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Many counselors feel pressure to use manualized treatment approaches because of pressure from 3rd-party payers. Unfortunately, this is not always the best practice, especially in cases of complex trauma, in which a very strong therapeutic relationship is a vital component of successful treatment. Relational–cultural theory provides an alternative conceptual lens for treating complex cases and is a natural fit for counselors' professional identity. This case illustrates how a counselor used a relational–cultural conceptualization as a guide in treating a client with complex presenting concerns.

Many third-party payers, including both private insurance and providers of public benefits, are pushing for short-term, manualized, evidence-based treatments for serious mental and emotional disorders (Marquis, Douthit, & Elliott, 2011). In turn, this push has a strong influence over counseling practices, because the entity that holds the money holds the power. Most counseling clients do not pay for their sessions out of pocket; therefore, they often have very little power in the context of their treatment. Those who hold optimistic beliefs about the efficacy of short-term, manualized treatments are not without good reason to do so. Manualized treatment protocols have indeed been scientifically validated by statistically significant studies in controlled settings (Sanderson, 2003) and have a certain amount of face validity. However, on an anecdotal level at least, counselors often encounter cases that do not respond well to such manualized treatments. In fact, manualized treatment protocols may simply remediate people's symptoms without fully addressing the substance of their problems. Whereas psychologists and psychiatrists tend to practice from

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an illness orientation, counselors are oriented by their professional identity toward a wellness-based approach to their work (Kaplan & Gladding, 2001). So, whereas clinicians in the other helping professions see their job as treating mental illness by remediating unwanted symptoms, counselors conceptualize their clients' problems as being the understandable result of a poor fit between person and environment and generally being developmental in nature. Counselors, then, often find themselves feeling torn between providing treatment they believe to be in the best interests of their clients (but for which they will not be appropriately compensated) and treatment that will allow counselors to make a living but will merely gloss over their clients' symptoms.

RELATIONAL–CULTURAL THEORY

Relational–cultural theory (RCT) was developed in the late 20th century by scholars at the Stone Center at Wellesley College and by Carol Gilligan (Gilligan, 1982; Jordan, Kaplan, Miller, Stiver, & Surrey, 1991). RCT came in response to the traditional beliefs held by the psychological community that separation and individuation are the ultimate goals of human development. This traditional view pathologizes what many in the field now understand to be the normal developmental needs of women, labeling women's need for connection as "dependent," and conceptualizing it as a tendency to become "enmeshed." RCT holds that all people, and particularly women, develop in relationship with others and that relationship is a key force in development (Gilligan, 1996; Miller & Stiver, 1997).

This tendency for mental health professionals to pathologize women's normal developmental needs can lead to dangerous territory, holding the potential for damaging effects on clients. When an individual is led to believe that what she desires most is in some way unhealthy or unnatural, she will do what she can to suppress those desires and label them as many in the mainstream psychological community do: as evidence that the individual is overly dependent or "needy." This, in turn, may lead the individual to question her reality as she experiences it, because she now feels that she must deny what she knows to be a fundamental truth about herself. This leaves her feeling torn between being true to herself and being what she is led to believe is mentally healthy, thus leading her to further question the accuracy of her perception of reality and to further disconnect her from her sense of self (Jordan, 1995).

The conditions necessary for optimal development are not necessarily met in all relationships, and there is indeed the potential for some relationships to impede or stifle growth. The growth-fostering relationships that RCT theorists hold out as the ideal toward which all individuals should strive are characterized by five core conditions. These conditions include the experience of zest or vitality, empowerment to take action, increased knowledge of both self and other, a sense of worth, and the desire to seek out more relationships (Miller

& Stiver, 1997). Relationships in which these "five good things" occur are certainly not to be characterized by terms such as *enmeshment*, *regression*, and *dependency*. According to RCT, psychological problems are not the result of a failure to individuate, but are instead the result of disconnection.

Because counselors, by virtue of their professional identity, assume a wellness model and a belief that all people are doing their best within their respective contexts, RCT seems to be an excellent fit for counselors (Duffey & Somody, 2011). Unfortunately, this theory is still considered to be outside of the mainstream of psychological theories, as evidenced by its status as a footnote in counseling theory and techniques courses. Therefore, it may be helpful to illustrate how it could be used as a lens for case conceptualization. The individual whose case is discussed in the following section presented with complex and pervasive concerns that could not be easily addressed with standard, evidence-based approaches.

THE CASE OF JOAN

Background

Joan was a 60-year-old, divorced, White woman who had been receiving dialectical behavior therapy (DBT) treatment at a community mental health agency for approximately 8 months before she was transferred to my caseload. (Note: All names have been changed to maintain confidentiality.) As a newly minted professional counselor, I gladly took Joan on as one of my first clients in my new position. I had met Joan once before during my internship, when I covered for her regular therapist when that therapist was on vacation. I recall noticing then that Joan was already very committed to therapy and was working hard to learn her DBT skills. During the interim between the time my internship ended and when I was granted my license, Joan and her regular therapist hit an impasse, and Joan requested a new therapist. I was surprised to find out that she specifically requested me because she felt that I had helped her somehow during our initial encounter.

Presenting Problems

Among the concerns that she brought to counseling, Joan had been previously diagnosed with traits of borderline personality disorder (BPD), and indeed, she met many of the criteria. The few relationships she had were very intense; she relied heavily on her daughter, Lynne, and her male friend, Joe, but these relationships were chaotic and involved a great amount of conflict. Her moods were also problematic; it was not unusual for her to alternate between experiencing intense anger, shame, sadness, anxiety, and despair all within the period of 1 or 2 hours. Her thinking featured many of the cognitive distortions that individuals with BPD tend to experience, particularly the dichotomous thinking, should statements, labeling, and personalization/blame (American Psychiatric Association, 2000). Fortunately, the one domain associated with BPD that remained intact in Joan's case was her behavior. She was never suicidal, she never

self-harmed, she was abstinent from drugs and alcohol, she was not sexually promiscuous, and she did not engage in any other high-risk behavior. Joan even remarked on a few occasions that it was a miracle that she had not attempted suicide or turned to drugs as a result of her problems. Because her case was quite complicated in so many other ways, her well-regulated behavior was the saving grace that prevented me from becoming overly discouraged or severely burnt out.

Therefore, because Joan's behavior was relatively well regulated, her treatment fell mainly within the realm of the second stage of DBT, the goal of which is for the client to achieve "non-anguished emotional experiencing" (Rizvi & Swenson, 2010). Unlike the first stage of DBT, there are no clearly articulated protocols for the second stage other than a recommendation to use prolonged exposure protocol (Foa, Hembree, & Rothbaum, 2007) for presentations that include posttraumatic stress disorder. Otherwise, the therapist has, in this second stage, considerable freedom to use a variety of therapeutic techniques and interventions as long as he or she practices within the principles of DBT. In short, the main principles of DBT are to maintain a balance between change and acceptance, be mindful of how the behavior of both the client and the therapist influence one another, and embrace a dialectical philosophy (Linehan, 1993). This lack of a rigid set of rules for how therapy was to be conducted was eventually what allowed Joan to make significant progress later in her treatment. Additionally, the fact that the agency and her provider of mental health benefits still considered her to be receiving DBT allowed her treatment to continue much longer than it might have otherwise. This was because of the severity of Joan's symptoms and DBT's status as an evidence-based practice. Were it not for this seemingly perfect storm of diagnoses, symptoms, treatment choice, level of care, and Joan's source of mental health benefits, her treatment likely would have followed a very different course.

Possibly the most challenging part of her case for me to deal with was the way her dissociative symptoms affected our treatment. She frequently felt emotionally numb, and she often made reference to feeling as though there were two of her. It is important to note that neither Joan nor I ever considered the possibility that she suffered from dissociative identity disorder or any kind of psychosis; rather, she was keenly aware that she had "sectioned off" parts of herself, and—to borrow some terminology from object relation (Stark, 2002)—that the reality that her observing ego observed was not always the same version of reality that her experiencing ego experienced. As I look back on her case, I recall that I often felt as though I was talking to more than one individual. Joan's presentation alternated between being quite competent, committed, expressive, and even insightful at times, and presenting as utterly helpless, withdrawn, and avoidant at other times. It was nearly impossible for me to anticipate which parts of Joan I would see from week to week, and so it seemed as though we were often starting from square one in each session.

Choppy Waters

I began to feel frustrated with our sessions. Joan spent a significant portion of our time together complaining about her medical problems and what she perceived to be the unsatisfactory treatment she received for those problems. She would verbalize the belief that she needed to increase her socialization but would then start crying and insisting that she neither wanted nor needed friends. She was quick to find fault with others, but typically saw herself only as a victim. There were times when I considered the possibility that she may have achieved the most benefit from therapy that she could, given her level of functioning, and that she would eventually drop off of my radar altogether someday. In short, I did not have high hopes for Joan's success in therapy, and, as a result, I found myself wavering between criticizing myself for being unable to help her more and wishing she would just drop out so I could forget about her and how incompetent I felt in our work together.

Gains and Some Clues

Later in our 1st year together, Joan and I saw some progress in her treatment, and she was able to use her coping skills more consistently and effectively. A highlight of this was what we later called a "marathon skills session." She patiently and skillfully tolerated being bounced around on the phone among several customer service representatives over the course of 3 hours, which resulted in her getting a lower rate on her cable bill. Ordinarily, this would have been a highly stressful experience for her, to which she would have responded by hysterically crying or lashing out in frustration. Whereas most people become frustrated in similar situations, there were additional factors that made this experience even harder for Joan than it would have been for a typical person. The various customer service representatives with whom she spoke were inconsistent in the information they gave about her account. I had learned during our time together that inconsistency from any person triggered extreme levels of anger, fear, and anxiety in Joan. We began to understand that this was a key relational image for her, because it was a familiar feeling that she often experienced when she was still married to her ex-husband, Bill. While they were married, Bill was often unpredictable and was abusive toward Joan, and it was common for him to "change the rules" on her just as she was beginning to figure out how to keep some amount of peace in the relationship. Joan's relational images, then, included the experiences that people were highly unpredictable, that she had no effect on what happened in her relationships, that she was in danger when she was unable to anticipate other people's behavior, and that therefore all relationships were frightening and dangerous.

This offered an important clue about how the central relational paradox (Miller & Stiver, 1997) played into Joan's difficulty in so many facets of her life. From the RCT theory of development, relationships are the means by which all people develop (Miller, 1986; Miller & Stiver, 1997). The paradox is that we need and

long for relationships to grow and thrive, but, to keep our relationships, we need to keep certain parts of ourselves that we deem unacceptable out of our relationships. In Joan's case, she had all but completely disconnected from her desire for relationships altogether. It seems that this may have been the reason for both Joan's and my experience that there were two of her, because she allowed parts of herself that she deemed worthy or appropriate to come into our therapeutic relationship, and she kept other parts of her identity to herself. This second, internal part of her identity included fear, self-doubt, and her knowledge of unspeakable truths about herself. This divide in her experience of herself also provides an explanation for why I had often felt that we were going nowhere in our counseling.

Roots of Dissociation

As our treatment progressed, I learned more about her history of trauma. Not surprisingly, the abuse she suffered had not begun with her ex-husband. She shared with me that her father had verbally, physically, and sexually abused her from her earliest memory until she got married and moved out of the house. He would often defend his verbal and physical abuse by telling her that he was doing it for her own good and that God wanted him to be harsh to teach Joan to be a "good" girl. As for the sexual abuse, it was so pervasive throughout her upbringing that it barely occurred to her that it could have been considered sexual abuse at all; although it felt wrong to her, she assumed that her aversive feelings about it were an overreaction. She learned early on to shut out parts of herself that did not match the reality that she was taught to believe, and, by dissociating from these memories, she was eventually able to forget what happened to her.

Advocating for Self Versus Succumbing to Authority

As we were updating her treatment plan approximately 6 months into our therapeutic relationship, I asked her about her treatment goals for the upcoming year. She responded matter-of-factly that she needed to make friends, to be able to get out in public more, and to meet people. She stated that her reason for having these goals was that she knew they were something she needed to do, particularly because all of her previous therapists told her that she needed to do them. Just as I began to write it into her plan, she suddenly became emotionally dysregulated and backpedaled at lightning speed.

"I don't really need friends though," she insisted, "I do just fine by myself. I have no need to go out and do anything with people. I am perfectly happy to keep to myself, to do my scrapbooking, my photography, and to spend time with my cats."

She went on to explain, with a certain amount of urgency, that not only did she feel content to be alone, but that she also had no intention of setting a treatment goal pertaining to socialization. With every sentence her affect heightened, her tone of voice became more intense, and she even began to stutter a bit as she spoke. She was at once angry and terrified: angry that other people who did not fully understand her situation would presume to dictate such a

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delicate matter in her treatment, and terrified of the prospect of revisiting the old relational images that had played out with her parents, her ex-husband, and even Joe. At that time I had difficulty truly understanding her position, and I shared my colleagues' opinion that Joan desperately needed healthy connections with others more than anything else at that point. However, when I saw the extreme nature of her distress, I decided to back off. There had to be a good reason for Joan to be as upset as she was, and I did not feel right about taking a patriarchal "therapist knows best" stance to bend Joan to my will.

I now believe that my decision to back off may have been the best decision I made in our therapeutic relationship. I suspect that my willingness to let Joan work at her own pace rather than imposing my arbitrary expectations onto her treatment led her to trust me more. Joan's increased trust in me made it possible for our relationship to evolve into one that came closer to approximating the kind of growth-fostering relationship that is necessary for healing.

In the Bubble

Approximately 1 year later, I got a closer look than ever at Joan's dissociated self. She had been reading a book written for victims of childhood abuse, and, at one point, the book asked the reader to make a list of people that the reader considers safe and a list of those considered unsafe. It was not surprising that Joan had very few people on her safe list; I was happy to find out that I had earned my place in that select group. What was surprising, however, was that her friend Joe appeared on both the safe and the unsafe list. She explained that she considered Joe to be safe because they had known each other for many years and that he provided for her in important ways. Joe gave her rides to her therapy sessions and to the doctor when she had car trouble or when she was too ill to drive. He also accompanied Joan on her visits to her beloved elderly aunt who lived out of state. The two had each supported the other when they had suffered serious illnesses and underwent invasive surgical procedures at various points in their lives. Joe was Joan's only human companion. On the other hand, he also had a quick temper and verbally abused her when he became angry. He did not respect Joan's wishes for him to refrain from using certain inflammatory language, nor did he respect her ability to make her own decisions. Joan described him as the most judgmental person she knew and stated that she did not, in fact, consider him to be safe at all. As she continued describing their relationship, she came to the conclusion that she very much wanted to find other people on whom she could rely and that, after she did, she would break ties with Joe. This was something she had alluded to once before nearly 1 year earlier, but, this time, she went into more depth. Furthermore, now the contrast was even starker between her justifications for claiming that Joe was safe versus her experience of Joe as unsafe.

When she would dissociate like this, Joan described it as "being in a bubble." Inside the bubble was Joan's true self, the self that she went great lengths to keep out of relationships for the sake of her own safety. Starting in her earliest

memories, she said she had no choice but to use disconnection as a survival strategy. Joan's true self was well aware that Joe was not a safe person with whom to be in relationship. On the other hand, her survival depended on building a metaphorical bubble around herself that allowed her to function in the world. The parts of her that made up the outside of the bubble denied the existence of Joan's inner experience and even denied that the bubble existed at all. This was the brave face that she put forward to the world: the Joan that told herself that Joe was safe, that she should follow her therapists' advice to make friends, and that maybe the horrors of her childhood had not even happened as she remembered them.

Turning a Corner

Around the same time that Joan began to increase her awareness of the bubble, she began to make huge gains in therapy. I had relinquished control over the process and content of our sessions to Joan, as long as what we were doing was productive in terms of addressing her trauma. Each week, Joan began our sessions with a brief review of the week and then went right into discussing her impressions of the chapters of the self-help book she had been reading. She gained more and more insight into her experience of having been victimized for so many years, and, with each week, her narrative gained complexity. She was even able to verbalize empathy for her abusers and for those who colluded to allow the abuse to continue. My job as Joan's therapist had changed from coaching Joan on how to cope with problems within the framework of a manualized treatment protocol to observing, processing, and accepting Joan's experience through a relational lens.

CONCLUSION

Joan's concerns were complicated and presented serious obstacles to treatment. The most problematic of these was her bubble, because it interfered with her ability to truly connect with her counselor to form a strong therapeutic alliance. I found that our eventual progress resulted from my honoring her need for her strategies of disconnection and the turning of my focus away from my concern about outcomes. Somewhat ironically, Joan's outcome was much better than it would have been had I remained focused on outcomes. We were also fortunate that Joan's treatment was taking place within our agency's DBT program, because this allowed us to continue our work much longer than we might have in a different context with regard to treatment, level of care, and reimbursement. She now reports that she voluntarily increased her socialization and has achieved better mental and emotional well-being than she had expected to achieve in her lifetime.

Although RCT is an excellent fit for counselors, philosophically speaking, this theoretical framework presents challenges with regard to implementation. To allow one's practice to be informed by RCT principles, the counselor must

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be willing to give up a fair amount of control over treatment and some of the power that he or she has in the therapeutic relationship. Because there are no clearly defined protocols to follow, the counselor needs to rely much more on his or her intuition and be willing to simply accompany clients on their journeys of healing and growth. A particular challenge here lies in how to do this without allowing the session to devolve into an occasion for the client to air complaints and worries without also actively working toward personal growth. This requires counselors to be highly self-aware and comfortable with themselves, because it is nearly impossible for a client to have a mutually empathic, mutually empowering, growth-fostering relationship with a counselor who is unwilling or unable to cultivate these kinds of relationships in his or her own life. These challenges notwithstanding, the counselor who uses RCT principles to guide his or her understanding of human development and behavior will find an opportunity to challenge traditionally held beliefs about the nature of the work of therapy. Such a shift may eventually result in counselors being able to achieve a more nuanced, comprehensive understanding of the nature of emotional well-being and thus provide more meaningful treatment to clients.

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