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Odnos med klientom in terapevtom v okviru sistemskega pristopa: usklajevanje razlik

Ključne besede: postmoderna paradigma, odpuščanje, sprava, terapevtski delovni odnos, družinska terapija, psihoanaliza, eksistencialna, na osebno usmerjena in kognitivna terapija, empirično podprta praksa, zloraba, travma, posttravmatska stresna motnja

Povzetek: Postmoderna paradigma družinskim terapevtom dovoljuje, da sprejmejo in prilagodijo ti. "sodelovalni" terapevtski odnos, v katerem sta klient in terapevt sopotnika v odkrivanju samega sebe in v katerem je glavni poudarek na razumevanju klientovih izkušenj. V članku raziskujeva možnosti usklajevanja tega, kar vemo o terapevtskem odnosu s klasičnimi metodami in tehnikami družinske terapije, kjer so intervence "trdne". Nujna in logična posledica postmodernega mišljenja je tudi ta, da je prišlo do premika v psihoterapevtskem izobraževanju in usposabljanju, kjer so se za sistemske terapevte pokazali koristni tudi psihoanalitski pristopi kot sta eksistencialni in na osebo usmerjeni pristop. Preko raziskav in študij kliničnih primerov prikaževa pozitivne učinke takega izobraževanja in usposabljanja za zdravljenje zlorab, nasilja in travm na različnih ravneh družinskih izkušenj. Integracija sistemskega načina mišljenja, psihoanalitskih pristopov in postmodernega narativnega okvirja je pomembna, ker omogoča terapevtom, da se lažje prilagodijo na nestalno, raznoliko okolje in skupaj s klienti soustvarjajo nove rešitve in strategije za stalno spreminjajoče se in večkrat škodljive okoliščine sodobnega globaliziranega sveta.

The Client-Therapist Relationship within the Systems Frame: Reconciling the Differences

Key words: postmodern paradigm, forgiveness, reconciliation, therapeutic alliance, family therapy, psychoanalysis, existential, person centered and cognitive therapy, evidenced-base practice, abuse, trauma, PTSD

Abstract: The Postmodern Paradigm granted family therapists global permission to accept the all-important "collaborative" therapeutic relationship in which both client and therapist are mutually involved in a journey of self discovery in which primary emphasis is placed upon understanding the client's experiences. This paper examines the importance of reconciling the therapeutic relationship and the techniques, which originate from systemic models of family therapy directing "fixed" interventions. The benefits of other psychoanalytical approaches such as existential and person-centered therapy will also be considered as a necessary and logical consequence of postmodern thinking as well as a critical shift in clinical training. The positive effects of such training in the healing of abuse, violence and trauma on different levels of family experiences will be explored through research and case studies. The integration of purely systemic thinking, psychoanalytical approaches and the postmodern narrative frame is significant in that it has the potential to help clinicians to adapt more easily to the "non-fixed," diversified world environment in order to cocreate new solutions and strategies with their clients for our ever-changing and often times damaging global circumstances.

The Postmodern Paradigm

White and Epston (1990) track a shift that replaces elements belonging to a "normative" or modern approach in psychotherapy such as absolute truth, fixed ideas, certainty and consistency with elements belonging to a postmodern dialogue such as lifelikeness, subjective and varying perspectives, indeterminacy, fluid process and inter-relational narrative dialogue. In this shift, consideration is given to the interaction of narration, multicultural diversity, gender sensitivity and client participation.

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By helping clients externalize the problem and engage in alternative stories, multiple perspectives and numerous voices, for example, clinicians have significant "healing" possibilities in the theory and practice of Marriage and Family Therapy since they are no longer on the outside looking in and instead, help clients construct a new reality through culture, viewpoint and language.

In the telling and re-telling of their stories, clients become existential and person-centered "experts" taking control of authorship in their lives. As privileged authors, they take back the power from what Foucault believed was formerly the modern, "dominant" story**.** By taking the stance of "not knowing," therapists let go of their dominant story and power and support the power of the client (White & Epston, 1990).

Deconstructionist Jacques Derrida also points out the ambiguity of the dominant story since in any kind of text, one is always likely to encounter gaps and ambiguities that require constant negotiation. Therefore, clients are always engaged in the process of co-navigation with the therapist through a flow of constantly changing narratives in which they act as protagonists, rather than as passive voices, in the interpretation and re-telling of their stories (Hoyt, 1994).

Joining – one of the most significant pieces in this therapist-client conversation – include the therapist's identifying with the client's position, using a friendly language, accepting the client's way of doing things, being non-confrontational and non-judgmental and complimenting positive actions. Since, when clients feel they are being supported and validated, they are more likely to seek and make changes in their behaviors.

Enabling Forgiveness and Reconciliation within the Postmodern Paradigm

Enabling forgiveness and reconciliation are also significant processes within the postmodern paradigm. While interpersonal conflicts and cycles of mutual violence within families often lead to hurt and dissolution of trust, family members can recover a feeling of wellbeing by engaging in a process of forgiveness and reconciliation.

While this is a long and tedious process in which therapists are critical to the facilitation of healing, the therapist can create the space for clients to recognize the value of forgiveness, regret and apologies**.** Through empathetic conversation, it is possible for therapists to create better ways of thinking and interacting that inspire forgiveness and reconciliation. As therapists, for example, we can help clients recognize that the person who caused the most pain should take more responsibility in acknowledging mistakes, apologize, and try to repair, while the "other" needs to take more responsibility to forgive and restore the relationship (Tomm, 2004). As clinicians we must also be aware that repeated and unnecessary suffering can also occur when powerful negative feelings are directed towards the self. In such situations, movements towards self-forgiveness are healing.

Case Study – Remembering to Forgive

Ed, age 52, was recently referred to the agency by his 52 year-old wife, Mary who was concerned about Ed's fall from sobriety as a way to cope with severe depression and anxiety resulting from a long-term history of alcoholism and physical and sexual trauma. After establishing a safe, collaborative and non-judgmental environment, Ed reluctantly admitted his story of sexual abuse (as both victim in childhood and perpetrator of his 12 year-old daughter from a previous marriage).

After spending 8 years in prison for his crime, Ed began to suffer from chronic pain and flashbacks – triggered by the noises made by his 13 year-old autistic son – anxiety and depression and an inability to communicate effectively with his second wife, Mary and their children.

Given the complexity of Ed's stories experiences or dominant narrative, we at the agency felt that it would be best to help Ed "externalize" the problem and thus, re-story his narrative.

We used the postmodern technique of the letter – "remembering to forgive" as a clinical intervention.

Although Ed recognized his behavior and that of his perpetrator as inappropriate and destructive, he was helped to recognize that both he and his perpetrator had been justly punished for their crimes. He also realized that by continuing to punish himself with severe guilt (flashbacks), self-medication, depression, anxiety and separating from his children, Ed was continuing to repeat dysfunctional patterns.

By seeing the events as external to himself, and by re-storying his narrative and using letters to forgive, Ed began a journey of healing from intense personal suffering and continued public punishment.

After three months, Ed was able to obtain forgiveness from his daughter, forgive his perpetrator and himself. A six-month follow-up found Ed less anxious and depressed and beginning to reconnect with his current family.

The Therapeutic Alliance

The therapeutic alliance was a critical piece in Ed's recovery. Understanding emerged from the work of both Ed and his therapist together through a "relational way of knowing and being." As Marriage and Family Therapist (MFT), Pocock (1997) states: "Feeling understood often seems to be a profound relational experience of discovering that one is more acceptable and comprehensible to the other." Furthermore, according to Pocock (1997),

"Family therapists have created artificial, unnecessary and unhelpful borders which obscure the possibilities of a deeper appreciation of the concepts of understanding and feeling understood which I believe are central to some contemporary psychoanalytic projects" (p. 286).

The working alliance concept actually has its origin in psychodynamic theory. As

Taft & Murphy (2007) remind us it was Freud who first articulated the importance of "displays of interest, openness and understanding" on the part of the therapist in order to get the patient to recognize a more positive and "reality-based sense of trust and attachment."

At present, alliance is most commonly defined as the client's sense that there is mutual understanding and agreement about what needs to happen in therapy (goals) and how to go about achieving the goals/tasks. Therapeutic tasks and goals are thought to be products of the cognitive processes mediated through the language of clients and therapists. According to Bordin (1994), for example, the therapist's tasks, goals, roles, etc are the ongoing, joint, interactive accomplishments of people in conversation.

Kozart (2002) refers to alliance as "the methods by which the patient and therapist sustain attention to sensible goals." However, it is not goals and tasks themselves which clients find therapeutic, but the process of working together on mutually agreed-upon goals for change.

Furthermore, in working specifically with couples and families, we recognize the need for greater consideration of the dynamic nature of the therapeutic alliance in treating distress symptoms particularly when family members and the therapist develop into a "reflective and collaborative team" in which there is a sense of agreement about what needs to be done and how it is to be done (Johnson et al, 2002). With two or more clients, for example, family therapy creates a setting that presents unique and difficult challenges, demands and processes not found in individual psychotherapy. The therapist is challenged to simultaneously accommodate and construct differing needs and programs for each client in the family system.

In their research, Taft & Murphy (2007) specifically highlight the importance of the working alliance with respect to treatment compliance and positive outcome in interventions for perpetrators of partner violence and stress the importance of the therapeutic relationships in their application of attachment theory to interventions with partner violent men (e.g., exploring unresolved trauma and abuse perpetrated by childhood attachment figures in a non-judgmental,

understanding way).

In their quantitative study, Brown, O'Leary, and Feldbau (1997) found that the ratings of the alliance were the strongest predictors of outcome. The most frequent reason for non-completion of treatment in working with partner violence, for example, was lack of a sympathetic therapeutic alliance and that there were significant associations between alliance ratings and reductions in both physical and psychological aggression in post treatment. This study is further highlighted and supported by other qualitative studies–conducted with in-depth interviews with perpetrators of partner violence and their victims. Taft & Murphy's 2007 study, for example, predicts that the most frequent response as to the success of therapy – at 86% - was the effectiveness of the therapist or group leader.

Some specific strategies, (e.g., Miller & Rollnick, 2002) are derived from motivational enhancement therapy (MET) and include the provision of tailored motivational feedback following initial assessment sessions, collaborative development of a therapy contract with specific goals, exploration of the costs and benefits of abusive behavior, and open discussions (reflective listening) of the consequences of not making positive changes in therapy. These strategies prove particularly helpful in working with partner violence ($p < .01$).

As therapists, however, we must also recognize that empathy is the cornerstone of the therapeutic alliance. Empathy is summarized as the ability to empathize with others and the ability to sense another's world as if it were their world – a critical process to all human relationships and an essential ingredient (Omdahl, 1995).

According to Bohart & Greenberg, (1997) and Corey (2009), when empathy is operating on three levels – interpersonal, cognitive and affective – it is one of the most powerful tools therapists have at their disposal since it helps clients pay attention and value their experiencing, see earlier experiences in new ways, modify their perceptions of themselves, others and the world, and increase their confidence in making choices and pursuing a course of action. It is the therapist's ability to reflect the experiences of clients then, that helps produce in clients' self-understanding and clarification of their beliefs and worldviews.

Expanding the need for ethno-cultural empathy within the Therapeutic Alliance –

with respect to race and ethnicity – is equally critical since the population of the United States is becoming more diverse. In 2000, 29% of all Americans were racial and ethnic minority individuals. Population projections now indicate that by the year 2015, racial and ethnic minorities will comprise one third of all Americans and by the year 2050, that figure will increase to nearly half (47%) of the U.S. population (U.S. Census Bureau, 2000).

According to Wang, Davidson et al., (2003) more than tolerance is needed to adapt and evolve with these growing diversity and social changes. Developing and drawing on ethno-cultural empathy (i.e., empathy directed toward people from racial and ethnic cultural groups who are different from one's own ethno-cultural group) has been suggested by scholars as a promising way to promote the mutual understanding between various racial and ethnic groups on both cognitive and affective levels.

Ridley & Lingle (1996) have developed the most complete model of cultural empathy composed of three subordinate processes – cognitive, affective and communicative. While cognitive process can be understood as a cultural perspective-taking and cultural self-other differentiation, the affective process includes vicarious affect and expressive concerns and the communicative process includes probing for insight and conveying accurate understanding. If all these subordinate processes are explored and understood in therapy, cultural empathy is more likely to flourish.

It was Wang et al., (2003), that actually developed a quantitative measure of Ethno-cultural empathy known as the Scale of Ethno-cultural Empathy (SEE) – a self-report instrument that measures empathy toward people of racial and cultural backgrounds different from one's own.

They identified four factors of the SEE from strongest to weakest – Empathetic Feeling and Expression, Empathic Perspective Taking, Acceptance of Cultural Differences and Empathetic Awareness – which closely replicate the theoretical constructs of empathy found in pre-existing literature.

Reconciling Postmodern Family Therapy and Psychoanalysis

In reviewing thirty years of research evidence, Miller et al., (1995) conclude that

"it is the similarities, rather than the differences between models, which accounts for most of the change in therapy. Most outcomes seem to be determined, not by therapy or therapist variables, but by the particular balance of strengths, resources and difficulties of the clients" (p.968).

After all, Freud's greatest discovery was not of the unconscious, but of the acceptance that a person receives merely in the repeating of their story to a listener – a relatively new theme in family therapy – although an ancient one in psychoanalysis.

"When family therapy makes a straw man out of psychoanalysis," notes Pocock, (1997), "a nation state of tyrants, fault-finders and know-it-alls – it leaves out a central, hopeful and humanizing psychoanalytic assumption that people, no matter how crazy, frightened or depressed they feel, may be understandable in light of their experiences" (p. 291).

Deconstruction, for example, recognizes how description – being bound by the mystifications of language and description – puts out of our mind all other ways of thinking about the complex reality. Derrida (1972) collectively refers to these other ways of thinking as "*difference"*. Deconstruction is the method of allowing into awareness these other perspectives – some of which may be closer to that which is really going on. "*Difference"* is, after all, the hidden part of every story. The trace – or the obscured remnant of what is hidden, the unconscious wish or disowned motive – can sometimes be brought into the realm of consciousness (Pocock, 1997).

Furthermore, since the self is made up of storied (or internalized) relational and other "lived experiences" which serves as a map in orientating to current relationships, these storied experiences are unconscious, and thus, by definition, relatively inaccessible. The unconscious, viewed by Holmes (1996) as "an inner representational world, populated by significant others, acts, then, as a template for intimate relationships and can explain recurrent patterns for relationship difficulty (e.g., object relations theory)".

Therefore, as clinicians, we must allow for this "*difference"* and the need to explore other possibilities outside of the structure of the systems frame. As Pocock (1997) stated, for example,

"Theory, I think is important but it needs to be light, to be held consciously and with a loose grip. The difficulty with theory is its tendency to both rigidify and slip from consciousness awareness in the mind of the therapist with a corresponding loss of reflexivity; a self-conscious awareness that what we see is determined by our choice of theory as lens" (p. 294).

The use of multiple lenses seems the logical consequence of postmodernism and keeps us open to, and interested in, all metaphors for change, while cognizant of their limitations, excesses and risks. According to Knight, (2007), for example,

"The therapeutic methods suggested by one theory appear at first glance to so violate the precepts of another theoretical framework that the line between them seems so bold, even impenetrable. The successful therapist is one who finds how effective approaches to therapy can comfortably nestle within a larger theoretical framework, regardless of the boundaries that appear to make such integration untenable" (p. 111).

Towards and Integration: Existential, Person Centered and Cognitive Therapy

Existential therapy is more a way of thinking than any specific model since it is grounded on the premise that we are free and responsible for our own choices and actions and that we are the

authors of our lives and thus define its pathways. Since a major aim of therapy is to encourage clients to reflect on life, to recognize alternatives and decide among them. The therapist's role is to encourage the client to explore options for creating a "meaningful existence" (Corey, 2009).

Existential therapists place focus on their relationship with the client, which is the stimulus for change. The core of this relationship is respect, which implies faith in the client's ability to cope and "discover alternative ways of being". Therefore, the therapeutic alliance is the powerful joining of forces which helps support the journey ahead. There is a de-emphasis – within existential therapy – on techniques, and a priority given to understanding a client's world.

The purpose of Ottens & Hanna's (1998), study was to show how a merging of these "different" therapies might contribute to a greater range of options for therapists. The authors attempt to show a surprisingly wide number of connections between these two schools. We learn, for example that phenomenological-existential approaches to psychology have provided a rich contextual base for Beck's cognitive therapy since in existential therapy, there is a basic cognitive notion that people construct personal meaning and that these meanings profoundly influence their lives (Riskind,1995).

In addition, other cognitive-behavioral principals are linked with existentialism. These include the roles of schemas in mediating emotional responses to situations, the importance of distilling personal meaning from experiences, and the existence of incorrect information-processing that contribute to distorted or misinformed perceptions of reality.

In sum, we find many similarities between cognitive and existential therapies such as

an empathetic and collaborative therapist-client relationship functioning as the essential vehicle for bringing about change. We also find in both therapies interpersonal and environmental factors – namely the importance of reconciling self and the other – as well as an interest in object relations theory, an understanding a person's world in detail and depth or being-in-the world, and personality constructs of social dependence and autonomy.

To the extent that cognitive therapy addresses interpersonal or relationship issues, it comes face-to-face with key existential concepts; "the inseparability of self and world" and how psychotherapy is concerned with the totality of human experience (Halling & Nill, 1995). As such, existential and cognitive therapies provide insight into the content and structure of the ontological schemas that individuals construct to make sense of "emotionally significant" life experiences. Not only are these "core ontological presuppositions" existentially constituted, but examining them in therapy is important for understanding how clients make sense out of their everyday perceptions and problems.

This, of course, underscores the argument that working with core schemas is important in that people's problems are generally not about events or circumstances in themselves, but what these signify and what their possible choices are (Ottens & Hanna, 1998).

Case Study – Sara

A 32 year-old woman, Sara, presented in therapy with low self-esteem, depression, and a lack of interest in life. She stated that "life seems to hold nothing for me, I have no life." When asked about her parents, Sarah related a story of how her mother was very happy when her sister was born but was told by her mother that "she was just an accident." Sarah reported that this confirmed what she had known all along – that her mother did not care about her – thus a core and primordial schema was isolated which shaped how Sarah felt about herself and others in the present.

By the therapist's reframing the experience by asking whether this might be why Sarah did not believe that she had the right to live a life of her own, Sarah replied, "I never looked at is this way but I think so." From that point of view of disputing being worthless or unlovable over the next three sessions, Sarah reported that this realization of not having a right to her own life, led

to feeling a lot better. In order to deal with Sara's residual "sense of emptiness," however, the therapist asked her to form an image of her mother and to report the feelings she felt.

The feelings were those of coldness, rejection and hurt. Sarah was then asked to recreate the image of her mother, putting warmth and tenderness in her eyes and giving her a loving smile. The thoughts which came to Sarah's mind, then, were ones of being "accepted," of "being at home" and of value, and just being "herself." The therapist then reminded Sarah that she could reproduce the wonderful feeling whenever she wanted, but it was her choice to feel that way.

Over the next three sessions, Sarah reported a greater sense of her own being. A 6-month follow-up with Sarah revealed that she was taking more time for her own enjoyment and reported very few moments of depression (Ottens & Hanna, 1998).

Furthermore, existential and cognitive therapies demonstrate many possibilities from a multicultural perspective. Existential counseling, for example, can be useful in helping clients of all cultures find meaning and harmony in their lives because it focuses on the core issues that all of us must accept and confront – love, anxiety, suffering and death – and ones that transcend the boundaries that separate cultures.

The person-centered approach shares many concepts and values with existential therapy such as the client's potential to understand and resolve their problems, the client's ability to establish a greater degree of independence and integration, and the therapist's ability to recognize the importance of therapist-client relationship in self-healing with technique as being secondary.

According to Rogers (1961), for example, three attributes create a growth-promoting climate in which individuals can move forward – congruence/realness, unconditional positive regard (acceptance and caring), and accurate empathic understanding (an ability to deeply grasp the subjective world of another person). When these are present, clients can explore their lives in freedom.

Like existential therapy, person-centered therapy is a humanistic approach to psychotherapy – emphasizing the primacy of the client's internal process and the therapist's attending to it in a nondirective manner. When a therapist provides congruence, nondirective approaches, unconditional positive regard and empathetic responding – the actualizing potential of the client will be released and the client will begin to change and grow.

Person-centered therapy also assumes that the most valuable answers emerge from within the client, who possesses the innate inclination toward "health, development, and wholeness," and whose experience of life best informs the therapeutic direction ultimately taken. (Knight, 2007)

As is the case in existential therapy, one of the many strengths of the person-centered approach is its impact on diverse cultural groups. For instance, Carl Rogers has had a global impact with his approach reaching as many as 30 countries and methods translated into 12 languages. In addition to this global impact, the emphasis on core conditions makes the person-centered approach useful in understanding diverse world-views. It is a potent way of working with the message and meaning of diverse groups through empathy and understanding since these conditions are universal.

Bohart (2003), for example, claims that the person-centered philosophy makes this approach particularly appropriate for working with diverse cultures since the counselor does not assume the role of the expert who is going to impose "the right way of being" on the client. The therapist is, instead, a fellow explorer who attempts to understand the client's phenomenological world in an interested, accepting, and open way and checks with the client to confirm that the therapist's perceptions are accurate.

Integration in Family Therapy

As Gouze & Wendel (2008), note, "The field of Marriage and Family Therapy is currently at a crossroads. The challenge for contemporary therapists is how to incorporate the wisdom of pre-

vious models with the accountability that comes from evidence-based practice" (p. 269). Their statement is very telling in that it recognizes one of the purposes of the study – the increased need for increasingly complex, integrated models of assessment and treatment.

Lebow (1997) argued that integrative models – as such - allow for more flexibility in treatment and greater consonance with postmodern epistemological trends since these approaches are more consistent with the idea that variables that cut across theoretical models or specific empirical approaches may account for the largest amount of change in therapy in general, and in marriage and family therapy specifically.

Gouze & Wendel, for example, repeat the core competencies established by the AAMFT which similarly specify the need for integrated treatment, with specific attention to multiple levels of understanding that crosscut endogenous and contextual or social structural factors. "The interplay of 'principles of human development', 'psychopathology', and 'organic problems', with observable cultural and contextual factors, evidence based treatment, and measurable outcomes will necessarily result in the continuous modification of intervention as treatment progresses" (p. 269).

Integrative Module-Based Family Therapy (IMBFT)

Furthermore, according to Gouze & Wendel(2008), the nine integrative modules that reflect multiple understanding in family therapy include: psychiatric and related medical conditions; attachment and relationship issues; family structure; developmental ideas; affect regulation; behavior regulation; cognitive and narrative work; mastery of self-efficacy and the community.

Consideration of these modules provides a way of practicing for clinicians that maintains a broader view of human life and functioning and affirms the importance of general clinical skills or the art of therapy, while at the same time, making focal, evidence-based intervention or the science of therapy central to treatment.

In addition, cultural dimensions are subjected systematically to observation and consideration in choosing appropriate interventions with IMBFT. However, as IMBFT is increasingly refined and subjected to scientific inquiry such as outcome research – it promises to provide a more significant meeting point for practitioners from multiple disciplines (e.g., Marriage and Family Therapy, Psychiatry, Psychology, Social Work, and Counseling.)

Towards An Integration in Dealing with Trauma and Abuse

Trauma is an unavoidable part of ALL human experience and affects every dimension or aspect of the person. Psychological trauma has been posited to underlay or contribute to a wide range of psychiatric disorders and medical problems. Trauma, for example, disconnects the person physiologically, emotionally, spiritually, cognitively, interpersonally and socially from himself and from others. A national comorbidity study done by Kessler et al., (1999) found that 60% of men and 51% of women interviewed reported having experienced at least one major traumatic event in their lifetime with the prevalence rate for PTSD among this group being 25%.

However, the process of narrative and interactive dialogue within both postmodernism and psychotherapy provide a supportive environment in which to deal with issues surrounding traumatic "relational" experiences such as childhood physical, sexual and emotional abuse, combat experience of soldiers and civilians, criminal assault, death or near death experiences, natural and man-made disasters, terrorism and torture, domestic abuse and sexual assault and rape.

The communication between the client and therapist and the therapeutic relationship are critical factors in the success of trauma therapy. Psychotherapy, for example, uses this "relational" dynamic to heal the wounds caused by previous relationships helping clients regain self-confidence, trust and empowerment as well as idea of movement in their client's lives in the direction of their choosing (e.g., existentialism and person-centered therapy).

Since the "self" manages trauma in childhood by hiding it in closed-places in the psyche that remain dormant as the "operational self" matures, if the physical/sexual transgression of the child's world is traumatic, the sensory, emotional and cognitive processing are interrupted. A part of the "self" is, in effect, left behind in time and unable to grow. This defensive "false self" performs constantly and non-functionally to avoid any interpersonal situation that might suggest the unbearable threat from the past (Ottens & Hanna, 1998)

The "lost part of the self" recovered by trauma work must be integrated into the conscious, maturing character, so that the whole self is then available to work through a more functional process. Feelings and perceptions that have been kept from awareness can then be released, understood, and translated into a more independent sense of identity (Masterson, 1993).

It is the goal of therapy to address the defenses (e.g., denial, avoidance and so on) that support the "false self" and to interrupt their rigid and indiscriminate use. Masterson (1993), for example, encourages clinicians to take a new look at Freud's original trauma theory – especially in recognizing the stressors that impinge on the child from the outer world and their effects – splitting, dissociation, and the arrestment of the ego – which not only lead to trauma, but also lead to comorbidity with a "disorder of self." As Masterson (1993) reminds us personality disorder may also be complicated by the presence of other disorders. Posttraumatic stress disorder, for example, is based on the coexistence of physical and/or sexual abuse. Sometimes the posttraumatic stress disorder is obvious, and, at other times, it can be quite hidden, not revealing itself until after many sessions of psychotherapy.

Both the British Psychological Society and APA also recognize that individuals can equally develop false beliefs or memories with inaccurate details as well as recover valid and historically accurate memories. Therefore, it seems best for therapists to avoid making determinations about the accuracy or inaccuracy of a client's memories and maintain, instead, an open, patient and tolerant view of the confusing and uncertain nature of the client's resolution of the matter.

According to Enns et al., (1998), competence is also an important prerequisite for therapists working with clients who have experienced "relational" abuse. Clinicians should consider augmenting their theoretical knowledge with subjects such as "basic memory principles", "autobiographical memory", the psychobiology of trauma, trauma memory research, typical coping skills and the "forms of dissociation."

In this frame, assessment should be understood as a shared and ongoing experience between the therapist and client. The client and therapist, for example, should work together to identify the nature and hypotheses about the nature and source of the client's problems, since naming the causes empowers the client.

As every clinician knows, abuse-related trauma is manifested through a wide range of problems. As a result, the therapist naturally avoids unwarranted inferences about the meaning of the client's symptoms and includes information about race, social class, culture, disability, sexual orientation in the way these may influence the trauma.

Furthermore, as in all psychotherapeutic work, abuse-related trauma practitioners adhere to basic principles of empathy, genuineness, and respect for the client. It is important for the psychotherapy relationship to model a cooperative, collaborative and supportive partnership**.** The role of the therapist is to help the client regain power over his or her own life and recover from doubt (e.g., existential and person-centered therapy). The therapist is attentive to the client's level of integration and readiness to discuss trauma-related content, while always remaining open to interpretation. As Enns et al, (1998) suggest, the most accurate view of the client's past is likely to emerge if the client and therapist wait before rendering immediate judgment about the historical accuracy of various feelings, images, cognitions and emotions that the client experiences, and learn to slowly understand this material over time.

Evidenced-Base Practices: Models Utilized in Treating Trauma and PTSD

The Wits Trauma Counseling Model

The Wits Trauma Counseling Model addresses survivor guilt (which emerges when someone had died in a traumatic incident), self-blame (related to the belief that the person could have done more to prevent what happened), and encourages mastery (e.g., restoring coping skills through relaxation, cognitive techniques, distraction and time structuring, and facilitating creation of meaning by engaging in the client's cultural, political, spiritual and existential levels. Sherman (1998) identifies five logical strategies to follow within this model: supportive adaptive coping skills; normalizing the abnormal; decreasing avoidance; altering attributions of meaning and facilitating integration of self. Eagle (1998) also advocated an integrative approach – "reconciling the differences" – which combines psychodynamic principles (e.g., existentialist and person-centered) with cognitive-behavioral interventions. As is the case in the former, the cognitive approach aims to facilitate the development of coping skills and to assist individuals in identifying and correcting cognitive distortions and faulty attributions of meaning.

The Wits Trauma Counseling Model encompasses short-term, structured psychotherapeutic interventions that emphasize the recovery process. Recovery must include working through the meaning that the individual has attached to the traumatic event(s) – e.g., his/her life history, personality, social support and the broader socio-cultural/political context in which the individual(s) live and are traumatized – (Herman, 1992). It is important to take into account the socio-political context within which the victimization occurs, because it affects the meaning, which the event has for the individual, as well as the process of working through the trauma or violence. Such an understanding may assist the client is deriving meaning structures which move the personal to a broader understanding of the societal context. The model has been effectively used in the treatment of criminal, sexual, political or domestic violence as well as accidents, natural disasters and traumatic bereavement. It has been found to provide successful outcomes with a variety of socioeconomic, cultural / ethnic and age groups. (Hajiyiannis & Robertson, 1999)

The epistemological philosophy underpinning the model is perhaps its greatest strength – the explicit recognition that trauma impacts on both internal, psychodynamic processes, as well as intervention which is structured and problem-oriented. The model suggests that clients tell the story which imposes a time sequence on the event and transforms sensory and episodic memories to the realm of processed thought in the safety of the therapeutic relationship. The model suggests that therapists normalize the symptoms, conveying to their clients that symptoms and reactions are normal responses to abnormal events and that they will diminish in time. Researchers recommend that the model expand its scope by working with the elderly and those in need of anger management (Hajiyiannis & Robertson, 1999).

The affects of trauma are thought to be much broader than the diagnosis of PTSD and overlap with many other diagnostic categories. One study (Teicher et al., 2003) found that almost two-thirds of children with documented abuse suffer from a variety of other psychiatric disorders such as dissociative disorders, borderline personality, bipolar depression, substance abuse, oppositional defiant disorders, and attention deficit disorders depending on preexisting neural physiology, cognitive deficits, emotional maturity, gender, past experiences, coping skills, relationships with others and socio-cultural factors (Wheeler, 2007).

In traumatic events, the experience is so overwhelming that the event is not fully processed and is stored as it was at the time of the disturbing event in a state-specific form and does not get linked to other networks in an adaptive way (Shapiro, 2001). Psychotherapy has the potential to facilitate proper information processing so that painful memories are integrated with other more adaptive memories. The clinician seeks to create emotional arousal and novel sensory experiences that activate implicit memories. These are necessary to access the state dependent memories

that link neural networks in the brain to more positive, adaptive, information networks.

AIP treatment seeks to successfully navigate the client through two distinct phases. Phase 1 seeks safety and symptom stabilization involves increasing external and internal resources (e.g., ability to manage positive and negative emotions, spiritual beliefs, a belief in oneself (ego strength), and ability to stabilize). Decisions are made where to target interventions based on a comprehensive assessment of the strengths and resources the personal already has, keeping in mind, that when comorbidity exists, the period of stabilization may be longer.

Phase 2 is aimed at processing the painful memories so that the person can move towards enhancing future visioning and self-actualization (e.g., EMDR). The patient is able to move from phase 1 to phase 2 when he/she can establish a useful distance from the traumatic event, when there is no current crisis, when there is a support system in place, when the person can self-soothe and manage his/her emotions, when there is no major dissociative disorder, and when living conditions are stable.

Seeking Safety

Seeking Safety is a fascinating present-focused therapeutic modality designed to help people attain safety from trauma/PTSD and substance abuse (e.g., simultaneous disorders). The model was developed at Harvard Medical School/McLean Hospital (2002) by Dr. Lisa Najavits.

Safety is described as the first stage of healing from trauma and substance abuse. It includes critical, integrative components such as encouraging clients to ask for help (interpersonal), building compassion rather than self-loathing (cognitive), and recognizing the red and green flags – the signs of danger and safety and be prepared with a safety plan – what they will do to stay safe (behavioral).

Najavits, (2003) developed a 21-item Seeking Safety Adherence Scale which measures the success of Seeking Safety therapy in a variety of settings (e.g., inpatient/outpatient, group/individual). Many aspects of the therapeutic relationship measured included: warmth and caring, management of crisis and extreme emotion, helpfulness, listening, level of engagement, and case management. Outcomes for individuals with trauma/PTSD were promising with SS treatment proving effective in many treatment areas.

Conclusion

Our hope was to present ways to broaden family therapist's "ways of being" with clients who continue to suffer from trauma, abuse and violence especially given our every-changing and damaging global circumstances. It is not unusual to hear contemporary family therapists describe their work as efforts to "save the world" or "to save the world one family at a time". These sentiments have been embedded within family therapy since its beginning. Our field's most fundamental theories demonstrate this yearning to "save the world" (Scott, 2001).

If the field of family therapy is to successfully and meaningfully contribute towards change in families and the world, it must allow for theoretical integration, disavow therapeutic dogmatism, and embrace effective treatment modalities. For example, without an ability to successfully integrate psychoanalysis – the totality of human experience – with the systems frame, and without the constant consideration of the importance of the therapeutic alliance, our hope as family therapists to broaden the "ways of being" with our clients is compromised. The allowance for integration, in particular, still seems to be lacking in our field. It is our hope that we have inspired future research to explore this as well as to continue to explore the significance of therapeutic alliance and outcome and evidence-based practice when dealing with global trauma, abuse and violence. ❑

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