informal, encounters. Namely, they anticipate rejecting or critical reactions. However, the associated reluctance to open up can manifest itself in an obscure way and might not always be transparent. Therefore, it is important for clinicians to have an apprehension of the dominant interpersonal patterns of their patients, keeping in mind the underlying logic behind them. It is only by constituting a different other – i.e., responding in another way than anticipated by the patient – that the therapeutic setting can start to form a safe environment to express oneself openly. Therapy can provide a way for patients to revise and rework their view on and position in interpersonal interactions. Ultimately, therapy should not aim to mould or sculpt the subject to a certain model. On the contrary, patients should have a sense of agency in their relationships and be able to feel free to express and pursue their own desires openly and position themselves in interactions in a dynamic way. These objectives in no way correspond to any certain fixed template that could be casted into strict treatment objectives or goals.

In the same vein, no straightforward treatment guidelines can be formulated. The formation of a supportive environment heavily relies on the experience of the patient, which, again, is contingent on the underlying interpersonal dynamics. Therefore, it is not a matter of *which* interventions a therapist uses, but rather *the effects* the interventions produce in a particular case, i.e., whether the interventions are used responsively. Therefore, therapists should be attentive to the impact their interventions have, by not only being aware of the underlying interpersonal dynamics, but also by tracking the patients response in terms of distress or symptoms. In this context, it is important that therapists adapt their interventions to the needs of the patient, regardless of what their theoretical ideals or protocolized manuals proscribe.

As a final point, we strongly recommend case formulations for the assessment and treatment of patients with a complex trauma background. Case formulations not only provide a broad, in-depth and contextual description of the clinical picture a patients presents with. It also allows a dynamic application of theoretical and scientific knowledge in practice, which provides the necessary tools to understand the underlying dynamics of the patients symptoms and, consequently, can help guide the treatment. In complex trauma, this is especially salient, because therapy should be tailored dependent on the dominant interpersonal patterns that transpire in the treatment and their effects on the treatment process.

References

Abma, R., Verbrugge, A., van Heijst, A., Gerritsen, M., ... Glas, G. (2010). *Psychotherapie als wetenschappelijk en economisch product: Het einde in zicht?* Tilburg, Nederland: KSVG.

Allen, J., Huntoon, J., & Evans, R. (1999). Complexities in complex posttraumatic stress disorder in inpatient women: Evidence from cluster analysis of MCMI-III personality disorder scales. *Journal of Personality Assessment, 73*(3), 449-471.

American Psychological Association (2017). *Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder (PTSD) in Adults*. Retrieved from https://apa.org/PTSD-guideline/

Amos, J., Segal, L., & Cantor, C. (2015). Entrapped Mother, Entrapped Child: Agonic Mode, Hierarchy and Appeasement in Intergenerational Abuse and Neglect. *Journal of Child and Family Studies, 24*(5), 1442-1450.

Arntz, A. (1994). Treatment of borderline personality disorder: A challenge for Cognitive-Behavioral Therapy. *Behaviour Research and Therapy, 32*(4), 419-430.

Barber, J. P., & Crits-Christoph, P. (1996). Development of a Therapist Adherence/Competence Scale for Supportive-Expressive Dynamic Psychotherapy: A Preliminary Report. *Psychotherapy Research, 6*(2), 81-94.

Barber, J. P., Luborsky, L., Crits-Christoph, P., & Diguer, L. (1995). A comparison of core conflictual relationship themes before psychotherapy and during early sessions. *Journal of Consulting and Clinical Psychology, 63*(1), 145-148.

Bistoen, G. (2016). *Trauma, Ethics and the Political beyond PTSD: The Dislocations of the Real.* Houndsmills, Basingstoke: Palgrave Macmillan.

Beutler, L. E., Someah, K., Kimpara, S., & Miller, K. (2016). Selecting the most appropriate treatment for each patient. *International Journal of Clinical and Health Psychology, 16*(1), 99-108.

Blatt, S. J. (2004). *Experiences of depression: Theoretical, clinical and research perspectives.* Washington, DC: American Psychological Association.

Bohart, A. C. & Tallmann, K. (2010). Patients: The neglected common factor in psychotherapy. In B. L. Duncan, S. D. Miller, B. E. Wampold, & M. A. Hubble (Eds.) *The heart and soul of change: Delivering what works in therapy* (2nd ed., p. 83-111). Washington, DC: American Psychological Association.

Brown, N. C., Kallivayalil, D., Mendelsohn, M., & Harvey, M. R. (2012). Working the double edge: Unbraiding pathology and resiliency in the narratives of early-recovery trauma survivors. *Psychological Trauma: Theory, Research, Practice, and Policy, 4*(1), 102-111.

Castonguay, L., Boswell, J. F., Constantino, M. J., Goldfried, M. R., & Hill, C. E. (2010). Training Implications of Harmful Effects of Psychological Treatments. *American Psychologist, 65*(1), 34-49.

Chance, S. E., Bakeman, R., Kaslow, N. J., Farber, E., & Burge-Callaway, K. (2000). Core conflictual relationship themes in patients diagnosed with borderline personality disorder who attempted, or who did not attempt, suicide. *Psychotherapy Research, 10*(3), 337-355.

Cloitre, M., Garvert, D. W., Brewin, C. R., Bryant, R. A., & Maercker, A. (2013). Evidence for proposed ICD-11 PTSD and complex PTSD: A latent profile analysis. *European Journal of Psychotraumatology, 4*:10.3402/ejpt.v4i0.20706.

Cloitre, M., Stolbach, B. C., Herman, J. L., van der Kolk, B., Pynoos, R., Wang, J., & Petkova, E. (2009). A Developmental Approach to Complex PTSD: Childhood and Adult Cumulative Trauma as Predictors of Symptom Complexity. *Journal of Traumatic Stress, 22*(5), 399-408.

Cloitre, M., Stavall-McClough, K. S., Miranda, R., & Chemtob, C. M. (2004). Therapeutic Alliance, Negative Mood Regualtion, and Treatment Outcome in Child Abuse-Related Posttraumatic Stress Disorder. *Journal of Consulting and Clinical Psychology, 72*(3), 411-416.

Chiriaco, S. (2012). *Le désir foudroyé: Sortir du traumatisme par la psychoanalyse.* Paris: Navarin/Le Champ Freudien.

Cook, J. M., Riggs, D. S., Thompson, R., Coyne, J. C., & Sheikh, J. I. (2004). Posttraumatic Stress Disorder and Current Relationship Functioning Among World War II Ex-Prisoners of War. *Journal of Family Psychology, 18*(1), 36-45.

Dattilio, F. M. (2006). Does the case study have a future in the psychiatric literature? *International Journal of Psychiatry in Clinical Practice, 10*, 195-203

DeJongh, A., Resick, P. A., Zoellner, L. A., van Minnen, A., Lee, C. W., Monson, C. M., . . . & Bicanic, I. A. (2016). Critical analysis of the current treatment guidelines for complex PTSD in adults. *Depression and Anxiety, 33*(5), 359-369.

DePrince, A. P., Chu, A. T., & Pineda, A. S. (2011). Links between specific posttrauma appraisals and three forms of trauma-related distress. *Psychological Trauma: Theory, Research, Practice, and Policy, 3*(4), 430-444.

Desmet, M. (2018). *The pursuit of objectivity in psychology.* Borgerhoff en Lomberigts: Gent.

Desmet, M., Meganck, R., Seybert, C., Willemsen, J., Van Camp, I., Geerardyn, F., … Kächele, H. (2013). Psychoanalytic Single Cases Published in ISI-Ranked Journals: The Construction of an Online Archive. *Psychotherapy and Psychosomatics, 82*(2), 120-121.

Dimidijian, S., & Hollon, S. D. (2010). How would we know if psychotherapy were harmful? *The American Psychologist, 65*(1), 21-33.

Drapeau, M., & Perry, J. C. (2009). The Core Conflictual Relationship Themes (CCRT) in Borderline Personality Disorder. *Journal of Personality Disorders, 23*(4), 425-431.

Dulsster, D., & Vanheule, S. (2019). On Lacan and supervision: A matter of super-audition. *British Journal of Psychotherapy*,*35*(1), 54-70.

Eells, T. D. (2007). History and Current Status of Psychotherapy Case Formulation. In T. D. Eells (Ed.) *Handbook of psychotherapy case formulation, second edition* (pp. 3-33). New York & London: The Guilford Press.

Eells, T. D., Kendjelic, E. M., & Lucas, C. P. (1998). What's in a case formulation? Development and use of a content coding manual. *The Journal of Psychotherapy, Practice, and Research, 7*(2), 144-153.

Ebert, A., & Dyck, M. J. (2004). The experience of mental death: The core feature of complex posttraumatic stress disorder. *Clinical Psychology Review, 24*, 617-635.

Elklit, A., Hyland, P., & Shevlin, M. (2014). Evidence of symptom profiles consistent with posttraumatic stress disorder and complex posttraumatic stress disorder in different trauma samples. *European Journal of Psychotraumatology, 5*: 10.3402/ejpt.v5.24221.

Elliott, R., Slatick, E., & Urman, M. (2001). Qualitative change process research on psychotherapy: Alternative strategies. *Psychologische Beiträge, 43*, 69-111.

Fishman, D. B., & Messer, S. B. (2013). Pragmatic case studies as a source of unity in applied psychology. *Review of General Psychology, 17*, 156–161.

Ford, J. D. & Courtois, C. A. (2014). Complex PTSD, affect dysregulation, and borderline personality disorder. *Borderline Personality Disorder and Emotion Dysregulation, 1*(1), 9.

Ford, J. D., Courtois, C. A., Steele, K., van der Hart, O., & Nijenhuis, E. R. S. (2005). Treatment of Complex Posttraumatic Self-Dysregulation. *Journal of Traumatic Stress, 18*(5), 437-447.

Frueh, B. C., Turner, S. M., Beidel, D. C., & Cahill, S. P. (2001). Assessment of social functioning in combat veterans with PTSD. *Aggression and Violent Behavior, 6,* 79-90.

Gleiser, K., Ford, J. D., & Fosha, D. (2008). Contrasting exposure and experiential therapies for complex posttraumatic stress disorder. *Psychotherapy, 45*(3), 340-360.

Godbout, N., Sabourin, S., & Lussier, Y. (2009). Child Sexual Abuse and Adult Romantic Adjustment: Comparison of Single- and Multipe-Indicator Measures. *Journal of Interpersonal Violence, 24*(4), 693-705.

Harvey, M. R. (1996). An ecological view of psychological trauma and trauma recovery. *Journal of Traumatic Stress, 9*(1), 3-23.

Hatfield, D., McCullough, L., Frantz, S. H., & Krieger, K. (2010). Do we know when our clients get worse? An investigation of therapists' ability to detect negative client change. *Clinical Psychology and Psychotherapy, 17*(1), 25-32.

Herman, J. L. (1992). *Trauma and Recovery.* New York, NY: Basic Books.

Hodgdon, H., Kinniburgh, K, Gabowitz, D., Blaustein, M. E., & Spinazzola, J. (2013). Development and Implementation of Trauma-Informed Programming in Youth Residential Treatment Centers Using the ARC Framework. *Journal of Family Violence, 28,* 679-692.

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the working alliance inventory. *Journal of Counselling Psychology, 36,* 223-233.

Hovens, J. E., Bramsen, I., & van der Ploeg H. M. (2009). *Zelfinventarisatielijst Posttraumatische Stressstoornis*. Amsterdam: Pearson Assessment and Information B.V.

Iwakabe, S. (2005). Pragmatic meta-analysis of case studies. *Annual Progress of Family Psychology, 23,* 154-169.

Iwakabe, S., & Gazzola, N. (2009). From single-case studies to practice-based knowledge: Aggregating and synthesizing case studies. *Psychotherapy Research, 19*(4), 601-611.

Jackson, J. L., Chui, H. T., & Hill, C. E. (2011). The Modification of Consensual Qualitative Research for Case Study Research: An Introduction to CQR-C. In C. E. Hill (Ed.), *Consensual Qualitative Research: Practical Resources for Investigating*

Social Science Phenomena (pp. 285-303). Washington, DC: American Psychological Association.

Jepsen, E. K. K., Langeland, W., & Heir, T. (2013). Impact of dissociation and interpersonal functioning on inpatient treatment for early sexually abused adults. European Journal of Psychotraumatology, 4. doi:10.3402/ejpt.v4i0.22825

Kazdin, A. E. (2009). Understanding how and why psychotherapy leads to change. *Psychotherapy Research, 19*(4-5), 418-428.

Kinet, M. (2016). *Trauma binnenstebuiten. Verbanden bij psychische wonden.* Antwerpen/ Apeldoorn: Garant.

Lacan, J. (1998). *The seminar of Jacques Lacan. Book XI. The Four Fundamental Concepts of Psychoanalysis.* (A. Sheridan, Trans.). J.-A. Miller (Ed.). New York and London: W. W. Norton & Company. (Original published in 1973)

Lawson, D. M., Davis, D., & Brandon, S. (2013). Treating complex trauma: Critical interventions with adults who experienced ongoing trauma in childhood. *Psychotherapy (Chic), 50*(3), 331-335.

Lawson, D. M., & Quinn, J. (2013). Complex trauma in children and adolescents: Evidence-based practice in clinical settings. *Journal of Clinical Psychology, 69*(5), 497-509.

Levitt, H. M., Bamberg, M., Creswell, J. W., Frost, D. M., Josselson, R., Suárez-Orozco, C. (2018). Journal article reporting standards for qualitative primary, qualitative meta-analytic, and mixed methods research in psychology: The APA Publications and Communications Board task force report. *The American Psychologist, 73*(1), 26-46.

Levitt, H. M., Pomerville, A., & Surace, F. I. (2016). A qualitative meta-analysis examining clients' experiences of psychotherapy: A new agenda. *Psychological Bulletin, 142*(8), 801-830.

Liotti, G. (2004). Trauma, dissociation and disorganized attachment: Three strands of a single braid. *Psychotherapy: Theory, research, practice, training, 41*, 472-486.

Liotti, G. (2013). Phobias of Attachment-Related Inner States in the Psychotherapy of Adult Survivors of Childhood Complex Trauma. *Journal of Clinical Psychology: In Session, 69*(11), 1136-1147.

Luborsky, L. (1984). *Principles of psychoanalytic psychotherapy: A manual for supportive-expressive treatment.* New York, NY: Basic Book.

Luborsky, L., & Crits-Christoph, P. (1998). *Understanding Transference: The Core Conflictual Relationship Theme Method* (2nd Ed.). Washington, DC: American Psychological Association.

Luyten, P., Blatt, S. J., & Corveleyn, J. (2006). Minding the Gap between Positivism and Hermeneutics in Psychoanalytic Research. *Journal of the American Psychoanalytic Association, 54*(2), 571-610.

Ma, E. Y., & Li, F. W. (2014). Developmental trauma and its correlates: A study of Chinese children with repeated familial physical and sexual abuse in Hong Kong. *Journal of Traumatic Stress, 27*(4), 454-460.

Markey, S. (2006). Over de behandeling van aktuaalneurose: Een gevalstudie. *Psychoanalytische Perspectieven, 24*(3-4), 379-390.

Meganck, R., Desmet, M., Bockting, C., Inslegers, R., Truijens, F., De Smet, M. … Vanheule, S. (2017). The Ghent Psychotherapy Study (GPS) on the differential efficacy of supportive-expressive and cognitive behavioral interventions in dependent and self-critical depressive patients: Study protocol for a randomized controlled trial. *Trials,* 18, 126.

Okey, J. L., McWhirter, J. J., & Delaney, M. K. (2000). The Central Relationship Patterns of Male Veterans with Posttraumatic Stress Disorder: A Descriptive Study. *Psychotherapy, 37*(2), 171-178.

Pagura, J., Cox, B. J., Sareen, J., & Enns, M. W. (2006). Childhood adversities associated with self-criticism in a nationally representative sample. *Personality and Individual Differences, 41*(7), 1287-1298.

Patton, M. Q. (2002). Qualitative designs and data collection. In *Qualitative research and evaluation methods* 3rd ed., (pp. 228-247). London, England: Sage.

Pearlman, L. A., & Courtois, C. A. (2005). Clinical Applications of the Attachment Framework: Relational Treatment of Complex Trauma. *Journal of Traumatic Stress, 18*(5), 449-459.

Pelcovitz, D., van der Kolk, B., Roth, S., Mandel, F., Kaplan, S., & Resick, P. (1997). Development of a criteria set and a structured interview for disorders of extreme stress (SIDES). *Journal of Traumatic Stress, 10*(1), 3-16.

Polkinghorne, D. E. (2005). Language and meaning: Data collection in qualitative research. *Journal of Counseling Psychology, 52*(2), 137-145.

Polkinghorne, D. E. (1999). Traditional Research and Psychotherapy Practice. *Journal of Clinical Psychology, 55*(12), 1429-1440.

Pressley, J. & Spinazzola, J. (2015). Beyond Survival: Application of a Complex Trauma Treatment Model in the Cristian Context. *Journal of Psychology & Theology, 43*(1), 8-22.

Resick, P. A., Bovin, M. J., Calloway, A. L., Dick, A. M., King, M. W., … & Wolf, E. J. (2012). A critical evaluation of the complex PTSD literature: implications for DSM-5. *Journal of Traumatic Stress, 25*(3), 241-51.

Schrans, D. (2018). *Het Imaginaire en het Symbolische in Lacans conceptualisering van de overdracht en de finaliteit van de kuur tussen 1938 en 1956: Een conceptueel literatuuronderzoek.* Universiteit Gent. Faculteit Psychologie en Pedagogische wetenschappen, Gent.

Shafran, N., Shahar, G., Berant, E., & Gilboa-Schechtman, E. (2016). Representations of Self and Parents, and Relationship Themes, in Adolescents with Post Traumatic Stress Disorder (PTSD). *Journal of Abnormal Child Psychology, 44*, 887-899.

Soenens, B., Vansteenkinste, M., & Van Petegem, S. (2015). Let Us Not Throw Out the Baby With the Bathwater: Applying the Principle of Universalism Without Uniformity to Autonomy-Supportive and Controlling Parenting. *Child Development Perspectives, 9*(1), 44-49.

Steele, K., van der Hart, O., & Nijenhuis, E. R. S. (2001). Dependence in the treatment of complex posttraumatic stress disorder and dissociative disorders *Journal of Trauma and Dissociation, 2*(4), 79-116.

Stein, H., & Allen, J. G. (2007). Mentalizing as a framework for integrating therapeutic exposure and relationship repair in the treatment of a patient with complex posttraumatic psychopathology. *Bulletin of the Menninger Clinic, 71*(4), 273-290.

Stiles, W. B. (1998). Responsiveness in Psychotherapy. *Clinical psychology: science and practice, 5*(4), 439-458.

Stiles, W. B. (2013). The Variables Problem and Progress in Psychotherapy Research. *Psychotherapy, 50*(1), 33-41.

Teodorescu, D. S., Heir, T., Hauff, E., Wentzel-Larsen, T., & Lien, L. (2012). Mental health problems and post-migration stress among multi-traumatized refugees attending outpatient clinics upon resettlement to Norway. *Scandinavian Journal of Psychology, 53*(4), 316-332.

Tummala-Narra, P., Kallivayalil, D., Singer, R., & Andreini, R. (2012). Relational experiences of complex trauma survivors in treatment: Preliminary findings from a naturalistic study. *Psychological Trauma: Theory, Research, Practice, & Policy, 4*(6), 640-648.

van der Kolk, B. A. (2005). Developmental Trauma Disorder. Toward a rational diagnosis for children with complex trauma histories. *Psychiatric Annals, 35*(5), 401-408.

van der Kolk, B. A., Roth, S., Pelcovitz, D., Sunday, S., & Spinazzola, J. (2005). Disorders of Extreme Stress: The Empirical Foundation of a Complex Adaptation to Trauma. *Journal of Traumatic Stress, 18*(5), 389-399.

Vanheule, S. (2015). *Psychodiagnostiek anders bekeken: Kritieken op de DSM. Een pleidooi voor functiegerichte diagnostiek.* Tielt: Lannoo.

Van Nieuwenhove, K. (2018). Talking about Trauma: Could I, Would I, Should I? *Psychoanalytische Perspectieven, 36*(3), 235-248.

Verhaeghe, P. (2004). *On being normal and other disorders: A manual for clinical psychodiagnostics.* New York, NY, USA: Other.

Verhaeghe, P., & Vanheule, S. (2005). Actual neurosis and PTSD: The impact of the other. *Psychoanalytic Psychology, 22*(4), 493-507.

Waldinger, R. J., Seidman, E. L., Gerber, A. J., Liem, J. H., Allen, J. P., & Hauser, S. T. (2003). Attachment and core relationship themes: wishes for autonomy and closeness in the narratives of securely and insecurely attached adults. *Psychotherapy research, 13*(1), 77-98.

Walsh, D., & Downe, S. (2005). Meta-synthesis method for qualitative research: A literature review. *Journal of Advanced Nursing, 50*(2), 204-211.

Walsh, K., Fortier, M. A., & DiLillo, D. (2010). Adult Coping with Childhood Sexual Abuse: A Theoretical and Empirical Review. *Aggression and Violent Behavior, 15*(1), 1-13.

Wampold, B. E. (2007). Psychotherapy: The humanistic (and effective) treatment. *The American psychologist, 62*(8), 855-873.

Wagemans, A., Van Minnen, A., Sleijpen, M., & deJongh, A. (2018). The impact of childhood sexual abuse on the outcome of intensive trauma-focused treatment for PTSD. *European Journal of Psychotraumatology, 9*(1): 1430962.

Wilczek, A., Weinryb, R. M., Barber, J. P., & Gustavsson, P. (2010). The Core Conflictual Relationship Theme (CCRT) and psychopathology in patients selected for dynamic psychotherapy. *Psychotherapy research, 10*(1), 100-113.

Wiseman, H. & Tishby, O. (2017) Applying relationship anecdotes paradigm interviews to study client–therapist relationship narratives: Core conflictual relationship theme analyses, *Psychotherapy Research, 27*(3), 283-299.

Zilberstein, K., & Messer, E. A. (2010). Building a Secure Base: Treatment of a Child with Disorganized Attachment. *Clinical Social Work Journal, 38*, 85-97.

ENGLISH SUMMARY

The nature and change of interpersonal relationship patterns in psychodynamic therapy for patients with a complex trauma background

This dissertation concerns the nature of interpersonal relationships in complex trauma in terms of the interpersonal consequences and the importance of working through dominant interpersonal patterns in treatment.

In *Chapter 1*, we delineate the differences between traumatic experiences and traumatic reactions. At the level of the experience, there is a distinction between events that are acute or chronic and events that are interpersonal or not interpersonal in nature (Verhaeghe, 2004). This way, we can differentiate between acute non-interpersonal traumatic events (e.g., a natural disaster), acute interpersonal traumatic events (e.g., assault), chronic non-interpersonal traumatic events (e.g., famine), and chronic interpersonal traumatic events or complex trauma (e.g., childhood abuse, Herman, 1992). The dominant conceptualization of traumatic reactions departs from an implicit mechanical logic in which complaints or symptoms are understood as the logical consequence of being exposed to certain traumatic events. When this mechanical approach also transpires in the treatment, there is the potential risk that subjective processes in the development of symptoms are not taken into account (Bistoen, Vanheule, & Craps, 2014).

We departed from a psychoanalytic/psychodynamic frame of reference to address the importance of the relationship between subject and Other with regards to the development of symptoms associated with the experience of one or more traumatic events. People give *meaning* to their experiences and the process of signification occurs in the relationship between subject and Other. The Other not only refers to specific others of flesh and blood, but also to language and broader cultural influences. In the relationship between subject and primary caregivers, a representational Symbolic-Imaginary framework, from which the subject reflects and understands him/herself, others, and the world, and gives meaning to what happens around him/her, is shaped (Verhaeghe, 2004). Drawing from this perspective, trauma can be understood as a breach in the Symbolic-Imaginary framework, causing a brutal confrontation with the Real (Bistoen, 2016; Chiriaco, 2012). To answer the question why some people do and others do not succeed in compartmentalizing a traumatic experience, we refer to a disturbed dialectical exchange between subject and Other. We discuss the situation in which in the primary relation

between subject and Other an insufficient amount of words and representations were offered to or adopted by the subject. In the confrontation with a traumatic experience, the subject cannot fall back on a Symbolic-Imaginary framework to represent or transform the traumatic Real. Another possibility is that a Symbolic-Imaginary framework was formed in a traumatic relationship between subject and Other in order to deal with the traumatic antecedents. We conclude that, for the assessment and treatment of patients with a complex trauma background, it is crucial to gain insight in the process of signification, i.e., the way in which the subject understands him/herself, others, and the world.

In *Chapter 2*, we provide an overview of the theoretical and empirical literature with regards to interpersonal features in complex trauma. We used "Complex trauma OR complex PTSD OR DESNOS" AND "Interpersonal OR relation" as our search terms on Web of Science and selected 94 articles according to the following inclusion criteria: a) the abstract or title contains an explicit focus on interpersonal features in trauma, b) the primary diagnosis is trauma-related, and c) articles are written in English. The results of our thematic analysis (Brown & Clarke, 2006) show that interpersonal features transpire on three interrelated research lines, namely research with regards to the etiology, consequences and treatment of complex trauma.

At the level of *etiology*, research shows that exposure to complex trauma causes more severe psychological suffering than (repeated) non-interpersonal traumatic events (Cloitre, Garvert, Brewin, Bryant, & Maercker, 2013; Ehring & Quack, 2010; Newman, Riggs, & Roth, 1997). Especially in the context of childhood abuse, when the abuse is perpetrated by primary caregivers, the psychological consequences are detrimental (Forbes et al., 2014; Kisiel et al., 2014). Drawing from attachment theory, this is explained by the important developmental processes, such as the development of emotion-regulation skills and interpersonal skills, that take place in the relationship between subject and primary caregivers (Briere, Hodges, & Godbout, 2010; Ehring & Quack, 2010), which are necessary to adequately deal with adverse circumstances. In the context of complex trauma, these developmental processes are subverted (Briere & Jordan, 2009; Pressley & Spinazzola, 2015) and specific interpersonal patterns or schemas, i.e., characteristic ways to think about yourself, others, and the world, are formed in order to deal with the unsafe situation (DePrince, Chu, & Pineda, 2011; Walsh, Fortier, & DiLillo, 2010). These dominant interpersonal patterns persist and influence the way subjects with a complex trauma history relate to others in adulthood (Gleiser, Ford, & Fosha, 2008; Ma & Li, 2014; van der Kolk et al., 1996; Zilberstein & Messer, 2007).

With regards to the *interpersonal consequences*, especially the lack of trust in others has been put forward as a core determining feature in complex trauma (Jepsen, Langeland, & Heir, 2013; Lawson, Davis, & Brandon, 2013; Tummala-Narra, Kallivayalil, Singer, & Andreini, 2012). Further, a negative self-image, with feelings of shame, guilt, helplessness, vulnerability and worthlessness, prevails (Allen, Huntoon, & Evans, 1999; Ebert & Dyck, 2004). There are several studies that have examined characteristic interpersonal patterns via the Core Conflictual Relationship Theme (CCRT) method (Luborsky & Crits-Christoph, 1998). The CCRT operationalizes characteristic interpersonal patterns by describing the dominant wish (W), de perceived or anticipated response of the other (RO) and the perceived own reaction (response of self, RS). The results of these studies suggest that the dominant CCRT components in complex trauma are the wish to be loved and understood (Chance, Bakeman, Kaslow, Farber, & Burge-Callaway, 2000) or to oppose, control and hurt others (Drapeau & Perry, 2009). Others are perceived as rejecting and opposing (Chance et al., 2000), controlling or bad (Drapeau & Perry, 2009). The patient feels numb (Drapeau & Perry, 2009) or disappointed and depressed (Chance et al., 2000).

Concerning the *treatment* of complex trauma, several researchers emphasize the importance of addressing interpersonal difficulties in treatment (Ford, Courtois, Steele, van der Hart, & Nijenhuis, 2005; Newman et al., 1997) via a phase-based approach, in which in a first phase the focus lies on safety, stability, and the development of emotional, behavioural and relational skills (Cloitre et al., 2011; Drozdek, 2015). In this context, a first and vital step is the formation of a durable and safe therapeutic relationship (Arntz, 1994; Herman, 1992; Ford et al., 2005). The therapeutic relationship is assumed to be the basis from which to revise and work through the interpersonal dynamics that were established in the relation of the patient vis-à-vis his/her primary attachment figures (Blalock et al., 2013; Pressley & Spinazzola, 2015). However, developing a safe therapeutic relationship is challenging because dominant interpersonal patterns also influence the relationship between subject and therapist – i.e., patients enter treatment with a deep-rooted lack of trust (Ebert & Dyck, 2004; Gleiser et al., 2008; Pearlman & Courtois, 2005). There are several treatment modalities that primarily focus on stability (Gleiser et al., 2008; Jepsen et al., 2013; Zorzella, Muller, & Classen, 2014). In other treatment models, stability is a prerequisite to explore, integrate and work through the traumatic experiences in the next stages of treatment (Cloitre et al., 2011; Drozdek, 2015).

The results of our systematic literature review clearly demonstrate the importance of interpersonal features in complex trauma etiology, consequences, and treatment. We conclude that several questions remain unanswered, especially with regards to the nature of interpersonal

patterns and the way treatment can address the interpersonal difficulties associated with complex trauma. Questions such as how the therapeutic relationship is established, which interventions contribute to the formation of a safe therapeutic relationship and how interpersonal dynamics change throughout the course of treatment remain unanswered. This observation resulted in the following research questions:

- What is the specific nature of the interpersonal patterns in complex trauma?
- How do interpersonal patterns change throughout treatment?
- How is a safe therapeutic relationship established in treatment?
- Which interventions are used to address interpersonal problems in treatment?

These questions are investigated in *three systematic single case studies.* Single case studies allow an in-depth study of the complex and dynamic structure of interpersonal patterns and the process of change (Desmet, 2018; Stiles, 2003; Toomela, 2007). The cases are selected on the basis of two inclusion criteria, namely 1) a history of repeated and chronic interpersonal violence – i.e., complex trauma, and 2) therapy focuses on (working through) interpersonal difficulties. The cases are selected from the larger research projects (Single Case Studies, SCS, and Ghent Psychotherapy Study, GPS, Meganck et al., 2017) conducted at the department of Psychoanalysis and Clinical Consulting. The extensive data collection in these projects makes rigorous and systematic outcome and process studies possible. Dominant interpersonal patterns are assessed via the Inventory of Interpersonal Problems (IIP-32, Horowitz, Alden, Wiggins, & Pincus, 2000) and the Core Conflictual Relationship Theme (CCRT) method (Luborsky & Crits-Christoph, 1998), in which several Relationship Episodes – i.e., narrative accounts of specific interactions between patient and a specific other – are coded on the basis of standard categories consisting of 35 Ws, 30 ROs and 31 RSs. The therapeutic relationship is studied via a qualitative thematic analysis (Brown & Clarke, 2006) and the Working Alliance Inventory (WAI, Horvath & Greenberg, 1989). Therapeutic interventions are examined with the Penn Adherence/Competence Scale for Supportive-Expressive Therapy (PACS-SE, Barber & Crits-Christoph, 1996). Every intervention is categorized as a neutral or general intervention (e.g., neutral questions), a supportive intervention (e.g., empathy, acceptance) or an expressive intervention (e.g., feedback on the dominant interpersonal patterns). We use consensus procedures to systematize our research with triangulation over researchers, methods and instruments (Jackson, Chui, & Hill, 2011). Next to that, we provide a rich description of the broader context, the interpersonal patterns and the process of change (Desmet, 2018; Fishman & Messer, 2013; Vanheule, 2015).

In *Chapter 3*, we study the specific nature of interpersonal patterns and the changes in these patterns throughout treatment in the case of James. At the beginning of treatment, James is 23 years old. He suffers from dissociative episodes in which he, amongst other things, cheats on his girlfriend Rebecca and buys expensive devices without having any recollection of doing these things. This causes serious problems in his relationship with Rebecca. James' symptoms can be traced back to his traumatic background. James' father physically and verbally abused him and his brothers. Next to that, James notes that sexuality was always a great taboo and that he did not get any allowance, notwithstanding all the chores he was obligated to do around the house. Correspondingly, in James' adult romantic relationship, Rebecca is very reluctant to talk about her lack of sexual interest and, furthermore, she forces him to do several chores before he is allowed to buy something he wants. Both in his childhood and adult relationships, James shows a deep-rooted pattern of obliging to others' wishes whilst feeling frustrated and disappointed. These patterns translate to the following dominant CCRT components at the beginning of treatment: the wish 'to be close to others' and 'to be respected', others are perceived as 'rejecting' and 'distant', and James feels 'disappointed' and 'depressed'.

In the middle of the treatment process, James attempts suicide. His mother and his friend Holly are very loving, understanding and supportive towards James. The dominant CCRT components show how his wish 'to be respected' and 'to be close to others' are fulfilled because others 'respect' him, 'are helpful', and 'love' him, rendering James feeling 'respected' and 'loved'.

In contrast to the second phase in which there seems to be an idealization of interactions with others, at the end of treatment, James takes up a more dynamic and nuanced position vis-à-vis himself and others. The dominant wish remains 'to be close to others' and 'to be respected'. The responses of others are characterized by negative (RO 'oppose me', 'are rejecting', 'are angry') and positive (RO 'respect me', 'understand me', 'are cooperative') reactions. This results in primarily positive reactions; James feels 'open', 'self-confident' and 'self-controlled'. All in all, whereas James used to remain silent and would bottle his frustrations up, he now expresses his own desires and feelings more openly.

In *Chapter 4*, we discuss the case of Amy and study how dominant interpersonal patterns change throughout the therapy process. At the start of treatment, Amy is 26 years old. She has a history of physical and psychological abuse perpetrated by her father. He regularly called her 'insane' or 'crazy' and threatened to put her in a mental institution. In her adult relationships, Amy still fears to be labelled crazy by others and she is unable to openly express her feelings.

Next to that, keeping in mind what others might think of her, she sometimes consciously alters what she says in order to avoid others suspecting her to be crazy.

At the beginning of treatment, Amy's wish 'to be open', 'to be understood', and 'to be respected' are answered by others being 'not understanding', 'controlling', rejecting' and 'disrespectful'. Correspondingly, Amy wishes 'to not be hurt' and 'to have control over others' and she is 'not open' and 'controlling' vis-à-vis others. Next to that, Amy feels 'anxious', 'ashamed', 'angry', 'helpless', 'uncertain' and 'disappointed'.

In the middle of treatment, the wish 'to not be hurt' is no longer on the forefront. However, the wishes 'to be understood', 'to be accepted', 'to be respected' and 'to be open' are continuously being answered by others being 'distant' and 'not understanding'. This does not prevent Amy to be 'open', notwithstanding her persisting feelings of 'anger', 'helplessness', 'uncertainty' and 'anxiety'.

At the end of treatment, the perceived response of others remains negative (RO 'are rejecting', 'are unhelpful, 'oppose me', 'are not understanding'). These responses keep evoking feelings of 'anger', 'helplessness', disappointment' and 'uncertainty'. Nevertheless, Amy feels 'self-confident' and 'independent' in relation towards others. Next to the wish 'to be understood' and 'to be accepted', the wish 'to be my own person', 'to feel good about myself', 'to assert myself' and 'to be independent' prevail. The changes in her dominant interpersonal pattern translate in taking a distance from those people who (sometimes intentionally) cause her harm, such as her boyfriend and her mother, and in opening up to others that show to be trustworthy, such as certain girlfriends.

With regards to the therapeutic process, our data suggests that the therapeutic relationship was easily established. The scores on the WAI subscales (Horvath & Greenberg, 1989) show that from the start up until the end of treatment, there is a feeling of mutual trust (bond scale) and consensus about the treatment goals (goal scale) and treatment trajectories (task scale). The qualitative analysis of the semi-structured Client Change Interviews (CCI, Elliott, Slatick, & Urman, 2001) peri- and post-treatment shows that Amy appreciates the therapist's neutrality, acknowledgment and empowerment. She notes that she – in parallel with her other relationships – expected that the therapist would judge and reprimand her. Because this was not the case, she could open up safely in treatment. Additionally, Amy mentions the fact that she could steer the conversation herself and that the therapist did not push her in any direction as beneficial factors of the treatment.

Based on the literature, we would expect more supportive techniques at the beginning of treatment. In contrast, we see, in Amy's case, that the therapist primarily uses expressive

interventions throughout the entire treatment. At first, these interventions are mainly focused on gathering information and insights into the dominant interpersonal patterns. Quite early in therapy, expressive interventions are also used to give feedback about dominant interaction patterns and to facilitate change in terms of taking up a new position vis-à-vis others. Supportive techniques are initially used to build trust and hope. As the treatment progresses, supportive techniques are mostly used to recognize, accept and respect Amy and to support the marked changes.

We conclude that Amy's dominant interpersonal patterns transpire in the treatment and influence the therapeutic relationship. Amy initially expected the therapist to react in the anticipated, negative way. However, the therapist did not respond with reproaches or admonitions, which meant that Amy no longer had to resort to her typical ways of keeping silent or controlling what she says. Because of the new relational experience that was created within the therapeutic framework, it was possible for Amy to communicate her feelings, thoughts and desires in an open way to the therapist. Outside of therapy, Amy also showed a new, confident and open attitude towards others and she took a distance from those who insistently responded to her in a negative way.

Pam's case is discussed in *Chapter 5*. We examine interpersonal patterns throughout treatment, the formation of the therapeutic relationship and which therapeutic interventions are used throughout treatment. At the start of treatment, Pam is 33 years old. She meets the criteria of seasonal major depressive disorder, agoraphobia and body dysmorphic disorder. At the age of 17, Pam was diagnosed with epilepsy. She has a history of childhood psychological and physical abuse perpetrated by her mother. Currently, she still suffers the domination of her parents, which mostly transpires in having to endure their criticism without being able to defend herself. At the start of treatment, Pam's dominant interpersonal pattern can be described as the wish 'to avoid conflict' on the one hand, and 'to not be responsible or obligated', 'to assert myself' and 'to be respected' on the other. Others are frequently perceived as 'rejecting' and 'controlling', which is accompanied by the tendency to 'not be open', to 'be dependent' and to 'feel anxious'. This dominant interpersonal pattern not only describes Pam's relation vis-à-vis her parents in the past and in the present, but also the way she currently interacts with others (e.g., partner, bosses).

As treatment progresses, the perceived responses of others as 'rejecting' and 'controlling' are supplemented with others being perceived as 'disrespectful', 'not understanding' and 'distant'. Next to the wish 'to avoid conflict', the wishes 'to be accepted',

‘to be respected’, ‘to be liked’ and ‘to be open’ emerge. Considering the negative responses of others, Pam remains ‘not open’ and she feels ‘helpless’, ‘uncertain’, ‘angry’, ‘anxious’, ‘dependent’, ‘disappointed’, and ‘unloved’.

At the end of treatment, interpersonal relationships insist on being dominated by the negative perceived responses of others (RO ‘are strong’, ‘are controlling, ‘are not understanding’, ‘don’t respect me’, ‘are distant’, ‘are rejecting’, ‘are not trustworthy’) and negative responses of Pam herself (RS ‘am not open’, ‘am dependent’, ‘feel disappointed’, ‘oppose others’, ‘am helpless’). The way in which Pam expresses her desires still points in the direction of wanting others to be genuinely interested in her (W ‘to be respected’, ‘to have trust’, ‘to be liked’, ‘to be accepted’, ‘to be understood’) and the wish to maintain open communications (W ‘to be open’, ‘to be opened up to’). The most important shift in Pam’s dominant interpersonal patterns is that, whereas at the beginning of treatment she expresses her wishes in a passive way, as treatment progresses, she gives more and more expression to her own desire to be acknowledged as a person and to be able to interact with others in a virtuous way.

The quantitative and qualitative analyses of the therapeutic relationship indicate that trust was seemingly established quite easily. Pam describes the therapist as a friendly and professional person, with whom she can express herself openly. The quantitative and qualitative measures are, however, insufficiently apt to assess the underlying interpersonal dynamics. That is, there are indications that the dominant interpersonal patterns also influence the therapeutic relationship. Although Pam rationally acknowledges that the therapeutic context is a safe environment to talk, an inherent sense of trust is lacking.

This observation can be associated with the erratic sequence of the therapeutic interventions throughout treatment. At first, the therapist uses more expressive interventions. It is only after 12 therapy sessions that more supportive interventions are introduced. Expressive interventions are mainly used to map the dominant interpersonal patterns and to explore and revise them. At this instance, Pam shows a great reluctancy, which is reflected in her brief and dismissive answers (e.g., ‘I don’t know.’). Next to that, Pam starts to suffer from somatic complaints, going from vague bodily distress to epileptic insults and depressed feelings. Pam connects the deterioration in her overall well-being to the stress resulting from talking about her interpersonal difficulties. After the 11th therapy session, Pam sends a message to her therapist in which she expresses her doubts to continue treatment because she no longer wanted to be an inconvenience to the therapist. Hereupon, the therapist discusses Pam’s case in supervision. She questions her own desire to address the traumatic relationship between Pam

and her parents and she comes to the conclusion that a more supportive approach, with more emphasis on the somatic complaints and the (interpersonal) issues Pam experiences in the here and now, would better suit Pam. In the sessions that follow, there is a marked difference in the extent to which supportive and expressive techniques are used. More specifically, there is a clear preponderance of supportive interventions and more attention is paid to boundaries. This is illustrated by the fact that the therapist focuses on issues that Pam brings to the table, such as having a daily routine, her relationship with her body, and the importance of a stable job. When interpersonal issues are being discussed, the therapist is more cautious and less perseverant. Further, she builds expressive interventions or interpretations on a supportive foundation. This does not mean that dominant interpersonal patterns and the interpersonal problems Pam experiences are shunned by the therapist. On the contrary, the therapist addresses the multiple levels in Pam's complaints, in the sense that Pam's current interpersonal issues can be associated with and are influenced by her relationship vis-à-vis her primary caregivers. The therapist now leaves it up to Pam to explore these issues or not. Because Pam feels much better at the end of therapy, she decides to not go into these themes, but expresses her intention to contact the therapist again if the interpersonal issues would start to interfere with her daily life.

All in all, we conclude that Pam had a new relational experience in treatment in which she could open up more safely because the therapist took up another position. This was made possible by supportive techniques, but also by more general, 'neutral' interventions, by which the therapist expressed a genuine interest in what Pam had to say. Nevertheless, we also have to conclude that Pam's dominant interpersonal patterns barely changed and that Pam continues to experience issues of trust towards others. Although treatment brought about symptomatic relief, fundamentally, little has changed in the way Pam relates to others.

In *Chapter 6*, we compare the findings of James, Amy and Pam via a meta-synthesis (Iwakabe & Gazzola, 2009) and discuss the commonalities and differences with regards to the nature and change of dominant interpersonal patterns and the therapeutic process. A higher order abstraction of the data of the three cases allows for new insights, beyond the level of the individual case (Walsh & Downe, 2005), by which we can expand our knowledge about interpersonal patterns in complex trauma.

The dominant interpersonal patterns, coded according to the CCRT, show some remarkable commonalities over the three cases. In all cases, the dominant wish consists of the wish 'to be respected' on the one hand, and 'to not be hurt' on the other. Others are perceived as 'rejecting', 'not understanding', 'disrespectful', and 'distant'. The main response of the

subject is feeling ‘angry’. In all three cases, it is clear that frustrations are not expressed openly. The subjects rather passively subject themselves to the whims of others. This also transpires in other dominant reactions, such as ‘not being open’, ‘being dependent’ and ‘feeling helpless’.

Our findings with regards to the dominant interpersonal patterns bear some resemblances with the literature, but mainly warrant nuance and further scrutiny (Stiles, 2013). Our results support the finding that the dominant wish can be described as a wish ‘to be close and accepted’ and ‘to be loved and understood’ (Chance et al., 2000; Okey, McWirthey, & Delaney, 2000). The contrasting wish ‘to oppose others’, ‘hurt others’ and ‘control others’ (Drapeau & Perry, 2009; Frueh, Turner, Beidel, & Cahill, 2001) only transpires in the case of Amy. It must be noted that these wishes, together with the wish to not be hurt, are rather a consequence of the anticipated frustration of the desire to be acknowledged and loved.

With regards to the dominant perceived response of others, there is evidence for the perception of others as ‘rejecting’ and ‘controlling’. In this context, the most remarkable observation is that a lack of trust (RO ‘are not trustworthy’) is only mentioned explicitly a couple of times, whereas in the literature this has been put forward as a core feature of complex trauma (Hodgdon, Kinniburgh, Gabowitz, Blaustein, & Spinazzola, 2013; Pearlman & Courtois, 2005). This does not mean, however, that distrust did not implicitly influenced the relation between our subjects and others.

The subjects’ own responses of feeling ‘depressed’, ‘helpless’ and ‘disappointed’ correspond with the findings of Ebert and Dyck (2004) and Godbout, Sabourin, and Lussier (2009). Contrary to what we would expect on the basis of the available literature (Allen et al., 1999), feelings of ‘shame’ and ‘guilt’ are less on the forefront. Instead, feelings of ‘anger’ are more preponderant (Frueh et al., 2001), albeit these feelings are not openly expressed. The inability to express anger can be associated with the tendency to avoid the anticipated negative responses of others, which boils down to the frustration of the wish to be loved and to be nurtured.

What stands out in all three cases is that they *avoid* the *critical and rejecting responses* of others by taking in a *passive position*, not expressing their thoughts and feelings (of *anger*). This pattern colours the interpersonal relationships in childhood, vis-à-vis primary caregivers, and in adulthood, vis-à-vis parents, partners, et cetera. In this way, our results provide support for the idea that in early relationships interpersonal schemas develop, which colour all later relationships (Gleiser et al., 2008; Walsh et al., 2010), including the relationship vis-à-vis the therapist.

Because the therapists positioned themselves differently than James, Amy and Pam expected – according to their typical interactions with others – they no longer have to avoid the anticipated negative response, which creates opportunities to explore, revise and work through the dominant interpersonal patterns. As treatment progresses, we see that the dominant wish 'to not be hurt' moves to the background and passively formulated wishes ('I don't want...') make room for more actively formulated desires ('I want....'). There is also a marked shift in the dynamic relation between the (anticipated) responses of others and their own reactions. Whereas in the middle of treatment own positive or negative responses depend on the positive or negative reaction of the other – which suggests that the patient is still subject to the response of the other – at the end of treatment, the mainly negatively perceived responses of others are no longer associated with negative thoughts or feelings. Next to the fact that all three subjects show a more active and dynamic position in their relationships, we cannot determine a typical interpersonal pattern from the wide variety of positive and negative responses of others and self at the end of treatment. We conclude that the treatment enabled the subjects to move past fixed ways of relating to others.

From the comparison of the therapeutic processes of Amy and Pam, the remarkable finding that the therapeutic relationship is seemingly established quite early in treatment goes against the general accepted idea that the therapeutic relationship is difficult to install due to a lack of trust (Pearlman & Courtois, 2005). A distinction must be made between directly observable information (questionnaires, interviews) and the underlying interpersonal dynamics, which implies we have to nuance our findings. In both cases, albeit in a subtle and unconscious way, dominant interpersonal patterns repeat themselves in the treatment. This is evident from Pam's statement that she trusts the therapist because the therapist is bound to professional secrecy and the repeated remark of Amy that what she is about to say might sound crazy. Because Pam and Amy implicitly expect a negative reaction from their therapists, they initially do not feel safe enough to expose themselves in treatment. It is only when the therapists manifest themselves as a different other that Amy and Pam could open up more safely. The most important implication is that issues of trust must be taken into account, albeit a lack of trust might not always be presented overtly. It is the task of the therapist to be aware of the underlying dynamics that influence the therapeutic relationship, beyond the more explicitly expressed qualities of their relationship. The results of our research illustrate the importance of assessing dominant interpersonal patterns and avoiding a repetition of the typical patterns by taking up another position.

The interventions used by the therapists throughout the course of Pam and Amy's treatment show very different sequences than what we would have expected on the basis of the literature. We expected that supportive techniques would dominate the early stages of treatment. However, both in Pam and Amy's case, expressive techniques are used early in treatment to gather information about dominant interpersonal patterns. As treatment progresses, more and more expressive interventions are used to question the dominant patterns and to work towards a different way of relating to others. Here, there is an important difference in the treatment trajectories of Amy and Pam. Amy is able to examine her position vis-à-vis others. This enables the therapist to keep using expressive interventions to explore and revise interpersonal patterns and to use supportive techniques only explicitly to foster and support the marked changes. In Amy's case, non-verbal gestures and intonation contribute to a supportive atmosphere. In contrast to Amy, Pam is not able to safely explore interpersonal issues, which is reflected in a worsening of her condition. After discussing her case in supervision, Pam's therapist changes her treatment approach by applying more supportive interventions and by focusing more on issues that Pam herself struggles with, such as her body image and daily routine. This causes a noticeable improvement in Pam's overall well-being. In Pam's case, asking neutral questions (i.e., general interventions) also has a supportive effect. To conclude, both therapists clearly aligned their treatment approach to the (divergent) impact their interventions had on their patients.

On the basis of the accumulated findings, we can put forward several clinical implications. First, therapists should be aware of the impact their interventions have on patients (Dimidijian & Hollon, 2010). It does not suffice to monitor complaints and symptoms via a systematic assessment (e.g., by administering self-report questionnaires), because there might be a discrepancy between the objective estimation of the patient and the unconscious dynamics or underlying processes. Second, therapists should adept their therapeutic interventions responsively to the needs of the patient (Stiles, 1998). Third, it is recommended to discuss (difficult) patients in supervision (Dulsster & Vanheule, 2019) in order to shed light on the dynamic interactions between (the complaints of the) patient and (the interventions of the) therapist and to explore other perspectives with regards to the treatment. Fourth, therapists should facilitate patients' autonomy or agency in treatment (Levitt, Pomerville, & Surace, 2016). In other words, patients should have a sense of control and should be able to steer the therapeutic conversations themselves. A last and all-encompassing clinical implication is that therapists should be aware of the nature of interpersonal patterns in assessing and treating patients with a complex trauma background. The importance of this cannot be underestimated,

because a repetition of dominant interpersonal patterns in treatment can not only have devastating consequences for the formation of the therapeutic relationship, but it is also important to establish a new relational experience by taking up another position in order to create a safe environment in which interpersonal difficulties can be discussed, revised and worked through.

These clinical implications are directly related to the theoretical and empirical implications with regards to the assessment and treatment of disorders related to complex trauma. In the literature, there is a tenacious discussion with regards to the categorization of symptoms related to complex trauma. The question that is asked here is whether these symptoms are a more extreme expression of the classic Post Traumatic Stress Disorder (PTSD, Teodorescu, Heir, Hauff, Wentzel-Larsen, & Lien, 2012) or manifestations of other syndromes, such as Complex PTSD (CPTSD, Herman, 1992) or Disorders of Extreme Stress Not Otherwise Specified (DESNOS, van der Kolk, 2005). The results of our research show that every patient reacts in a unique and singular way (Harvey, 1996) and seeks help for very diverse reasons, going from classic symptoms of PTSD to interpersonal difficulties and depression (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). The *clinical case formulation* (Vanheule, 2015) offers a way to map these unique clinical profiles. A case formulation integrates information from multiple sources, such as information about the individual patient (complaints, context, interpersonal functioning, et cetera), theoretical reflections, and research findings. In this way, it is possible to establish a (theory-driven) understanding of the mechanisms underlying the development of symptoms (Eells, Kendjelic, & Lucas, 1998). By relating the manifestation of symptoms to a certain theory, case formulations also offer ways to reflect about treatment trajectories (Vanheule, 2015) and, more specifically, to act with adequate responsiveness in treatment (Stiles, 1998).

In the broader research field, there is also a strong debate concerning ‘the’ treatment of disorders related to complex trauma (Resick et al., 2012; de Jongh et al., 2016). The main source of dispute is whether or not a stabilization phase is necessary. Also here, clinical case formulations offer a solution, because it is assumed that every treatment should be tailored to the individual patient and, moreover, should be adjusted flexibly according to new information that might come to the fore (Polkinghorne, 1999).

The limitations of our research allow us to explore several interesting avenues for further research. With regards to our sample, we point to the relative homogeneity of our cases in terms of symptom severity and traumatic background. It follows that more research is necessary to explore the nature of dominant interpersonal patterns and their influence on the treatment

process in patients with more severe symptomatic or characterological disfunctions, patients with overt issues of trust, and patients who do not connect their suffering to their traumatic background. Next to that, it would be interesting to study interpersonal dynamics in cases without a complex trauma background. One of the limitations of the CCRT method is the difficulty to differentiate between patients with different psychopathologies (Wiczek et al., 2010). By investigating the underlying mechanisms, we can clearly demonstrate how CCRT components are interwoven with a traumatic background and how interpersonal patterns influence the therapeutic process. Qualitative process-studies can further enrich our understanding about other patient groups by investigating how dominant interpersonal patterns are rooted in the history of the patient and in which ways the dominant patterns influence the therapeutic process. Further, it would be interesting to take into account other factors, such as the personality style of the patient. It has been assumed that anaclitic and introjective patients benefit more from structured/supportive and open/expressive therapies, respectively (Meganck et al., 2017). However, research regarding the underlying assumption that personality styles influence the way patients interact and relate to others – including a therapist – is scarce. Therefore, it would be interesting to study the (divergent) nature of interpersonal patterns in patients with an anaclitic and introjective personality style and to explore how these patterns influence the treatment process.

In conclusion, dominant interpersonal patterns and the process of change in treatment are clearly interconnected. We found that interpersonal patterns, which develop in the relationship between subject and primary caregivers, can grow into deeply rooted interactional patterns that are repeated in adult relationships, including the relationship vis-à-vis a therapist. A new relational experience, in which the therapist demonstrates a different position, creates opportunities to revise fixed interpersonal patterns, allowing a new relationship between the subject and him/herself, others, and the world. Based on these findings, we have established the importance of gaining insight into dominant interpersonal patterns and to give shape to the treatment in a responsive way. We have advocated for a case formulation approach, in which theoretical reflections and research findings are integrated with information of the individual case to dynamically give shape to the assessment and treatment process. More qualitative, process studies are needed to further enhance our understanding of interpersonal dynamics and their influence on the therapy process.

References

Allen, J., Huntoon, J., & Evans, R. (1999). Complexities in complex posttraumatic stress disorder in inpatient women: Evidence from cluster analysis of MCMI-III personality disorder scales. *Journal of Personality Assessment, 73*(3), 449-471.

Arntz, A. (1994). Treatment of borderline personality disorder: A challenge for Cognitive Behavioral Therapy. *Behaviour Research and Therapy, 32*(4), 419-430.

Barber, J. P., & Crits-Christoph, P. (1996). Development of a Therapist Adherence/Competence Scale for Supportive-Expressive Dynamic Psychotherapy: A Preliminary Report. *Psychotherapy Research, 6*(2), 81-94.

Bistoen, G. (2016). *Trauma, Ethics and the Political beyond PTSD: The Dislocations of the Real.* Houndsmills, Basingstoke: Palgrave Macmillan.

Bistoen, G., Vanheule, S., & Craps, S. (2014). Nachträglichkeit: A Freudian perspective on delayed traumatic reactions. *Theory & Psychology, 24*(5), 668-687.

Blalock, J. A., Minnix, J. A., Mathew, A. R., Wetter, D. W., McCullough, J. P., & Cinciripini, P. M. (2013). Relationship of Childhood Trauma to Depression and Smoking Outcomes in Pregnant Smokers. *Journal of Consulting and Clinical Psychology, 81*(5), 821-830.

Briere, J., Hodges, M., & Godbout, N. (2010). Traumatic stress, affect dysregulation, and dysfunctional avoidance: A structural equation model. *Journal of Traumatic Stress, 23*(6), 767-774.

Briere, J., & Jordan, C. E. (2009). Childhood maltreatment, intervening variables, and adult psychological difficulties in women: An overview. *Trauma, Violence & Abuse, 10*(4), 375-388.

Brown, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101.

Chance, S. E., Bakeman, R., Kaslow, N. J., Farber, E., & Burge-Callaway, K. (2000). Core conflictual relationship themes in patients diagnosed with borderline personality disorder who attempted, or who did not attempt, suicide. *Psychotherapy Research, 10*(3), 337-355.

Chiriaco, S. (2012). *Le désir foudroyé: Sortir du traumatisme par la psychoanalyse.* Paris: Navarin/Le Champ Freudien.

Cloitre M., Courtois, C. A., Charuvastra, A., Carapezza, R., Stolback, B. C., & Green, B. L. (2011). Treatment of Complex Trauma: Resutls of the ISTSS Expert Clinician Survey on Best Practices. *Journal of Traumatic Stress, 24*, 615-627.

Cloitre, M., Garvert, D. W., Brewin, C. R., Bryant, R. A., & Maercker, A. (2013). Evidence for proposed ICD-11 PTSD and complex PTSD: A latent profile analysis. *European Journal of Psychotraumatology, 4*:10.3402/ejpt.v4i0.20706.

DeJongh, A., Resick, P. A., Zoellner, L. A., van Minnen, A., Lee, C. W., Monson, C. M., . . . & Bicanic, I. A. (2016). Critical analysis of the current treatment guidelines for complex PTSD in adults. *Depression and Anxiety, 33*(5), 359-369.

DePrince, A. P., Chu, A. T., & Pineda, A. S. (2011). Links between specific posttrauma appraisals and three forms of trauma-related distress. *Psychological Trauma: Theory, Research, Practice, and Policy, 3*(4), 430-444.

Desmet, M. (2018). *The pursuit of objectivity in psychology*. Borgerhoff en Lomberigts: Gent.

Dimidijian, S., & Hollon, S. D. (2010). How would we know if psychotherapy were harmful? *The American Psychologist, 65*(1), 21-33.

Drapeau, M., & Perry, J. C. (2009). The Core Conflictual Relationship Themes (CCRT) in Borderline Personality Disorder. *Journal of Personality Disorders*, *23*(4), 425-431.

Drozdek, B. (2015). Challenges in treatment of posttraumatic stress disorder in refugees: Towards integration of evidence-based treatments with contextual and culture-sensitive perspectives. *European Journal of Psychotraumatology, 6*: 10.3402/ejpt.v6.24750.

Dulsster, D., & Vanheule, S. (2019). On Lacan and supervision: A matter of super-audition. *British Journal of Psychotherapy*,*35*(1), 54-70.

Ebert, A., & Dyck, M. J. (2004). The experience of mental death: The core feature of complex posttraumatic stress disorder. *Clinical Psychology Review, 24*, 617-635.

Eells, T. D., Kendjelic, E. M., & Lucas, C. P. (1998). What's in a case formulation? Development and use of a content coding manual. *The Journal of Psychotherapy, Practice, and Research, 7*(2), 144-153.

Ehring, T., & Quack, D. (2010). Emotion Regulation Difficulties in Trauma Survivors: The Role of Trauma Type and PTSD Symptom Severity. *Behavior Therapy, 41*, 587-598.

Elliott, R., Slatick, E., & Urman, M. (2001). Qualitative change process research on psychotherapy: Alternative strategies. *Psychologische Beiträge, 43*, 69-111.

Fishman, D. B., & Messer, S. B. (2013). Pragmatic case studies as a source of unity in applied psychology. *Review of General Psychology, 17*, 156–161.

Forbes, D., Lockwood, E., Phelps, A., Wade, D., Creamer, M., Bryant, R. A., … & O'Donnell, M. (2014). Trauma at the Hands of Another: Distinguishing PTSD Patterns Following Intimate and Nonintimate Interpersonal and Noninterpersonal Trauma in a Nationally Representative Sample. *Journal of Clinical Psychiatry, 75*(2), 147-153.

Ford, J. D., Courtois, C. A., Steele, K., van der Hart, O., & Nijenhuis, E. R. S. (2005). Treatment of Complex Posttraumatic Self-Dysregulation. *Journal of Traumatic Stress, 18*(5), 437-447.

Frueh, B. C., Turner, S. M., Beidel, D. C., & Cahill, S. P. (2001). Assessment of social functioning in combat veterans with PTSD. *Aggression and Violent Behavior, 6,* 79-90.

Gleiser, K., Ford, J. D., & Fosha, D. (2008). Contrasting exposure and experiential therapies for complex posttraumatic stress disorder. *Psychotherapy, 45*(3), 340-360.

Godbout, N., Sabourin, S., & Lussier, Y. (2009). Child Sexual Abuse and Adult Romantic Adjustment: Comparison of Single- and Multipe-Indicator Measures. *Journal of Interpersonal Violence, 24*(4), 693-705.

Harvey, M. R. (1996). An ecological view of psychological trauma and trauma recovery. *Journal of Traumatic Stress, 9*(1), 3-23.

Herman, J. L. (1992). *Trauma and Recovery.* New York, NY: Basic Books.

Hodgdon, H., Kinniburgh, K, Gabowitz, D., Blaustein, M. E., & Spinazzola, J. (2013). Development and Implementation of Trauma-Informed Programming in Youth Residential Treatment Centers Using the ARC Framework. *Journal of Family Violence, 28,* 679-692.

Horowitz, L. M., Alden, L. E., Wiggins, J. S., & Pincus, A. L. (2000*). Inventory of Interpersonal Problems*. London: The Psychological Corporation.

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the working alliance inventory. *Journal of Counselling Psychology, 36,* 223-233.

Iwakabe, S., & Gazzola, N. (2009). From single-case studies to practice-based knowledge: Aggregating and synthesizing case studies. *Psychotherapy Research, 19*(4), 601-611.

Jackson, J. L., Chui, H. T., & Hill, C. E. (2011). The Modification of Consensual Qualitative Research for Case Study Research: An Introdution to CQR-C. In C. E. Hill (Ed.), *Consensual Qualitative Research: Practical Resources for Investigating Social Science Phenomena* (pp. 285-303). Washington, DC: American Psychological Association.

Jepsen, E. K. K., Langeland, W., & Heir, T. (2013). Impact of dissociation and interpersonal functioning on inpatient treatment for early sexually abused adults. *European Journal*

Kisiel, C., Fehrenbach, T., Stolbach, B., Briggs, E. C., Layne, C. M., … & Spinazzola, J. (2014). Examining Child Sexual Abuse in Relation to Complex Patterns of Trauma Exposure: Findings from the National Child Traumatic Stress Network. *Psychological Trauma: Theory, Research, Practice, and Policy, 6*(1), 29-39.

Lawson, D. M., Davis, D., & Brandon, S. (2013). Treating complex trauma: Critical interventions with adults who experienced ongoing trauma in childhood. *Psychotherapy, 50*(3), 331-335.

Levitt, H. M., Pomerville, A., & Surace, F. I. (2016). A qualitative meta-analysis examining clients' experiences of psychotherapy: A new agenda. *Psychological Bulletin, 142*(8), 801-830.

Luborsky, L., & Crits-Christoph, P. (1998). *Understanding Transference: The Core Conflictual Relationship Theme Method* (2nd Ed.). Washington, DC: American Psychological Association.

Ma, E. Y., & Li, F. W. (2014). Developmental trauma and its correlates: A study of Chinese children with repeated familial physical and sexual abuse in Hong Kong. *Journal of Traumatic Stress, 27*(4), 454-460.

Meganck, R., Desmet, M., Bockting, C., Inslegers, R., Truijens, F., De Smet, M., … Vanheule, S. (2017). The Ghent Psychotherapy Study (GPS) on the differential efficacy of supportive-expressive and cognitive behavioral interventions in dependent and self-critical depressive patients: Study protocol for a randomized controlled trial. *Trials*, 18, 126.

Newman, E., Riggs, D. S., & Roth, S. (1997). Thematic Resolution, PTSD, and Complex PTSD: The Relationship Between Meaning and Trauma-Related Diagnoses. *Journal of Traumatic Stress, 10*(2), 197-213.

Okey, J. L., McWhirter, J. J., & Delaney, M. K. (2000). The Central Relationship Patterns of Male Veterans with Posttraumatic Stress Disorder: A Descriptive Study. *Psychotherapy, 37*(2), 171-178.

Pearlman, L. A., & Courtois, C. A. (2005). Clinical Applications of the Attachment Framework: Relational Treatment of Complex Trauma. *Journal of Traumatic Stress, 18*(5), 449-459.

Polkinghorne, D. E. (1999). Traditional Research and Psychotherapy Practice. *Journal of Clinical Psychology, 55*(12), 1429-1440.

Pressley, J. & Spinazzola, J. (2015). Beyond Survival: Application of a Complex Trauma Treatment Model in the Cristian Context. *Journal of Psychology & Theology, 43*(1), 8-22.

Resick, P. A., Bovin, M. J., Calloway, A. L., Dick, A. M., King, M. W., … & Wolf, E. J. (2012). A critical evaluation of the complex PTSD literature: implications for DSM-5. *Journal of Traumatic Stress, 25*(3), 241-51.

Stiles, W.B. (2003). When is a case study scientific research? *Psychotherapy Bulletin, 38*, 6-11.

Stiles, W. B. (1998). Responsiveness in Psychotherapy. *Clinical psychology: science and practice, 5*(4), 439-458.

Stiles, W. B. (2013). The Variables Problem and Progress in Psychotherapy Research. *Psychotherapy, 50*(1), 33-41.

Teodorescu, D. S., Heir, T., Hauff, E., Wentzel-Larsen, T., & Lien, L. (2012). Mental health problems and post-migration stress among multi-traumatized refugees attending outpatient clinics upon resettlement to Norway. *Scandinavian Journal of Psychology, 53*(4), 316-332.

Toomela, A. (2007). History of Methodology in Psychology: Starting Point, Not the Goal. *Integrative Psychological and Behavioral Science, 41,* 75-82.

Tummala-Narra, P., Kallivayalil, D., Singer, R., & Andreini, R. (2012). Relational experiences of complex trauma survivors in treatment: Preliminary findings from a naturalistic study. *Psychological Trauma: Theory, Research, Practice, & Policy, 4*(6), 640-648.

van der Kolk, B. A. (2005). Developmental Trauma Disorder. Toward a rational diagnosis for children with complex trauma histories. *Psychiatric Annals, 35*(5), 401-408.

van der Kolk, B. A., Pelcovitz, D., Roth, S., Mandel, F. S., McFarlane, A., & Herman, J. L. (1996). Dissociation, somatization, and affect dysregulation: The complexity of adaptation of trauma. *The American Journal of Psychiatry, 153*(7), 83-93.

van der Kolk, B. A., Roth, S., Pelcovitz, D., Sunday, S., & Spinazzola, J. (2005). Disorders of Extreme Stress: The Empirical Foundation of a Complex Adaptation to Trauma. *Journal of Traumatic Stress, 18*(5), 389-399.

Vanheule, S. (2015). *Psychodiagnostiek anders bekeken: Kritieken op de DSM. Een pleidooi voor functiegerichte diagnostiek.* Tielt: Lannoo.

Verhaeghe, P. (2004). *On being normal and other disorders: A manual for clinical psychodiagnostics.* New York, NY, USA: Other.

Walsh, D., & Downe, S. (2005). Meta-synthesis method for qualitative research: A literature review. *Journal of Advanced Nursing, 50*(2), 204-211.

Walsh, K., Fortier, M. A., & DiLillo, D. (2010). Adult Coping with Childhood Sexual Abuse: A Theoretical and Empirical Review. *Aggression and Violent Behavior, 15*(1), 1-13.

Wilczek, A., Weinryb, R. M., Barber, J. P., & Gustavsson, P. (2010). The Core Conflictual Relationship Theme (CCRT) and psychopathology in patients selected for dynamic psychotherapy. *Psychotherapy research, 10*(1), 100-113.

Zilberstein, K., & Messer, E. A. (2010). Building a Secure Base: Treatment of a Child with Disorganized Attachment. *Clinical Social Work Journal, 38*, 85-97.

Zorzella, K. P., Muller, R. T., & Classen, C. C. (2014). Trauma group therapy: The role of attachment and therapeutic alliance. *International Journal of Group Psychotherapy, 64*(1), 24-47

NEDERLANDSE SAMENVATTING

De aard en het belang van de interpersoonlijke verhouding in de behandeling van aan complex trauma gerelateerde problematieken

Dit proefschrift handelt over de aard van interpersoonlijke relaties in complex trauma in termen van de interpersoonlijke gevolgen en het belang van het doorwerken van dominante interpersoonlijke patronen in de behandeling.

In *hoofdstuk 1* wordt het onderscheid tussen traumatische ervaringen en traumatische reacties uitgewerkt. Op vlak van de ervaring kan een onderscheid gemaakt worden tussen gebeurtenissen die acuut of chronisch zijn en of er al of niet een interpersoonlijke component meespeelt (Verhaeghe, 2004). Op die manier kan gedifferentieerd worden tussen acuut niet-interpersoonlijke traumatische gebeurtenissen (bv. een natuurramp), acuut interpersoonlijke traumatische gebeurtenissen (bv. aanranding), chronisch niet-interpersoonlijke traumatische gebeurtenissen (bv. hongersnood) en chronisch interpersoonlijke traumatische gebeurtenissen of complex trauma (bv. kindermisbruik, Herman, 1992). De dominante visie op traumatische reacties vertrekt vanuit een impliciete mechanistische logica waarbij de klachten of symptomen worden begrepen als het logische gevolg op het meemaken van een bepaalde traumatische gebeurtenis. Het risico bestaat hierbij dat men, ook in de behandeling, geen rekening houdt met de subjectieve processen die betrokken zijn bij de ontwikkeling van symptomen (Bistoen, Vanheule, & Craps, 2014).

We vertrekken vanuit een psychoanalytisch/psychodynamisch kader om het belang van de relatie tussen subject en Ander aan te tonen met betrekking tot de ontwikkeling van symptomen ten gevolge van het meemaken van (een) traumatische gebeurtenis(sen). Mensen geven *betekenis* aan gebeurtenissen en dit betekenisverleningsproces verloopt binnen de verhouding tussen subject en Ander. De Ander verwijst niet alleen naar concrete anderen, maar ook naar de taal en de ruimere culturele invloeden. Binnen de verhouding tussen subject en primaire verzorgingsfiguren vormt zich een representationeel Symbolisch-Imaginair kader van waaruit het subject zichzelf, anderen en de wereld benadert en betekenis wordt verleend aan gebeurtenissen (Verhaeghe, 2004). Vanuit dit perspectief wordt trauma begrepen als een breuk in het Symbolisch-Imaginair kader waardoor het subject op een brutale wijze geconfronteerd wordt met het Reële (Bistoen, 2016; Chiriaco, 2012). Om de vraag te beantwoorden waarom

bepaalde personen er wel en anderen er niet in slagen om de traumatische gebeurtenis ‘een plaats te geven’, verwijzen we naar een verstoorde verhouding tussen subject en Ander. We bespreken hierbij de situatie waarbij in de primaire verhouding tussen subject en Ander onvoldoende woorden en representaties werden gegeven of overgenomen waardoor men bij de confrontatie met een traumatische gebeurtenis niet kan terugvallen op een Symbolisch-Imaginair kader om het traumatisch Reële te representeren of om te vormen. Een andere mogelijkheid is dat een Symbolisch-Imaginair kader tot stand kwam binnen een traumatische verhouding tussen subject en Ander waarbij het representationeel kader een antwoord moest bieden op de traumatische antecedenten. We besluiten dat het voor de diagnostiek en behandeling van patiënten met een geschiedenis van complex trauma cruciaal is om inzicht te verwerven in hoe het subject betekenis verleent, d.i. de manier waarop het subject zichzelf, anderen en de wereld begrijpt.

In *hoofdstuk 2* wordt een systematisch overzicht geboden van de beschikbare theoretische en empirische literatuur met betrekking tot de interpersoonlijke aspecten bij complex trauma. We hebben via Web of Science met de zoektermen “Complex trauma OR complex PTSD OR DESNOS” AND “Interpersonal OR relation¨” 94 artikels geselecteerd die voldoen aan volgende inclusiecriteria: a) uit abstract of titel blijkt dat het artikel focust op interpersoonlijke kenmerken bij trauma, b) de primaire diagnose is gerelateerd aan trauma en c) de Engelse taal wordt gehanteerd. Aan de hand van een thematische analyse (Brown & Clarke, 2006) vonden we dat interpersoonlijke aspecten bij complex trauma in drie gerelateerde onderzoekslijnen voorkomt, met name in onderzoek naar de etiologie, de gevolgen en de behandeling van complex trauma.

Op vlak van de *etiologie* toont het gros van empirische studies aan dat de blootstelling aan complex trauma leidt tot ernstiger psychisch lijden dan (herhaald) niet-interpersoonlijke traumatische gebeurtenissen (Cloitre, Garvert, Brewin, Bryant, & Maercker, 2013; Ehring & Quack, 2010; Newman, Riggs, & Roth, 1997). Vooral in de context van kindermishandeling, waarbij de gewelddaden gepleegd worden door primaire zorgfiguren, zijn de psychische gevolgen nefast (Forbes et al., 2014; Kisiel et al., 2014). Vanuit de hechtingstheorie kan dit verklaard worden aangezien binnen de verhouding tot de primaire zorgfiguren belangrijke ontwikkelingsprocessen zich voltrekken, zoals effectieve emotieregulatie en interpersoonlijke vaardigheden (Briere, Hodges, & Godbout, 2010; Ehring & Quack, 2010), die nodig zijn om met aversieve gebeurtenissen om te gaan. Bij complex trauma worden deze ontwikkelingsprocessen ondermijnd (Briere & Jordan, 2009; Pressley & Spinazzola, 2015) en

worden interpersoonlijke patronen of schema's, d.i. de karakteristieke manier om over zichzelf, anderen en de wereld te denken, gevormd om om te kunnen gaan met de onveilige situatie (DePrince, Chu, & Pineda, 2011; Walsh, Fortier, & DiLillo, 2010). Deze dominante interpersoonlijke patronen hebben een blijvende invloed op het functioneren en kleuren de manier waarop personen die blootgesteld werden aan complex trauma op latere leeftijd zich verhouden tot anderen (Gleiser, Ford, & Fosha, 2008; Ma & Li, 2014; van der Kolk et al., 1996; Zilberstein & Messer, 2007).

Op het niveau van de *interpersoonlijke gevolgen* wordt in de literatuur vooral het gebrek aan vertrouwen in anderen naar voorgeschoven (Jepsen, Langeland, & Heir, 2013; Lawson, Davis, & Brandon, 2013; Tummala-Narra, Kallivayalil, Singer, & Andreini, 2012). Verder worden interpersoonlijke interacties getekend door een negatief zelfbeeld waarbij gevoelens van schaamte, schuld, hopeloosheid, hulpeloosheid, kwetsbaarheid en waardeloosheid de bovenhand nemen (Allen, Huntoon, & Evans, 1999; Ebert & Dyck, 2004). Er zijn verschillende empirische studies die de karakteristieke verhouding tussen patiënt en anderen hebben bestudeerd aan de hand van de Core Conflictual Relationship Theme (CCRT) methode (Luborsky & Crits-Christoph, 1998). De CCRT biedt een operationalisatie voor de karakteristieke manier waarop een persoon in verhouding tot anderen staat via de beschrijving van de dominante wens (wish, W) de gepercipieerde respons van de ander (response of other, RO) en de gepercipieerde eigen reactie (response of self, RS). De resultaten wijzen uit dat de dominante CCRT componenten bij patiënten met een voorgeschiedenis van complex trauma bestaan uit de wens geliefd en begrepen te worden (Chance, Bakeman, Kaslow, Farber, & Burge-Callaway, 2000) of om anderen tegen te werken, te controleren of te kwetsen (Drapeau & Perry, 2009). Anderen worden gezien als afwijzend en dwarsbomend (Chance et al., 2000), controlerend of ronduit slecht (Drapeau & Perry, 2009). De patiënt zelf ervaart gevoelloosheid (Drapeau & Perry, 2009) of teleurstelling en depressiviteit (Chance et al., 2000).

Tot slot, op het niveau van de *behandeling* van aan complex trauma gerelateerde problematieken, gaan steeds meer stemmen op om in de therapie in te werken op de interpersoonlijke moeilijkheden waarmee patiënten kampen (Ford, Courtois, Steele, van der Hart, & Nijenhuis, 2005; Newman et al., 1997). Hierbij wordt een fasegerichte behandeling naar voorgeschoven waarbij in een eerste fase vooral gefocust moet worden op veiligheid, stabiliteit en de ontwikkeling van emotionele, gedragsmatige en relationele vaardigheden (Cloitre et al., 2011; Drozdek, 2015). Een eerste belangrijke stap hierbij is de formatie van een duurzame en werkbare therapeutische relatie (Arntz, 1994; Herman, 1992; Ford et al., 2005). De therapeutische relatie vormt immers de basis om de interpersoonlijke dynamieken die tot

stand gekomen zijn binnen de verhouding tot de primaire hechtingsfiguren te herzien en te herwerken (Blalock et al., 2013; Pressley & Spinazzola, 2015). De ontwikkeling van een veilige therapeutische verhouding wordt echter bemoeilijkt door het feit dat dominante interpersoonlijke patronen ook de relatie ten opzichte van de therapeut tekenen in die zin dat patiënten de behandeling starten met een fundamenteel gevoel van wantrouwen (Ebert & Dyck, 2004; Gleiser et al., 2008; Pearlman & Courtois, 2005). Er zijn verschillende behandelingsmodellen die vooral focussen op het tot stand brengen van stabiliteit (Gleiser et al., 2008; Jepsen et al., 2013; Zorzella, Muller, & Classen, 2014). Andere behandelingsmodellen schuiven stabilisatie naar voor als een voorwaarde om de traumatische ervaringen meer in de diepte te kunnen exploreren, integreren en verwerken in een volgende fase in de therapie (Cloitre et al., 2011; Drozdek, 2015).

Op basis van onze systematische literatuurstudie wordt het belang van de interpersoonlijke verhouding duidelijk aangetoond op vlak van de etiologie, gevolgen en behandeling van complex trauma. We besluiten dat verschillende vragen nog beantwoord dienen te worden en dit vooral op vlak van de aard van de interpersoonlijke dynamieken die spelen in de nasleep van complex trauma en de wijze waarop de behandeling hierop kan inspelen. Meer bepaald werd nog onvoldoende onderzocht op welke manier een veilige therapeutische relatie tot stand komt, welke therapeutische interventies bijdragen tot het tot stand komen van de therapeutische relatie en hoe interpersoonlijke dynamieken veranderen doorheen therapie. Hieruit ontsproten volgende onderzoeksvragen:

- Wat is de specifieke aard van de interpersoonlijke patronen bij complex trauma?
- Op welke wijze veranderen deze interpersoonlijke patronen doorheen therapie?
- Hoe komt de therapeutische relatie tot stand in de behandeling?
- Welke interventies worden gebruikt om interpersoonlijke problemen te adresseren in de behandeling?

Deze vragen worden onderzocht aan de hand van *drie systematische single case studies*. Single case studies laten toe om de complexe en dynamische structuur van interpersoonlijke patronen en het proces van verandering in de diepte te bestuderen (Desmet, 2018; Stiles, 2003; Toomela, 2007). De gevallen zijn aan de hand van twee inclusiecriteria geselecteerd, namelijk 1) er dient een voorgeschiedenis aanwezig te zijn van langdurig en herhaald interpersoonlijk geweld – d.i. complex trauma, en 2) de toegepaste behandeling betreft supportieve-expressieve psychodynamische therapie – d.i. een therapie die focust op (het doorwerken van) interpersoonlijke problemen. De cases zijn geselecteerd uit de ruimere onderzoeksprojecten

(Single Case Studies, SCS, en de Ghent Psychotherapy Study, GPS, Meganck et al., 2017) binnen de vakgroep Psychoanalyse en Raadplegingspsychologie omdat de ruime dataverzameling binnen deze projecten de rigoureuze uitwerking van systematische outcome- en processtudies mogelijk maakt. Dominante interpersoonlijke patronen zijn onderzocht via de Inventory of Interpersonal Problems (IIP-32, Horowitz, Alden, Wiggins, & Pincus, 2000) en via de Core Conflictual relationship Theme (CCRT) methode (Luborsky & Crits-Christoph, 1998) waarbij verschillende Relationship Episodes – d.i. fragmenten uit de transcripten van therapiesessies waarin specifiek wordt ingegaan op een interactie tussen de patiënt en een concrete andere persoon – gecodeerd worden aan de hand van standaardcategorieën die bestaan uit 35 Ws, 30 ROs en 31 RSs. De therapeutische relatie is bestudeerd aan de hand van een kwalitatieve thematische analyse (Brown & Clarke, 2006) en de Werkalliantievragenlijst (WAV, Horvath & Greenberg, 1989). Therapeutische interventies zijn geïnventariseerd via de Penn Adherence/Competence Scale for Supportive-Expressive Therapy (PACS-SE, Barber & Crits-Christoph, 1996) waarbij elke interventie is gecategoriseerd als een neutrale interventie (bv. neutrale vragen), een supportieve of ondersteunende interventie (bv. uitingen van begrip en acceptatie) of een expressieve interventie of interpretatie (bv. feedback over dominante interpersoonlijke patronen). Ons onderzoeksopzet is gesystematiseerd door de toepassing van consensusprocedures en triangulatie van onderzoekers, methodes en instrumenten (Jackson, Chui, & Hill, 2011). Daarnaast is er telkens ook een rijke beschrijving van de ruimere context, de interpersoonlijke patronen en het proces van verandering (Desmet, 2018; Fishman & Messer, 2013; Vanheule, 2015).

In *hoofdstuk 3* wordt de specifieke aard van interpersoonlijke patronen en de verandering in deze patronen doorheen de therapie bestudeerd in de casus van James. James is op het moment dat de therapie startte 23 jaar oud. Hij kampt met dissociatieve episodes waarin hij onder meer zijn vriendin, Rebecca, bedriegt en dure aankopen doet zonder zich daar achteraf iets van te herinneren. Dit zorgt voor ernstige problemen in zijn relatie met Rebecca. James' symptomen kunnen worden teruggekoppeld naar zijn traumatische voorgeschiedenis. James' vader pleegde verbaal en fysiek geweld jegens James en zijn broers. Daarnaast is duidelijk dat de thema's seksualiteit en geld zijn voorgeschiedenis tekenden. Zo vertelt James dat seksualiteit steeds in de doofpot werd gestoken en dat hij geen zakgeld kreeg, ondanks de vele klusjes die hij moest verrichten in en rond het ouderlijke huis. De parallel met zijn volwassen relatie bestaat eruit dat Rebecca erg weigerachtig is om te praten over het feit dat zij nagenoeg nooit zin heeft om te vrijen met James en daarnaast James ook zijn autonomie ontneemt door hem te

verplichten klusjes te verrichten in huis alvorens bepaalde aankopen te mogen doen. Zowel binnen zijn verhouding ten aanzien van zijn vader als in zijn latere verhoudingen vertoont James een duidelijk patroon van het inwilligen van de wensen van anderen ondanks het feit dat hij zich gefrustreerd en teleurgesteld voelt. Deze patronen vertalen zich in de volgende dominante CCRT componenten bij aanvang van de therapie: de wens voor nabijheid en om belangrijk te zijn voor anderen (W 'to be close to others', 'to be respected'), de respons van de ander die gepercipieerd wordt als afwijzend en distantiërend (RO 'rejecting', 'distant') en de eigen reactie die getekend wordt door teleurgestelde en depressieve gevoelens (RS 'disappointed', 'depressed').

Rond het midden van de therapie is er sprake van een mislukte zelfmoordpoging. De reacties van zijn directe omgeving (zijn moeder, vriendin Holly) zijn erg liefdevol, begripvol en ondersteunend. De dominante CCRT componenten tonen hoe zijn wens om gerespecteerd en geliefd (W 'to be respected', 'to be close to others') te worden binnen deze fase in de therapie wel ingewilligd wordt door de ander (RO 'respect me', 'are helpful', 'loves me') waardoor James zich erg geliefd en gerespecteerd voelt (RS 'feel respected', 'feel loved').

In tegenstelling tot de tweede fase waarin James over zijn verhoudingen spreekt op een eerder geïdealiseerde manier, zien we dat naar het einde van de therapie James een meer dynamische en genuanceerde houding aanneemt in de manier waarop hij zichzelf en anderen binnen zijn verhoudingen ziet. De dominante wens blijft deze naar nabijheid en om gerespecteerd te worden door anderen (W 'to be close to others', 'to be respected'). De reactie van de ander wordt nu zowel op een negatieve manier (RO 'oppose me', 'are rejecting, 'are angry') als op een positieve manier (RO 'respecting', 'understanding', 'cooperative') gepercipieerd. Dit resulteert in voornamelijk positieve reacties bij James zelf, waarbij hij zich meer open voelt, meer zelfvertrouwen heeft en het gevoel heeft meer controle te hebben over de desbetreffende situaties (RS 'am open', 'feel self-confident', 'feel self-controlled'). Er is dus een duidelijk contrast in de manier waarop James in verhouding treedt met de ander. Daar waar hij vroeger zijn mond hield en zijn frustraties opkropte, kan hij nu zijn eigen ideeën en gevoelens uitspreken en uitdrukken.

In *hoofdstuk 4* wordt in de casus van Amy bestudeerd op welke manier dominante interpersoonlijke patronen veranderen doorheen de therapie en hoe die verandering geplaatst kan worden binnen een therapeutisch proces. Bij aanvang van de therapie is Amy 26 jaar oud. Ze heeft een voorgeschiedenis van fysiek en psychologisch misbruik gepleegd door haar vader. Op verschillende momenten dreigde haar vader om Amy te laten institutionaliseren aangezien

ze ‘gek’ of ‘zot’ was. De vrees om als gek aanschouwd te worden door anderen tekent ook haar latere verhoudingen. Zowel in haar kindertijd als op volwassen leeftijd slaagt Amy er niet in om haar gevoelens op een vrije manier te uiten. Daarnaast vervormt ze soms bewust haar uitspraken en praat ze mensen naar de mond om te vermijden dat ze gek bevonden zou worden.

Bij de start van de therapie wordt Amy’s wens dat haar particuliere gevoelens, ambities en verlangens begrepen en gerespecteerd worden (W ‘to be open’, ‘to be understood’, ‘to be respected’) door anderen beantwoord met kritiek, dominantie, afwijzing en onbegrip (W ‘are not understanding’, ‘are controlling’, ‘are rejecting’, ‘don’t respect me’). De wens om zichzelf te beschermen en anderen te controleren (W ‘to not be hurt’, ‘to have control over others’) en de eigen reactie van stilte of manipulatie (W ‘am not open’, ‘am controlling’) kunnen binnen dit kader begrepen worden. Daarnaast vertoont Amy duidelijke gevoelens van angst, schaamte, kwaadheid, hulpeloosheid, onzekerheid en teleurstelling (RS ‘feel anxious’, ‘feel ashamed’, ‘feel angry’, ‘am helpless’, ‘am uncertain’, ‘feel distappointed’).

In het midden van de therapie zien we dat de wens om niet gekwetst te worden niet langer op de voorgrond staat. De wensen om begrepen, geaccepteerd en gerespecteerd te worden en om open te kunnen zijn (W ‘to be understood’, ‘to be accepted’, ‘to be respected’, ‘to be open’) blijven echter onthaald worden op onverschilligheid en onbegrip (RO ‘are distant’, ‘are not understanding’). Dit weerhoudt Amy niet om op een meer open manier in interactie met anderen te treden (RS ‘am open’) ondanks de blijvende gevoelens van kwaadheid, hulpeloosheid, onzekerheid en angst (RS ‘feel angry’, ‘am helpless’, ‘am uncertain’, ‘feel anxious’).

Op het einde van de therapie zien we dat de reacties van anderen blijvend negatief gepercipieerd worden (RO ‘are rejecting’, ‘are unhelpful’, ‘oppose me’, ‘are not understanding’). Deze responsen van anderen blijft gevoelens van kwaadheid, onzekerheid, hulpeloosheid, teleurstelling en onzekerheid opwekken (RS ‘feel angry’, ‘am helpless’, ‘feel disappointed’, ‘am uncertain’). Desalniettemin neemt Amy een meer zelfzekere en onafhankelijke houding aan in relatie tot anderen (RS ‘understand’, ‘am independent’, ‘feel self-confident’). Naast de wens om begrepen en geaccepteerd te worden (W ‘to be understood’, ‘to be accepted’), zien we op het einde van de therapie ook de wens verschijnen om zichzelf te kunnen zijn, op te kunnen komen voor zichzelf en zich daar ook goed bij te voelen (W ‘to be my own person’, ‘to feel good about myself’, ‘to assert myself’, ‘to be independent’). Deze verandering vertaalt zich in haar relaties in het nemen van afstand tegenover die personen die haar (soms moedwillig) kwaad berokkenen, zoals haar partner en haar moeder, en in het in

vertrouwen nemen van die personen die wel blijk geven van vertrouwen, zoals enkele vriendinnen.

Wat betreft het therapeutisch proces, blijkt dat de therapeutische relatie gemakkelijk geïnstalleerd kon worden. De scores op de subschalen van de WAV (Horvath & Greenberg, 1989) tonen dat bij aanvang en doorheen de therapie een gevoel aanwezig is van wederzijds vertrouwen en consensus over het doel en de richting van de therapie. Uit de kwalitatieve analyse van de semi-gestructureerde Client Change Interviews (CCI, Elliott, Slatick, & Urman, 2001) in het midden en op het einde van de therapie blijkt dat Amy vooral de neutrale, ondersteunende en geruststellende houding van de therapeut weet te appreciëren. Ze geeft specifiek aan dat ze – in parallel met andere verhoudingen – verwachtte dat de therapeut haar zou terechtwijzen en veroordelen. Aangezien dit niet het geval was, kon ze in de therapie openlijk communiceren. Een bijkomende factor die ze hierbij helpend vond, was het feit dat ze de therapie zelf kon sturen en niet in een bepaalde richting werd geduwd door de therapeut.

In tegenstelling tot wat we zouden verwachten op basis van de literatuur, namelijk dat veel supportieve technieken zouden aanwezig zijn bij aanvang van de therapie, zien we dat de therapeut vooral expressieve technieken gebruikt doorheen de volledige therapie. In eerste instantie zijn deze technieken vooral gericht op het verkrijgen van informatie en inzicht in de dominante interpersoonlijke patronen. Vrij vroeg in de therapie worden expressieve technieken ook aangewend om feedback te geven over de dominante interactiepatronen en het faciliteren van het innemen van een nieuwe positie ten aanzien van anderen. Supportieve technieken worden bij aanvang van de therapie vooral gebruikt om vertrouwen en hoop te installeren. Naarmate de therapie vordert, worden supportieve technieken vooral aangewend om blijk te geven van erkenning, acceptatie en respect en om de veranderingen waar Amy over getuigt te ondersteunen.

Op basis van de resultaten kunnen we besluiten dat de dominante interpersoonlijke patronen die Amy's interacties tekenen ook in de therapeutische verhouding verschijnen. Zo verwachtte Amy initieel dat de therapeut op de gebruikelijke negatieve wijze zou reageren. De therapeut reageerde echter niet met verwijten of aanmaningen waardoor Amy niet op haar typische manier van stilzwijgen of gemanipuleerde uitspraken was aangewezen. Door de nieuwe relationele ervaring die werd gecreëerd binnen het therapeutisch kader, was het mogelijk voor Amy om haar gevoelens, gedachten en verlangens op een openlijke manier te communiceren naar de therapeut toe. Buiten de therapie nam Amy ook een nieuwe, meer zelfverzekerde en open houding aan tegenover anderen en nam ze afstand van die personen die een blijvend negatieve houding tegenover haar aannamen.

De casus van Pam wordt besproken in *hoofdstuk 5*. De dominante interpersoonlijke patronen worden onderzocht bij aanvang en doorheen de therapie. Daarnaast wordt bestudeerd hoe de therapeutische relatie tot stand komt en welke interventies worden gebruikt doorheen de therapie. Pam is 33 jaar oud op het moment dat de therapie startte. Ze voldoet aan de criteria van een majeure depressieve stoornis met een seizoensgebonden karakter, agorafobie en een verstoring van de lichaamsbeleving. Op haar 17 jaar werd ze gediagnosticeerd met epilepsie. Pam heeft een voorgeschiedenis van psychologisch en fysiek misbruik gepleegd door haar moeder. Ook op volwassen leeftijd gaat ze gebukt onder de tirannie van haar ouders die zich vooral vertaalt in het veelvuldig moeten incasseren van kritiek zonder zich daartegen te kunnen verweren. Bij aanvang van de therapie kan Pams dominante interpersoonlijke patroon worden beschreven als de wens om enerzijds conflict te vermijden en niet gekwetst te worden en anderzijds om voor zichzelf te kunnen opkomen en gerespecteerd en erkend te worden (W 'to avoid conflict', 'to not be responsible or obligated' , 'to assert myself', to be respected'). De veelvuldig gepercipieerde kritiek en dominantie van anderen (RO 'are rejecting', 'are controlling') gaan gepaard met gevoelens van angst en de neiging om zich passief en zwijgend over te leveren aan de ander (RS 'am not open', 'am dependent', 'feel anxious'). Deze interpersoonlijke dynamiek karakteriseert niet alleen de verhouding van Pam ten opzichte van haar ouders in het verleden. Ook de manier waarop ze courant in interactie treedt met haar ouders en anderen (bv. partner, bazen) wordt gekleurd door dit interpersoonlijk patroon.

Naarmate de therapiesessies vorderen, wordt de manier waarop de reactie van anderen gepercipieerd wordt verder verduidelijkt. De nadruk komt hierbij niet alleen te liggen op het feit dat anderen kritisch en controlerend zijn (RO 'are rejecting', 'are controlling'). Het wordt ook zichtbaar dat anderen haar niet respecteren, onbegrip tonen en algemeen niet responsief, noch beschikbaar zijn (RO 'don't respect me', 'are not understanding', 'are distant'). Naast de wens om onder andere conflicten te vermijden (W 'to avoid conflict'), verschijnt ook de wens om erkend te worden in verschillende facetten (geaffirmeerd worden, gerespecteerd worden, anderen die interesse tonen, W 'to be accepted', 'to be respected', 'to be liked') en de wens meer open te zijn (W 'to be open'). Gezien de negatieve respons van anderen, blijft Pam zwijgen en voelt ze zich hulpeloos, onzeker, kwaad, angstig, afhankelijk, teleurgesteld en ongeliefd (RS 'am not open', 'am helpless', 'am uncertain', 'feel angry', 'feel anxious', 'am dependent', 'feel disappointed', 'feel unloved').

Op het einde van de therapie blijven de interpersoonlijke verhoudingen gekleurd door negatieve gepercipieerde responsen van anderen (RO 'are strong', 'are controlling', 'are not understanding', 'don't respect me', 'are distant', 'are rejecting', 'are not trustworthy') en

negatieve eigen responsen (RS ‘am not open’, ‘am dependent, ‘feel disappointed’, ‘oppose others’, am helpless’). De manier waarop Pam uitdrukking geeft aan haar verlangen wijst wel nog steeds meer in de richting van de wens dat anderen oprechte interesse tonen (W ‘to be respected’, ‘to have trust’, ‘to be liked’, ‘to be accepted’, ‘to be understood’) en de wens met anderen een open communicatie te kunnen onderhouden (W ‘to be open’, ‘to be opened up to’). De belangrijkste verschuiving in de dominante interpersoonlijke patronen in de casus van Pam kan dan ook als volgt samengevat worden. Daar waar bij aanvang van de therapie de wensen vooral op een passieve manier worden gearticuleerd, in de zin van het willen vermijden van de geanticipeerde negatieve respons van anderen, geeft Pam naarmate de therapie vordert steeds meer uitdrukking van een eigen verlangen om als persoon erkend te worden door anderen en op een deugdzame manier in interactie te kunnen treden met anderen.

Met betrekking tot het therapeutisch proces, blijkt uit de kwantitatieve en kwalitatieve analyses in eerste instantie dat een vertrouwensband tussen therapeut en patiënt vrij makkelijk geïnstalleerd wordt. Zo beschrijft Pam de therapeut als een vriendelijk en professioneel iemand waarbij ze zich open kan opstellen. De kwantitatieve en kwalitatieve maten zijn echter onvoldoende in staat om de onderliggende interpersoonlijke dynamieken in kaart te brengen. Er zijn immers indicaties dat de dominante interpersoonlijke patronen ook de therapeutische verhouding beïnvloeden. Hoewel Pam de therapeutische context rationeel inschat als een veilige omgeving om te praten, kan ze inherent geen gevoel van vertrouwen aan de dag leggen.

Deze observatie kan ook in verband gebracht worden met de grillige sequens in het gebruik van therapeutische interventies. De therapeut hanteert in eerste instantie meer expressieve interventies en past slechts na verloop van 12 therapiesessies meer supportieve interventies toe. Expressieve technieken worden vooral aangewend om de dominante interpersoonlijke dynamieken in kaart te brengen, verder te exploreren en door te werken. Pam neemt hier eerder een terughoudende houding aan en antwoordt steeds kort of afwijzend (bv. ‘Ik weet het niet.’). Daarnaast krijgt Pam meer last had van lichamelijke symptomen, gaande van een onbenoembare ervaren spanning tot het hebben van epileptische insulten en depressieve gevoelens. De achteruitgang in haar algemeen welbevinden linkt Pam direct aan de stress gekoppeld aan het bespreken van de moeilijke verhouding die ze ervaart ten opzichte van anderen. Het komt tot het punt dat Pam na sessie 11, een sessie waarna ze ook een epileptische aanval krijgt net na de therapiesessie, een e-mail stuurt naar de therapeut waarin ze haar twijfel uitdrukt om verder te komen spreken *omdat* ze de therapeut niet langer lastig wilt vallen. De therapeut bespreekt hierop de casus van Pam in supervisie. Hierin stelt ze haar eigen verlangen om rond de traumatische verhouding tussen Pam en haar ouders te werken in vraag en komt ze

tot de conclusie dat een meer supportieve aanpak, met meer aandacht voor de lichamelijke klachten en de (interpersoonlijke) moeilijkheden die Pam in het hier en nu ervaart, misschien meer aangewezen is. In de daaropvolgende sessies is er een duidelijk verschil in de mate waarin supportieve en expressieve technieken worden aangewend. Meer bepaald is er een duidelijk overwicht van supportieve technieken en is er meer aandacht voor de grenzen van Pam. Dit zien we bijvoorbeeld gereflecteerd in het feit dat de therapeut vaker focust op de moeilijkheden die Pam zelf naar voorschuift, zoals het hebben van een dagelijkse routine, de verhouding tot haar lichaam en het belang van een stabiele werksituatie. Wanneer dominante interpersoonlijke moeilijkheden nu aan bod komen, zien we ook dat de therapeut meer voorzichtig en minder volhardend is en haar expressieve interventies fundeert op een supportieve basis. Daarbij is het belangrijk om op te merken dat de dominante interpersoonlijke verhoudingen en de moeilijkheden die Pam daarin ervaart niet worden geschuwd. De therapeut wijst op verschillende instanties op de meerlaligheid van Pam's moeilijkheden, in die zin dat de moeilijkheden die Pam courant ervaart in verband kunnen worden gebracht met en beïnvloed worden door de verhouding tot haar primaire verzorgingsfiguren. De therapeut laat nu echter de keuze aan Pam om op deze thema's al of niet verder te werken. Gezien Pam zich beduidend beter voelt op het einde van de therapie, besluit ze deze piste niet verder te bewandelen met dien verstande dat ze de therapeut opnieuw zal contacteren mocht de problematische verhouding ten opzichte van anderen met haar dagelijks leven interfereren.

Ultiem kunnen we besluiten dat doordat de therapeut een andere positie innam een nieuwe relationele ervaring mogelijk werd gemaakt voor Pam waardoor ze in de therapie op een meer veilige manier kon communiceren. Hiertoe droegen niet alleen de prevalente supportieve technieken bij, maar ook de meer algemene, 'neutrale' interventies (bijvoorbeeld specifieke, niet geladen, vragen stellen om dieper in te gaan op een bepaalde situatie) waarmee de therapeute een oprechte interesse vertoonde in wat Pam te berde te brengen had. Desalniettemin dienen we ook te besluiten dat de dominante interpersoonlijke patronen waarmee Pam in de therapie stapte nauwelijks werden aangeroerd en dat Pam moeilijkheden bleef ervaren inzake het vertrouwen van anderen en open kunnen zijn ten aanzien van anderen. Samengevat kunnen we stellen dat hoewel de therapie symptomatische verlichting bracht, er fundamenteel weinig gewijzigd is in de manier waarop Pam in verhouding staat ten opzichte van anderen.

In *hoofdstuk 6* worden de bevindingen van de casussen van James, Amy en Pam met elkaar in verband gebracht en worden gelijkenissen en verschillen met betrekking tot de aard

en verandering van dominante interpersoonlijke patronen en het therapeutisch proces onderzocht aan de hand van een meta-synthese (Iwakabe & Gazzola, 2009). Via een hogere orde abstractie van de gegevens van de drie gevallen kunnen er nieuwe inzichten ontstaan, voorbij het niveau van de individuele casus (Walsh & Downe, 2005), waardoor we onze kennis over interpersoonlijke patronen bij complex trauma verder kunnen verruimen.

De dominante interpersoonlijke patronen, zoals gecodeerd aan de hand van de CCRT, vertonen enkele opmerkelijke overeenkomsten in de drie casussen. De dominante wens bestaat in alle drie de gevallen bij aanvang van de therapie uit een verlangen om gerespecteerd (W 'to be respected') te worden door anderen enerzijds en niet gekwetst te worden (W 'to not be hurt') anderzijds. Anderen worden gepercipieerd als afwijzend, onbegripvol, respectloos en afstandelijk (RO 'are rejecting', 'are not understanding', 'are disrespectful', 'are distant'). De voornaamste respons van de subjecten is een gevoel van kwaadheid (RS 'feel angry'). In alle drie de gevallen blijkt duidelijk dat ze hun frustraties niet openlijk kenbaar maken en zich eerder passief overleveren aan de caprices van anderen. Dit toont zich ook in andere dominante reacties zoals niet open zijn, afhankelijk zijn en zich hulpeloos voelen (RS 'am not open', 'am dependent', 'am helpless').

Onze bevindingen met betrekking tot de dominante interpersoonlijke patronen komen gedeeltelijk overeen met wat in de literatuur reeds werd gevonden, maar nopen vooral ook tot verdere nuancering (Stiles, 2013). We hebben ondersteuning gevonden voor de dominante wens voor erkenning en nabijheid (W 'to be close and accepted', 'to be loved and understood', Chance et al., 2000; Okey, McWirther, & Delaney, 2000). De contrasterende wens om anderen tegen te werken, te kwetsen of te controleren (W 'to oppose others', 'hurt others', 'control others' (Drapeau & Perry, 2009; Frueh, Turner, Beidel, & Cahill, 2001) komt enkel voor in de casus van Amy. Hierbij kan de kanttekening gemaakt worden dat deze wensen, samen met de wens om niet gekwetst te worden, eerder in functie staan van de geanticipeerde frustratie van het verlangen om erkend en geliefd te worden.

Met betrekking tot de dominante gepercipieerde respons van anderen is er sterke ondersteuning voor de perceptie van anderen als afwijzend en controlerend (RO 'are rejecting', 'are controlling'). De opmerkelijkste bevinding binnen deze context is dat een gebrek aan vertrouwen in de ander (RO 'are not trustworthy') slechts enkele malen expliciet wordt aangehaald terwijl dit in de literatuur als kerncomponent naar voor wordt geschoven (Hodgdon, Kinniburgh, Gabowitz, Blaustein, & Spinazzola, 2013; Pearlman & Courtois, 2005). Dit wil echter niet zeggen dat wantrouwen niet impliciet speelde binnen de verhouding tussen subject en anderen en binnen de therapeutische verhouding.

Wat betreft de eigen gepercipieerde respons in de verhouding tot anderen is er evidentie voor depressieve, hulpeloze en teleurgestelde gevoelens en de neiging om gesloten te zijn (RS 'feel depressed', 'am helpless', 'feel disappointed', Ebert & Dyck, 2004; Godbout, Sabourin, & Lussier, 2009). In tegenstelling van wat we zouden verwachten op basis van de literatuur (Allen et al., 1999) staan gevoelens van schaamte en schuld veel minder op de voorgrond. Daarentegen blijken gevoelens van kwaadheid veel meer aanwezig te zijn (Frueh et al., 2001), zij het dat deze gevoelens niet tot uitdrukking worden gebracht. Het onvermogen om kwaadheid te uiten kan in verband gebracht worden met het vermijden van de geanticipeerde negatieve respons van de ander, wat ook neerkomt op het niet ingewilligd worden van de wens naar liefde en zorg.

De dominante interpersoonlijke patronen kunnen over de drie gevallen heen als volgt worden samengevat: het subject probeert de *kritische en afwijzende reacties* van anderen te *vermijden* door een *passieve positie* in te nemen waarbij ze gedachten en gevoelens, die vooral getekend worden door een zekere *kwaadheid*, niet tot uitdrukking worden gebracht. Dit patroon tekent zowel de verhouding in de kindertijd, ten aanzien van de primaire verzorgingsfiguren, als in de volwassenheid, ten aanzien van ouders, partners, enzovoort. Op deze manier bieden onze resultaten ondersteuning voor het idee uit de hechtingstheorie dat in de vroege verhouding ten aanzien van de primaire zorgfiguren schema's ontwikkelen die alle latere verhoudingen kleuren (Gleiser et al., 2008; Walsh et al., 2010), waaronder ook de verhouding ten aanzien van de therapeut.

Doordat de therapeuten zich anders positioneren dan James, Amy en Pam verwachtten van anderen in hun onmiddellijke omgeving, is het voor hen niet langer nodig om de gevreesde negatieve respons te vermijden en kan ruimte gecreëerd worden om de interpersoonlijke patronen te exploreren en door te werken. We zien dat naarmate de therapie vordert de wens om niet gekwetst te worden (W 'to not be hurt') naar de achtergrond verdwijnt en passief geformuleerde wensen ('Ik wil niet dat…') plaats maken voor actief geformuleerde verlangens ('Ik wil dat …'). Er is ook een verschuiving in de dynamiek tussen de (geanticipeerde) respons van anderen en de eigen reacties. Daar waar in het midden van de therapie de eigen positieve of negatieve reactie veelal afhangt van en correspondeerde met de positieve of negatieve reactie van de ander – hetgeen suggereert dat de subjecten nog steeds een eerder passieve positie ten aanzien van de ander innemen – kunnen we vaststellen dat op het einde van de therapie de voornamelijk negatief gepercipieerde respons van de ander niet langer steeds gepaard gaat met negatieve gedachten of gevoelens. Buiten het feit dat alle drie de subjecten een meer actieve en dynamische positie in verhoudingen vertonen, kunnen we binnen de grote variëteit aan

positieve en negatieve responses van anderen en van de subjecten zelf geen typisch interpersoonlijk patroon identificeren op het einde van de therapie. Hieruit kunnen we besluiten dat de therapie het de subjecten mogelijk gemaakt heeft los te komen uit een eerder gefixeerde manier van in verhouding staan tot anderen.

Uit de vergelijking van de therapeutische processen van Amy en Pam komt de opmerkelijke bevinding naar voor dat de therapeutische verhouding schijnbaar vroeg binnen het therapeutisch proces geïnstalleerd wordt, wat indruist tegen het algemeen aanvaard idee dat door wantrouwen de therapeutische relatie moeilijk tot stand komt (Pearlman & Courtois, 2005). Er moet echter een onderscheid worden gemaakt tussen direct observeerbare gegevens (uit vragenlijst- en interviewmateriaal) en onderliggende interpersoonlijke dynamieken, wat impliceert dat deze bevinding genuanceerd moet worden. In beide gevallen kunnen we immers vaststellen dat dominante interpersoonlijke patronen zich op een subtiele en onbewuste manier herhalen binnen de therapie. Dit blijkt bijvoorbeeld uit de boodschap van Pam dat ze de therapeut vertrouwt omdat deze laatste gebonden is aan beroepsgeheim en de herhaalde opmerking van Amy dat wat ze gaat vertellen misschien wel raar zal klinken. Gezien Pam en Amy impliciet een negatieve reactie verwachten van hun therapeut, is het in eerste instantie niet veilig om zich bloot te geven in de therapie. Het is pas wanneer de therapeut manifest een andere positie inneemt, dat een veilige en meer open communicatie mogelijk wordt. Het belangrijkste besluit dat hieruit kan getrokken worden, is dat vertrouwenskwesties wel degelijk in acht dienen te worden genomen in de behandeling, maar dat een gebrek aan vertrouwen niet altijd even openlijk of duidelijk verschijnt in de therapie. Het is de taak van de therapeut om zich bewust te zijn van de onderliggende dynamieken die de verhouding tussen hem/haar en de patiënt tekenen, voorbij de meer expliciete of uitgesproken kwaliteiten van de therapeutische relatie. De resultaten van ons onderzoek wijzen hierbij op het belang van het in kaart kunnen brengen van de dominante interpersoonlijke patronen die de verhoudingen van de patiënt in het algemeen bepalen en het vermijden van de herhaling van de typische verhoudingsstijl door zich te positioneren als een andere ander.

De sterk verschillende therapeutische processen van Pam en Amy, in termen van de therapeutische interventies die worden aangewend door de therapeuten, druisen in tegen het verwachte patroon van een overwicht aan supportieve technieken bij aanvang van de therapie, gevolgd door meer expressieve technieken. Zowel bij Pam als bij Amy worden expressieve technieken vroeg in de therapie gebruikt om informatie te vergaren over dominante interpersoonlijke patronen. Naarmate de therapie vordert, worden steeds meer expressieve interventies gehanteerd om de dominante patronen in vraag te stellen en toe te werken naar een

andere manier van verhouden. Hier toont het behandelingstraject van Amy en Pam een belangrijk verschil. Amy is in staat om haar positie ten aanzien van anderen te ondervragen. Hierdoor kan de therapeut expressieve technieken blijven aanwenden om verder te werken rond de interpersoonlijke patronen en dragen supportieve technieken bij tot het ondersteunen van het proces van verandering. Specifiek in het geval van Amy hebben we ook gezien dat non-verbaal gedrag en intonatie mee kunnen bijdragen tot een supportieve sfeer waarbinnen expressieve technieken gebracht worden. Pam is anderzijds duidelijk niet in staat om op een veilige manier te praten over de punten waarop ze botst in interpersoonlijke verhoudingen, wat zich uit in een verslechtering van haar toestand. Na het bespreken van de casus van Pam in supervisie verandert de therapeut haar aanpak door meer supportieve technieken te gebruiken en meer te focussen op thema's die voor Pam belangrijk zijn, zoals haar lichaamsbeeld en dagelijkse routine. Dit zorgt voor een merkbare verbetering in de klachten. In het geval van Pam kan ook opgemerkt worden dat het stellen van neutrale vragen (d.i. algemene interventies) een ondersteunend effect kunnen hebben. Waar beide therapeuten dus van getuigen, is dat ze hun therapeutische aanpak duidelijk afstemmen op de (divergerende) impact die hun interventies hebben op de patiënt.

Op basis van de geaccumuleerde bevindingen kunnen we een aantal klinische implicaties naar voor schuiven. Ten eerste is het belangrijk dat therapeuten bewust zijn van de impact die hun interventies hebben op patiënten (Dimidijian & Hollon, 2010). Hierbij volstaat het niet om louter de symptomen en moeilijkheden te monitoren via systematische bevraging of vragenlijsten, aangezien er een discrepantie kan bestaan tussen de objectieve inschatting van de patiënt en de meer onbewuste dynamieken en onderliggende processen. Ten tweede is het aangewezen om als therapeut een zekere flexibiliteit aan de dag te leggen en therapeutische interventies responsief af te stemmen op de noden van de patiënt (Stiles, 1998). Ten derde kan het zinvol zijn om (moeilijke) patiënten te bespreken in supervisie (Dulsster & Vanheule, 2019) om licht te werpen op de dynamische wisselwerking tussen (de klachten van de) patiënt en (de interventies van de) therapeut en eventueel te komen tot nieuwe perspectieven met betrekking tot de behandeling. Ten vierde moeten patiënten voldoende autonomie of *agency* krijgen in de therapie en is het belangrijk om dit te faciliteren (Levitt, Pomerville, & Surace, 2016). Dit wilt zeggen dat patiënten onder meer in staat moeten gesteld worden om zelf de gesprekken te sturen, grenzen te kunnen stellen met betrekking tot de thema's die besproken worden en een gevoel van controle te ervaren in de therapie. Een laatste klinische implicatie die alle voorgaande omvat bestaat uit het belang zich bewust te zijn van de aard van interpersoonlijke patronen voor de diagnostiek en behandeling van patiënten met een geschiedenis van complex

trauma. Het belang hiervan is meervoudig, gezien de herhaling van dominante interpersoonlijke patronen in de therapie niet alleen nefaste gevolgen kan hebben voor de opbouw van de therapeutische relatie, maar ook nodig is om een andere positie te kunnen innemen en op die manier een ruimte te creëren waarin interpersoonlijke moeilijkheden kunnen besproken, herzien en doorwerkt worden, waardoor een andere verhouding net mogelijk wordt.

Deze klinische implicaties houden ook rechtstreeks verband met de theoretische en empirische implicaties met betrekking tot de diagnostiek en behandeling van aan complex trauma gerelateerde stoornissen. In de literatuur heerst een hardnekkige discussie met betrekking tot hoe de gevolgen van complex trauma het best kunnen gecapteerd worden. De vraag die hierbij wordt gesteld is of het hier gaat bij om meer extreme vormen van de klassieke Post Traumatische Stress Stoornis (PTSD, Teodorescu, Heir, Hauff, Wentzel-Larsen, & Lien, 2012) dan wel om een nieuw diagnostisch construct, zoals Complex PTSD (CPTSD, Herman, 1992) of Disorders of Extreme Stress Not Otherwise Specified (DESNOS, van der Kolk, 2005). De resultaten van ons onderzoek wijzen op het feit dat elke patiënt op een unieke en singuliere reageert op het meemaken van complex trauma (Harvey, 1996) en hulp vraagt voor zeer diverse redenen, gaande van de klassieke PTSD symptomen tot interpersoonlijke moeilijkheden en depressie (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). De *klinische casusformulering* (Vanheule, 2015) biedt meer mogelijkheden om deze unieke klinische profielen in kaart te brengen. Een casusformulering brengt informatie samen uit verschillende bronnen, waaronder informatie over de individuele patiënt (klachten, contextfactoren, interpersoonlijk functioneren, enzovoort), theoretische reflecties en onderzoeksbevindingen. Op deze manier kan men komen tot (een theoretisch gestuurd) begrip van de mechanismes die de ontwikkeling van symptomen kunnen verklaren (Eells, Kendjelic, & Lucas, 1998). Doordat de ontstaansgeschiedenis van de klachten gekoppeld wordt aan een bepaalde theorie, biedt een klinische casusformulering ook handvaten om na te denken over de behandeling (Vanheule, 2015) en, meer specifiek, om op een responsieve manier te handelen in de therapie (Stiles, 1998).

In de literatuur heerst immers ook een hevig debat over dé behandeling van aan complex trauma gerelateerde problemen (Resick et al., 2012; deJongh et al., 2016) waarbij het voornaamste punt van dispuut de al of niet noodwendigheid van een stabilisatiefase betreft. De klinische casusformulering heeft ook hier duidelijk een meerwaarde, gezien er vanuit gegaan wordt dat de behandeling afgestemd dient te worden op de singuliere patiënt en daarenboven ook flexibel moet aangepast kunnen worden op basis van bijkomende informatie (Polkinghorne, 1999).

De verschillende beperkingen van ons onderzoek laten toe om ook enkele interessante pistes voor bijkomend onderzoek te bespreken. Met betrekking tot onze steekproef, wijzen we op de relatieve homogeniteit in termen van de ernst van de klachten, de afwezigheid van openlijk wantrouwen en de duidelijke koppeling tussen de klachten en de traumatische voorgeschiedenis. Van daaruit volgt dat meer onderzoek nodig is naar de aard van dominante interpersoonlijke patronen en de invloed van deze patronen op het behandelingsproces bij patiënten met onder meer ernstigere symptomatische en karakteriële disfuncties, patiënten waarbij wantrouwen expliciet op de voorgrond staat en patiënten waarbij de ervaren klachten minder duidelijk gekoppeld worden aan de traumatische voorgeschiedenis. Daarenboven zou het interessant zijn om interpersoonlijke dynamieken te bestuderen in gevallen waar geen sprake is van een geschiedenis van complex trauma. Een van de beperkingen van de CCRT methode is namelijk dat er moeilijk gedifferentieerd kan worden tussen patiëntgroepen met een verschillende pathologie (Wilczek et al., 2010). Door het bestuderen van de onderliggende mechanismen kunnen we wel duidelijk aantonen hoe CCRT componenten in verband kunnen worden gebracht met een traumatische voorgeschiedenis en hoe interpersoonlijke patronen de therapie beïnvloeden. Kwalitatieve processtudies kunnen onze kennis ook verrijken voor andere patiëntgroepen door te bestuderen hoe dominante interpersoonlijke componenten inhaken op de voorgeschiedenis van de patiënt en op welke manier het therapeutisch proces beïnvloed wordt door de dominante patronen. Daarnaast zou het ook interessant zijn om andere factoren in rekening te brengen, zoals bijvoorbeeld de persoonlijkheidsstijl van de patiënt. In de literatuur wordt bijvoorbeeld naar voorgeschoven dat een anaclitische dan wel introjectieve persoonlijkheidsstijl noopt tot een meer gestructureerde/supportieve dan wel open/expressieve therapie, respectievelijk (Meganck et al., 2017). De achterliggende assumptie, namelijk dat de persoonlijkheidsstijl een invloed heeft de manier waarop de patiënt zich verhoudt tot anderen – en zo ook een therapeut – werd nog onvoldoende onderzocht. Daarom zou het interessant zijn om de (verschillende) aard van interpersoonlijke patronen te bestuderen bij patiënten met een anaclitische en introjectieve persoonlijkheidsstijl en op welke manier deze patronen verschijnen in en doorheen de therapie.

We besluiten dat er duidelijke verbanden bestaan tussen dominante interpersoonlijke patronen en het proces van verandering in de behandeling van patiënten met een geschiedenis van complex trauma. We hebben gevonden dat de interpersoonlijke patronen die voortkomen uit de verhouding met primaire zorgfiguren zich kunnen ontwikkelen tot vastgeroeste verhoudingspatronen die herhaald worden in volwassen relaties, ook ten aanzien van een therapeut. Een nieuwe relationele ervaring, waarbij de therapeut zich op een andere manier

positioneert, creëert mogelijkheden om de gefixeerde dominante interpersoonlijke patronen te gaan herwerken waardoor een nieuwe verhouding ten aanzien van zichzelf, anderen en de wereld mogelijk wordt. Vanuit deze bevindingen hebben we vastgesteld dat het als therapeut belangrijk is om zicht te krijgen op de dominante interpersoonlijke patronen en op een responsieve manier de behandeling vorm te geven. We hebben de klinische casusformulering, waarbij ook bevindingen uit onderzoek en theoretische reflecties worden aangewend, naar voorgeschoven als manier om diagnostiek en behandeling op een dynamische wijze vorm te kunnen geven. Verdere kwalitatieve, processtudies zijn nodig om ons begrip van interpersoonlijke dynamieken en hun invloed op het therapieproces te verruimen.

Referenties

Allen, J., Huntoon, J., & Evans, R. (1999). Complexities in complex posttraumatic stress disorder in inpatient women: Evidence from cluster analysis of MCMI-III personality disorder scales. *Journal of Personality Assessment, 73*(3), 449-471.

Arntz, A. (1994). Treatment of borderline personality disorder: A challenge for Cognitive Behavioral Therapy. *Behaviour Research and Therapy, 32*(4), 419-430.

Barber, J. P., & Crits-Christoph, P. (1996). Development of a Therapist Adherence/Competence Scale for Supportive-Expressive Dynamic Psychotherapy: A Preliminary Report. *Psychotherapy Research, 6*(2), 81-94.

Bistoen, G. (2016). *Trauma, Ethics and the Political beyond PTSD: The Dislocations of the Real.* Houndsmills, Basingstoke: Palgrave Macmillan.

Bistoen, G., Vanheule, S., & Craps, S. (2014). Nachträglichkeit: A Freudian perspective on delayed traumatic reactions. *Theory & Psychology, 24*(5), 668-687.

Blalock, J. A., Minnix, J. A., Mathew, A. R., Wetter, D. W., McCullough, J. P., & Cinciripini, P. M. (2013). Relationship of Childhood Trauma to Depression and Smoking Outcomes in Pregnant Smokers. *Journal of Consulting and Clinical Psychology, 81*(5), 821-830.

Briere, J., Hodges, M., & Godbout, N. (2010). Traumatic stress, affect dysregulation, and dysfunctional avoidance: A structural equation model. *Journal of Traumatic Stress, 23*(6), 767-774.

Briere, J., & Jordan, C. E. (2009). Childhood maltreatment, intervening variables, and adult psychological difficulties in women: An overview. *Trauma, Violence & Abuse, 10*(4), 375-388.

Brown, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101.

Chance, S. E., Bakeman, R., Kaslow, N. J., Farber, E., & Burge-Callaway, K. (2000). Core conflictual relationship themes in patients diagnosed with borderline personality disorder who attempted, or who did not attempt, suicide. *Psychotherapy Research, 10*(3), 337-355.

Chiriaco, S. (2012). *Le désir foudroyé: Sortir du traumatisme par la psychoanalyse.* Paris: Navarin/Le Champ Freudien.

Cloitre M., Courtois, C. A., Charuvastra, A., Carapezza, R., Stolback, B. C., & Green, B. L. (2011). Treatment of Complex Trauma: Resutls of the ISTSS Expert Clinician Survey on Best Practices. *Journal of Traumatic Stress, 24*, 615-627.

Cloitre, M., Garvert, D. W., Brewin, C. R., Bryant, R. A., & Maercker, A. (2013). Evidence for proposed ICD-11 PTSD and complex PTSD: A latent profile analysis. *European Journal of Psychotraumatology, 4*:10.3402/ejpt.v4i0.20706.

DeJongh, A., Resick, P. A., Zoellner, L. A., van Minnen, A., Lee, C. W., Monson, C. M., . . . & Bicanic, I. A. (2016). Critical analysis of the current treatment guidelines for complex PTSD in adults. *Depression and Anxiety, 33*(5), 359-369.

DePrince, A. P., Chu, A. T., & Pineda, A. S. (2011). Links between specific posttrauma appraisals and three forms of trauma-related distress. *Psychological Trauma: Theory, Research, Practice, and Policy, 3*(4), 430-444.

Desmet, M. (2018). *The pursuit of objectivity in psychology*. Borgerhoff en Lomberigts: Gent.

Dimidijian, S., & Hollon, S. D. (2010). How would we know if psychotherapy were harmful? *The American Psychologist, 65*(1), 21-33.

Drapeau, M., & Perry, J. C. (2009). The Core Conflictual Relationship Themes (CCRT) in Borderline Personality Disorder. *Journal of Personality Disorders*, *23*(4), 425-431.

Drozdek, B. (2015). Challenges in treatment of posttraumatic stress disorder in refugees: Towards integration of evidence-based treatments with contextual and culture-sensitive perspectives. *European Journal of Psychotraumatology, 6*: 10.3402/ejpt.v6.24750.

Dulsster, D., & Vanheule, S. (2019). On Lacan and supervision: A matter of super-audition. *British Journal of Psychotherapy*,*35*(1), 54-70.

Ebert, A., & Dyck, M. J. (2004). The experience of mental death: The core feature of complex posttraumatic stress disorder. *Clinical Psychology Review, 24*, 617-635.

Eells, T. D., Kendjelic, E. M., & Lucas, C. P. (1998). What's in a case formulation? Development and use of a content coding manual. *The Journal of Psychotherapy, Practice, and Research, 7*(2), 144-153.

Ehring, T., & Quack, D. (2010). Emotion Regulation Difficulties in Trauma Survivors: The Role of Trauma Type and PTSD Symptom Severity. *Behavior Therapy, 41*, 587-598.

Elliott, R., Slatick, E., & Urman, M. (2001). Qualitative change process research on psychotherapy: Alternative strategies. *Psychologische Beiträge, 43*, 69-111.

Fishman, D. B., & Messer, S. B. (2013). Pragmatic case studies as a source of unity in applied psychology. *Review of General Psychology, 17*, 156–161.

Forbes, D., Lockwood, E., Phelps, A., Wade, D., Creamer, M., Bryant, R. A., … & O'Donnell, M. (2014). Trauma at the Hands of Another: Distinguishing PTSD Patterns Following Intimate and Nonintimate Interpersonal and Noninterpersonal Trauma in a Nationally Representative Sample. *Journal of Clinical Psychiatry, 75*(2), 147-153.

Ford, J. D., Courtois, C. A., Steele, K., van der Hart, O., & Nijenhuis, E. R. S. (2005). Treatment of Complex Posttraumatic Self-Dysregulation. *Journal of Traumatic Stress, 18*(5), 437-447.

Frueh, B. C., Turner, S. M., Beidel, D. C., & Cahill, S. P. (2001). Assessment of social functioning in combat veterans with PTSD. *Aggression and Violent Behavior, 6,* 79-90.

Gleiser, K., Ford, J. D., & Fosha, D. (2008). Contrasting exposure and experiential therapies for complex posttraumatic stress disorder. *Psychotherapy, 45*(3), 340-360.

Godbout, N., Sabourin, S., & Lussier, Y. (2009). Child Sexual Abuse and Adult Romantic Adjustment: Comparison of Single- and Multipe-Indicator Measures. *Journal of Interpersonal Violence, 24*(4), 693-705.

Harvey, M. R. (1996). An ecological view of psychological trauma and trauma recovery. *Journal of Traumatic Stress, 9*(1), 3-23.

Herman, J. L. (1992). *Trauma and Recovery.* New York, NY: Basic Books.

Hodgdon, H., Kinniburgh, K, Gabowitz, D., Blaustein, M. E., & Spinazzola, J. (2013). Development and Implementation of Trauma-Informed Programming in Youth Residential Treatment Centers Using the ARC Framework. *Journal of Family Violence, 28,* 679-692.

Horowitz, L. M., Alden, L. E., Wiggins, J. S., & Pincus, A. L. (2000*). Inventory of Interpersonal Problems*. London: The Psychological Corporation.

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the working alliance inventory. *Journal of Counselling Psychology, 36,* 223-233.

Iwakabe, S., & Gazzola, N. (2009). From single-case studies to practice-based knowledge: Aggregating and synthesizing case studies. *Psychotherapy Research, 19*(4), 601-611.

Jackson, J. L., Chui, H. T., & Hill, C. E. (2011). The Modification of Consensual Qualitative Research for Case Study Research: An Introdution to CQR-C. In C. E. Hill (Ed.), *Consensual Qualitative Research: Practical Resources for Investigating Social Science Phenomena* (pp. 285-303). Washington, DC: American Psychological Association.

Jepsen, E. K. K., Langeland, W., & Heir, T. (2013). Impact of dissociation and interpersonal functioning on inpatient treatment for early sexually abused adults. *European Journal*

Kisiel, C., Fehrenbach, T., Stolbach, B., Briggs, E. C., Layne, C. M., … & Spinazzola, J. (2014). Examining Child Sexual Abuse in Relation to Complex Patterns of Trauma Exposure: Findings from the National Child Traumatic Stress Network. *Psychological Trauma: Theory, Research, Practice, and Policy*, *6*(1), 29-39.

Lawson, D. M., Davis, D., & Brandon, S. (2013). Treating complex trauma: Critical interventions with adults who experienced ongoing trauma in childhood. *Psychotherapy*, *50*(3), 331-335.

Levitt, H. M., Pomerville, A., & Surace, F. I. (2016). A qualitative meta-analysis examining clients' experiences of psychotherapy: A new agenda. *Psychological Bulletin, 142*(8), 801-830.

Luborsky, L., & Crits-Christoph, P. (1998). *Understanding Transference: The Core Conflictual Relationship Theme Method* (2nd Ed.). Washington, DC: American Psychological Association.

Ma, E. Y., & Li, F. W. (2014). Developmental trauma and its correlates: A study of Chinese children with repeated familial physical and sexual abuse in Hong Kong. *Journal of Traumatic Stress*, *27*(4), 454-460.

Meganck, R., Desmet, M., Bockting, C., Inslegers, R., Truijens, F., De Smet, M., … Vanheule, S. (2017). The Ghent Psychotherapy Study (GPS) on the differential efficacy of supportive-expressive and cognitive behavioral interventions in dependent and self-critical depressive patients: Study protocol for a randomized controlled trial. *Trials*, 18, 126.

Newman, E., Riggs, D. S., & Roth, S. (1997). Thematic Resolution, PTSD, and Complex PTSD: The Relationship Between Meaning and Trauma-Related Diagnoses. *Journal of Traumatic Stress, 10*(2), 197-213.

Okey, J. L., McWhirter, J. J., & Delaney, M. K. (2000). The Central Relationship Patterns of Male Veterans with Posttraumatic Stress Disorder: A Descriptive Study. *Psychotherapy*, *37*(2), 171-178.

Pearlman, L. A., & Courtois, C. A. (2005). Clinical Applications of the Attachment Framework: Relational Treatment of Complex Trauma. *Journal of Traumatic Stress*, *18*(5), 449-459.

Polkinghorne, D. E. (1999). Traditional Research and Psychotherapy Practice. *Journal of Clinical Psychology*, *55*(12), 1429-1440.

Pressley, J. & Spinazzola, J. (2015). Beyond Survival: Application of a Complex Trauma Treatment Model in the Cristian Context. *Journal of Psychology & Theology, 43*(1), 8-22.

Resick, P. A., Bovin, M. J., Calloway, A. L., Dick, A. M., King, M. W., … & Wolf, E. J. (2012). A critical evaluation of the complex PTSD literature: implications for DSM-5. *Journal of Traumatic Stress, 25*(3), 241-51.

Stiles, W.B. (2003). When is a case study scientific research? *Psychotherapy Bulletin, 38*, 6-11.

Stiles, W. B. (1998). Responsiveness in Psychotherapy. *Clinical psychology: science and practice, 5*(4), 439-458.

Stiles, W. B. (2013). The Variables Problem and Progress in Psychotherapy Research. *Psychotherapy, 50*(1), 33-41.

Teodorescu, D. S., Heir, T., Hauff, E., Wentzel-Larsen, T., & Lien, L. (2012). Mental health problems and post-migration stress among multi-traumatized refugees attending outpatient clinics upon resettlement to Norway. *Scandinavian Journal of Psychology, 53*(4), 316-332.

Toomela, A. (2007). History of Methodology in Psychology: Starting Point, Not the Goal. *Integrative Psychological and Behavioral Science, 41,* 75-82.

Tummala-Narra, P., Kallivayalil, D., Singer, R., & Andreini, R. (2012). Relational experiences of complex trauma survivors in treatment: Preliminary findings from a naturalistic study. *Psychological Trauma: Theory, Research, Practice, & Policy, 4*(6), 640-648.

van der Kolk, B. A. (2005). Developmental Trauma Disorder. Toward a rational diagnosis for children with complex trauma histories. *Psychiatric Annals, 35*(5), 401-408.

van der Kolk, B. A., Pelcovitz, D., Roth, S., Mandel, F. S., McFarlane, A., & Herman, J. L. (1996). Dissociation, somatization, and affect dysregulation: The complexity of adaptation of trauma. *The American Journal of Psychiatry, 153*(7), 83-93.

van der Kolk, B. A., Roth, S., Pelcovitz, D., Sunday, S., & Spinazzola, J. (2005). Disorders of Extreme Stress: The Empirical Foundation of a Complex Adaptation to Trauma. *Journal of Traumatic Stress, 18*(5), 389-399.

Vanheule, S. (2015). *Psychodiagnostiek anders bekeken: Kritieken op de DSM. Een pleidooi voor functiegerichte diagnostiek.* Tielt: Lannoo.

Verhaeghe, P. (2004). *On being normal and other disorders: A manual for clinical psychodiagnostics.* New York, NY, USA: Other.

Walsh, D., & Downe, S. (2005). Meta-synthesis method for qualitative research: A literature review. *Journal of Advanced Nursing, 50*(2), 204-211.

Walsh, K., Fortier, M. A., & DiLillo, D. (2010). Adult Coping with Childhood Sexual Abuse: A Theoretical and Empirical Review. *Aggression and Violent Behavior, 15*(1), 1-13.

Wilczek, A., Weinryb, R. M., Barber, J. P., & Gustavsson, P. (2010). The Core Conflictual Relationship Theme (CCRT) and psychopathology in patients selected for dynamic psychotherapy. *Psychotherapy research, 10*(1), 100-113.

Zilberstein, K., & Messer, E. A. (2010). Building a Secure Base: Treatment of a Child with Disorganized Attachment. *Clinical Social Work Journal, 38*, 85-97.

Zorzella, K. P., Muller, R. T., & Classen, C. C. (2014). Trauma group therapy: The role of attachment and therapeutic alliance. *International Journal of Group Psychotherapy, 64*(1), 24-47.

DATA STORAGE FACT SHEETS

Data Storage Fact Sheet Chapter 2

% Data Storage Fact Sheet

% Name/identifier study
% Author: Kimberly Van Nieuwenhove
% Date: January 29th 2019

1. Contact details
==========

1a. Main researcher

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If a response is not received when using the above contact details, please send an email to data.pp@ugent.be or contact Data Management, Faculty of Psychology and Educational Sciences, Henri Dunantlaan 2, 9000 Ghent, Belgium.

2. Information about the datasets to which this sheet applies
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Chapter 2 of this dissertation.

Van Nieuwenhove, K., & Meganck, R. (2017). Interpersonal Features in Complex Trauma Etiology, Consequences, and Treatment: A Literature Review. JOURNAL OF AGGRESSION MALTREATMENT & TRAUMA.

* Which datasets in that publication does this sheet apply to?:
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% Author: Kimberly Van Nieuwenhove
% Date: January 29th 2019

1. Contact details
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2. Information about the datasets to which this sheet applies
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* Reference of the publication in which the datasets are reported:
Chapters 3, 4, and 5 of this dissertation.

Van Nieuwenhove, K., Meganck, R., Cornelis, S., & Desmet, M. (2018). Core Conflictual Relationship Patterns in Complex Trauma: A Single-Case Study. Psychodynamic Practice: Individuals, Groups and Organisations, 24(3), 245-260.

Van Nieuwenhove, K., Truijens, F., Meganck, R., Cornelis, S., & Desmet, M. (2019). Working Through Childhood Trauma-Related Interpersonal Patterns in Psychodynamic Treatment: An Evidence-Based Case Study. Psychological Trauma: Theory, Research, Practice, and Policy (in press).

Van Nieuwenhove, K., Meganck, R., Acke, A., Cornelis, S., & Desmet, M. The Influence of Interpersonal Patterns on the Therapy Process in a Case of Childhood Trauma. (unpublished manuscript)

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