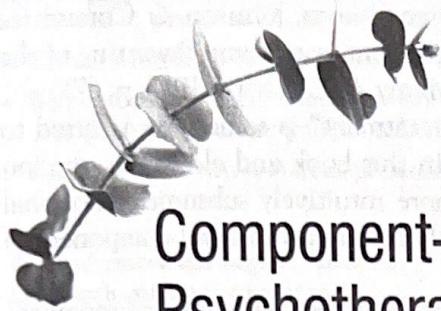


CHAPTER 1



Component-Based Psychotherapy with Adult Survivors of Emotional Abuse and Neglect

with Hilary B. Hodgdon

CONTINUE READING

At least three million children are victims of abuse or neglect each year in the United States. The vast majority of this maltreatment is perpetrated by the same adults these children rely upon for nurturance, protection, and, quite often, their very survival: parents and other primary adult caregivers or their romantic partners (Sedlak et al., 2010). Among maltreated children, more than half endure *psychological maltreatment*, characterized by repeated or ongoing exposure to severe *emotional abuse* or *emotional neglect* (Spinazzola et al., 2014). The American Professional Society on the Abuse of Children (APSAC) defines psychological maltreatment as “a repeated pattern of

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caregiver behavior or a serious incident that transmits to the child that s/he is worthless, flawed, unloved, unwanted, endangered, or only of value in meeting another's needs" (Myers et al., 2002, p. 81). It may also involve the terrorizing, rejecting, spurning, or exploiting of children (Kairys, Johnson, & Committee on Child Abuse, 2002), as well as the "persistent or extreme thwarting of the child's basic emotional needs" (Barnett, Manly, & Cicchetti, 1993, p. 67).

While the term "psychological maltreatment" is sometimes referred to interchangeably as psychological abuse, in this book and elsewhere, the former term is primarily used because it more intuitively subsumes emotional neglect in addition to verbal or emotional abuse as an integral component of this form of maltreatment.

Relational in nature, psychological maltreatment represents a fundamental disruption in the attachment bond through both a lack of attunement or responsiveness and overt acts of verbal and emotional abuse. These "attachment injuries" harm children by (1) undermining their development of an internal sense of psychological safety and security and (2) impeding their cultivation of capacities essential to successful life functioning, including emotion regulation, self-esteem, interpersonal skills, and self-sufficiency (Wolfe & McIsaac, 2011). In Table 1.1, we inventory various forms of emotional abuse and emotional neglect, along with some of the contextual factors that influence variability in the expression and effects of psychological maltreatment.

UNSEEN WOUNDS

Overlooked, underreported, and unsubstantiated in comparison to more overt or tangible forms of childhood maltreatment such as sexual or physical abuse, psychological maltreatment has historically constituted a "blind spot" for families, providers, researchers, and government agencies (Rosenberg, 1987). For example, one study examining child protective service case records revealed that while 50% of maltreated children had experienced psychological maltreatment, this abuse was officially noted in only 9% of cases (Trickett, Mennen, Kim, & Sang, 2009). In contrast to state and federal reports on the prevalence of psychological maltreatment, research studies on the prevalence of emotional abuse and emotional neglect in clinical and community samples most always reveal much higher rates of exposure, with community estimates ranging as high as 80% of children surveyed (Chamberland et al., 2005). An important study of over 11,000 trauma-exposed children and adolescents receiving treatment services across the United States through the National Child Traumatic Stress Network (NCTSN) found that impaired caregiving (impacting 40% of all youth assessed), psychological maltreatment (38%), and gross neglect (31%) were the third, fourth, and fifth most prevalent of 20 types of trauma assessed (Briggs et al., 2012).

TABLE 1.1. Variability of Emotional Abuse and Emotional Neglect Based on Type, Context, and Individual Factors

Variability in emotional abuse and emotional neglect
<ul style="list-style-type: none"> • Inflicted by part or all of caregiving system • With or without co-occurring abuse or other trauma • With associated affection (unintentional, inconsistent, or reactive psychological abuse or neglect) or negativity (intentional or malicious abuse or neglect) • Caregiver's capacity, resources, presence, and impairments
Types of emotional neglect (absence of warmth, support, nurturance)
<ul style="list-style-type: none"> • Caregiver is not physically present <ul style="list-style-type: none"> ▫ Forced to be physically absent due to work, military service, hospitalization, or incarceration ▫ Choosing to be absent due to substance or alcohol abuse or prioritizing another family • Caregiver is emotionally absent due to dissociation, severe depression, chronic mental illness, or developmental delays • Extreme family stress due to poverty, lack of social supports, or dangerous neighborhood interferes with caregiver's emotional availability • Caregiver ignores child's bids for attention or shuns child • Caregiver abandons the child for periods of time with no indication of when he or she will return or imposes extended periods of isolation from others
Types of emotional abuse
<ul style="list-style-type: none"> • Caregiver calls the child derogatory names or ridicules or belittles the child • Caregiver blames the child for family problems or abuse of the child • Caregiver displays an ongoing pattern of negativity or hostility toward the child • Caregiver makes excessive and/or inappropriate demands of the child • Child is exposed to extreme or unpredictable caregiver behaviors due to the caregiver's mental illness, substance or alcohol abuse, and/or violent/aggressive behavior • Caregiver uses fear, intimidation, humiliation, threats, or bullying to discipline the child or pressures the child to keep secrets • Caregiver demonstrates a pattern of boundary violations, excessive monitoring, or overcontrol that is inappropriate considering the child's age • Child is expected to assume an inappropriate level of responsibility or is placed in a role reversal, such as frequently taking care of younger siblings or attending to the emotional needs of the caregiver • Caregiver undermines child's significant relationships • Caregiver does not allow the child to engage in age-appropriate socialization • Child is exposed to relationship conflict between caregivers

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Historically, emotional abuse and neglect have been understudied compared to other forms of trauma and interpersonal victimization. And yet, whenever empirical research has shined light on these unseen wounds, "seisis" has been uncovered. For example, one of the first studies comparing the longitudinal effects of physical abuse, neglect, and psychological maltreatment found maternal verbal abuse and emotional unresponsiveness to be equally or more detrimental than physical abuse to attachment, learning, and mental health (Erickson, Egeland, & Pianta, 1989). Another early study found verbal, not physical, aggression by parents to be most predictive of adolescent physical aggression, delinquency, and interpersonal problems (Vissing, Strauss, Gelles, & Harrop, 1991).

Despite the proliferation of nearly 100 evidence-based or promising treatment models tailored to survivors of other forms of trauma designed to target particular posttraumatic symptoms or disorders, until now none have been specifically developed to treat adult or even child survivors of psychological maltreatment. In fact, many well-established, evidence-based, and widely disseminated treatments of adult traumatic stress omit assessment of exposure to childhood emotional abuse or emotional neglect entirely when conducting otherwise comprehensive trauma histories to identify clinical targets for intervention. Presumably, this is because these forms of trauma continue to be left out of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013) as adverse life experiences that "qualify" as causal (or "Criterion A") stressors for posttraumatic stress disorder (PTSD), the prevailing psychological trauma-related diagnosis in the United States since the establishment of this guide in 1980.

The lesser attention paid to psychological maltreatment is likely due to a confluence of societal and cultural factors. Notwithstanding compelling research from our Center revealing that psychological maltreatment typically serves as a "driver" of subsequent familial physical abuse and assault (Hodgdon, Suvak, et al., in press), and in and of itself psychological maltreatment is less likely to result in harm to the child that leaves overt physical "evidence." In contemporary Western societies, child sexual abuse and, increasingly, physical abuse have finally attained the status of consensus social taboo, motivating adults to intercede. Conversely, psychological maltreatment perpetrated by parents or other adult caregivers still largely remains in a gray area of (mis)perception regarding familial and cultural differences in parenting practices, or at worse as the unintentional consequence of ineffective or "stressed" parenting. Thus, it often fails to generate the larger systemic response from schools, pediatricians, child welfare, or law enforcement that is often necessary to result in intervention. Interestingly, as a society, we have a much easier time recognizing psychological abuse for what it is—and refusing to tolerate it—when it occurs outside the home, be it in our children's schools or communities perpetrated by peers (where we have renamed it "bullying") or when perpetrated against adults in the workplace (where we are quickest

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to condemn it as "harassment"). In contrast, valid assertions of the psychological maltreatment of children are often met with resistance, minimization, and even outright dismissal.

This societal "astigmatism" against recognizing psychological maltreatment clearly for what it is enables emotional abuse, and especially emotional neglect, to remain unseen or at least avoided by therapists, case workers, and other adults within a child's broader caregiving system. Perhaps more than for any other form of childhood maltreatment, providers can become complicit in "looking the other way" rather than defining emotionally aversive parenting behavior as psychologically abusive or neglectful and risk immersing themselves in a contentious and potentially ambiguous situation. Tragically, these patterns of familial and societal denial of the reality and consequences of psychological maltreatment heighten risk trajectories and exacerbate mental health disparities for this highly vulnerable subpopulation of trauma survivors. They contribute to the perpetuation of emotional abuse and neglect, with reduced likelihood of prevention, detection, and protective response, accurate understanding, or adequate intervention prior to adulthood.

A TURNING OF THE TIDE

Psychological maltreatment is finally beginning to receive greater recognition as a widespread and dangerous form of trauma in its own right and an important target of health disparities research and policy. Neuroscientific research has convincingly demonstrated specific and deleterious effects of emotional abuse and neglect perpetrated in childhood on brain development (for a seminal review, see Teicher & Sampson, 2016). The foremost leader in this research, Teicher has found parental verbal abuse to be an especially potent form of maltreatment, associated with large negative effects comparable to or greater than those observed in other forms of familial abuse on a range of outcomes including dissociation, depression, limbic irritability, anger, and hostility (Teicher, Sampson, Polcari, & McGreenery, 2006). Notably, when coupled with witnessing domestic violence, parental verbal abuse was found in that study to be associated with more severe dissociative symptoms than those observed in any other form of familial trauma or their combination, including sexual abuse. In 2012, the American Academy of Pediatrics released a special report identifying psychological maltreatment as the most challenging and prevalent form of child abuse and neglect (Hibbard, Barlow, MacMillan, & Committee on Child Abuse, 2012). Statements such as these echo emerging research findings from our Center documenting equivalent or greater immediate and long-term negative effects of childhood psychological maltreatment as compared to other forms of child victimization.

In our research using the Core Dataset (CDS) of the NCTSN, a large national sample of trauma-exposed children and adolescents, we found that

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psychological maltreatment was not only the most prevalent and earliest onset form of maltreatment, but also the most chronic form of trauma exposure out of 20 types of trauma assessed in the CDS (Spinazzola et al., 2014). Compared to physical and sexual abuse, psychological abuse, despite rarely being the focus of treatment, was the strongest predictor of symptomatic internalizing behaviors, attachment problems, anxiety, depression, and substance abuse and was equally predictive of externalizing behaviors and PTSD. In addition, psychological abuse was associated with equal or greater frequency than both physical and sexual abuse on over 80% of risk indicators assessed, and it was never associated with the lowest degree of risk across these three forms of maltreatment. Strikingly, experiences of emotional abuse or emotional neglect were found to carry greater "weight" or "toxicity" than other egregious forms of childhood abuse. Specifically, children and adolescents with histories of only psychological maltreatment typically exhibited equal or worse clinical outcome profiles than youth with combined physical and sexual abuse. In contrast, the co-occurrence of psychological abuse significantly potentiated the outcomes associated with either of those forms of maltreatment.

ADULT TRAUMA TREATMENT: CAN ONE SIZE REALLY FIT ALL?

The developmental disruptions that result from psychological maltreatment place children on a trajectory of continued difficulty over time. Interruption of one developmental step undermines mastery of subsequent developmental tasks, leading to an unfolding of impact that manifests over the course of the lifespan. In our clinical work, we have long regarded this form of childhood maltreatment as also having some of the most pervasive, complicated, and enduring effects on individuals across all aspects of identity and functioning. Accordingly, our approach to psychotherapy with adult clients contending with the aftermath of profound childhood psychological maltreatment differs in many important ways from traditional treatments for PTSD.

A large number of intervention models have been recognized as evidence-based treatments for PTSD based on carefully controlled clinical efficacy research (Foa, Keane, Friedman, & Cohen, 2010). However, much of the data on which these designations are based have been demonstrated to be constrained by conclusions derived from highly exclusionary study designs with adult survivors of acute traumatic events or those presenting with less complex clinical profiles and fewer risk indicators than is typically observed in clinical practice settings (Spinazzola, Blaustein, & van der Kolk, 2005). This raises fundamental questions about the generalizability of this body of research and the actual effectiveness of those treatments with real-life people who are seeking treatment for trauma, especially those suffering from more complex or treatment-resistant adaptations to trauma. This concern has led prominent trauma theorists and clinical researchers alike to challenge the

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adequacy of one-size-fits-all approaches to trauma treatment (e.g., Cloitre, 2015; Stein, Wilmot, & Solomon, 2016; Sykes, 2004).

In our experience working across the range of treatment settings with adult survivors of childhood emotional abuse and neglect—from community mental health centers and general outpatient clinics to trauma-specialty treatment centers and private practices, to inpatient, residential, and day-treatment settings—PTSD is the tip of the iceberg, if present at all. Through the accumulation of a substantial body of clinical wisdom, research, and scholarship over the past four decades, we have come to understand the legacy of chronic and severe childhood interpersonal violence, exploitation, attachment disruption, and neglect as a problem of complex trauma.

COMPLEX TRAUMA: THE MANY-NAMED FIEND

The quintessential unifying feature observed in our adult therapy clients with histories of chronic childhood trauma is this: their current difficulties are not merely linked to early life adversities; rather, the essence of these struggles, along with the core of their current identities and life narratives, cannot be meaningfully understood outside of the context of these formative experiences. For many of our clients, past experiences and present existence can appear to be hopelessly, inextricably entangled. Courtois (2004) articulated the first formal definition of complex trauma as a recurrent and escalating form of trauma occurring primarily within familial or intimate relationships. More recently, she elaborated on this definition in her excellent treatment book with Julian Ford:

traumatic attachment that is life- or self-threatening, sexually violating, or otherwise emotionally overwhelming, abandoning, or personally castigating or negative, and involves events and experiences that alter the development of self by requiring survival to take precedence over normal psychobiological development. (Courtois & Ford, 2013, p. 25)

The Complex Trauma Workgroup of the NCTSN (Cook et al., 2007; Spinazzola, Ford, et al., 2005; Spinazzola et al., 2013) has a similarly developmentally anchored definition of complex trauma as—a dualistic, pernicious, and progressive relationship between exposure and adaptation, concepts that have guided our thinking about the treatment of adult complex trauma.

Nearly as many other names and clinical conceptualizations have been offered in an effort to describe and define the problem of complex trauma as there are clinical experts, researchers, and scholars in the realms of traumatic stress, victimology, and public health. First among these was Terr's (1991) highly influential differentiation of Type I (exposure to single, shocking, intense traumatic events associated with more focal intrusive symptoms and cognitive

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misperceptions) and *Type II* (exposure to multiple, long-standing, or repeated extreme traumatic events associated with broader psychological consequences and personality/character impairment) trauma. While Terr did not use the term *complex trauma per se*, her conceptualization of Type II trauma has subsequently been attributed by some to be the origin of the complex trauma construct (e.g., Ford & Courtois, 2009). Even a largely overlooked conceptualization of complex trauma as constituting *Type III trauma* has been offered in the criminology literature (Solomon & Heide, 1999).

Foremost among conceptualizations of complex trauma is Herman's (1992a, 1992b) articulation of a diagnostic construct of the complexity of adaptation to trauma: *complex posttraumatic stress disorder* (CPTSD). For some time, this diagnostic construct was also described as *disorders of extreme stress not otherwise specified* (DESNOS; Pelcovitz et al., 1997; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005) in an effort to differentiate it from PTSD during and for some time following the DSM-IV field trials. An impressive body of empirical research on CPTSD has been amassed over the past two decades to bolster the widespread clinical support for and international recognition of this diagnostic construct (Cloitre et al., 2009, 2011; Cloitre, Garvert, Brewin, Bryant, & Maercker, 2013; de Jong, Komproe, Spinazzola, van der Kolk, & van Ommeren, 2005; Ford & Kidd, 1998; Ford & Smith, 2008; Ford, Stockton, Kaltman, & Green, 2006; Karatzias et al., 2017; Zucker, Spinazzola, Blaustein, & van der Kolk, 2006), despite lingering debate that the symptoms captured by CPTSD may more accurately be conceptualized as clinical correlates of a more severe form of PTSD (Wolf et al., 2015). More recently, a parallel stream of research and advocacy has been directed toward delineating and pursuing official nosological classification of *developmental trauma disorder* (DTD; D'Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012; van der Kolk, 2005), a diagnosis designed to capture the negative consequences of childhood complex trauma exposure on core regulatory capacities, domains of functioning, and risk trajectories (Ford et al., 2013).

Other complex trauma experts, most notably John Briere, have resisted establishment of a unitary diagnostic construct for complex trauma, emphasizing instead the variable expression of impairment across clusters of symptoms and domains of functioning influenced by the nature, number, and timing of trauma exposure in conjunction with individual differences in physiology, personality, temperament, and social context (Briere & Scott, 2015). Such researchers have focused instead on the effects of complex trauma exposure on phenomenological constructs such as *symptom complexity* (e.g., Briere, Kaltman, & Green, 2008; Hodges et al., 2013) and *complex posttraumatic states* (e.g., Briere & Spinazzola, 2005). Still other trauma and victimology researchers have created clinical constructs emphasizing the number of different types of trauma exposures in general (e.g., *cumulative trauma*; Agorastos et al., 2014; Karam et al., 2013) or else the number of different types of

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particular victimization experiences (*polyvictimization*; e.g., Finkelhor, Ormrod, & Turner, 2007) on the breadth and severity of clinical outcomes and risk trajectories. In turn, Ford and Courtois (2009) provide a useful differentiation of *complex psychological trauma*, *complex posttraumatic sequelae*, and *complex traumatic stress disorders*.

Finally, preventive medicine and public health researchers have independently generated constructs that overlap with facets of complex trauma exposure and adaptation. Paradigms such as *early life stress* (ELS), *toxic stress*, and *adverse childhood experiences* (ACEs) emphasize medical outcomes related to compounded experiences of maltreatment, neglect, or absence of a protective adult figure during childhood. Research on ELS (e.g., Garner et al., 2012) and toxic stress (e.g., Pechtel & Pizzagalli, 2011) has primarily focused on the effects of living with chronically activated bodily stress response systems on brain architecture, organ systems, and cognition. In a similar vein, the ACE framework has produced groundbreaking studies documenting the explicit link between an exponentially predictive risk of exposure to 10 different forms of familial trauma during childhood and a startlingly wide range of serious health conditions, diseases, and premature mortality in adulthood (e.g., Felitti et al., 1998).

ON THE SHOULDERS OF GIANTS

This book is intended primarily for clinicians as an applied guide to practice. Attempting an exhaustive review of the now rather extensive literature on adult complex trauma intervention would detract from this aim (for this purpose, we recommend Courtois & Ford, 2009). Nevertheless, this book would not exist without the foundation of four decades of complex trauma treatment theory, model development, and empirical validation that preceded it, and without the numerous luminaries in the field whose formative insights and essential groundwork guided our thinking and set the stage for the model introduced here. Prominent among these influences are Putnam's (1989) seminal book on the diagnosis and treatment of dissociation and the groundbreaking early writings on treatment of complex trauma by Herman (1992b) and van der Kolk, McFarlane, and Weisaeth (1996b). Chu (2011) offered an early practical guide for the treatment of CPTSD and dissociative disorders. Brown (Brown & Fromm, 1986) paved the way for modern understanding of the intersection between childhood trauma and altered states of consciousness in adulthood and provided innumerable strategies for working with dissociative self-states. Courtois (2010) and Roth (Roth & Batson, 1997) greatly expanded understanding of treatment of adult survivors of childhood incest. Pearlman and Saakvitne (1995a) and Pearlman (1998) produced lasting works exploring the effects of trauma treatment on the practicing therapist. In addition to being developers of major complex trauma treatment models in their

own right (Cloitre et al., 2006; Ford, 2015), Cloitre and Ford have spearheaded vital clinical research advancing the empirical basis for complex trauma intervention paradigms and diagnostic constructs (e.g., Cloitre et al., 2010; Ford et al., 2013). Most recently, Courtois and Ford (2013) have published the most sophisticated book to date on the nuance and sequencing of relational treatment of complex trauma.

Childhood emotional abuse and neglect leave behind a powerful residue. These experiences can shape survivors' attributions of self and perceptions of others, undermine their establishment of healthy attachment relationships, and obstruct their capacity to tolerate the receipt and expression of emotional intimacy. These effects can lead some survivors of psychological maltreatment to internalize an innate sense of failure or shame to a more global extent than that observed in response to nearly any other form of trauma. We find that adult survivors of severe and prolonged childhood emotional abuse and neglect present with clinical profiles and therapeutic needs that overlap with (but that are in important and nuanced ways distinct from) those observed in adults with other complex childhood traumatic experiences. As a result, it is our experience that adult survivors of childhood emotional abuse and neglect typically require therapeutic approaches that not only diverge from those offered by traditional PTSD-focused intervention models, but that also vary in focus and degree from those offered by existing complex trauma intervention paradigms. Accordingly, whereas the new framework we describe in this book has been designed for use in treatment with adult survivors of all forms of complex trauma, we pay particular attention to adults with pronounced histories of childhood emotional abuse and neglect.

MODELS AND MYTHS

Essentially, all models are wrong, but some are useful.

—GEORGE P. BOX

The question of how to facilitate psychic healing in adults suffering from the legacy of familial maltreatment has drifted in and (often been driven) out of the forefront of psychotherapeutic theory and practice, since the advent of psychology as a science in the late 19th century. In that time, many specific treatment models have been developed or adapted to address posttraumatic sequelae. Most of these interventions fall to a greater or lesser extent within one of what we loosely conceptualize as three predominant paradigms that emerged over more than a century of traumatic stress inquiry and research, acknowledgment and denial, remembering and forgetting. Each of these paradigms has made pivotal—and to our mind, essential—contributions to the evolution of our field.

The first and most enduring of these paradigms has concentrated on the intentional activation and processing of traumatic memories as the primary