A Brief Note on Research Support for the Risking Connection® Approach

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Mental health practitioners who use the *Risking Connection* (RC) model find it to be an extremely effective treatment, helping clients to feel more in control of their lives, less symptomatic, more self-aware, and more engaged with life. Workers, too, report feeling more hopeful, helpful, and better equipped to do their jobs using the approach outlined in RC. *Risking Connection* is grounded in constructivist self-development theory, a clinical theory that provides a framework for understanding and treating trauma survivors (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). The staff of the Traumatic Stress Institute/Center for Adult & Adolescent Psychotherapy LLC has treated hundreds of trauma survivors over the past 14 years using the *Risking Connection* approach. On the basis of both CSDT and our clinical experience, we believe that adoption of the RC approach will lead to better client outcomes as well as overall higher staff morale and less turnover. We are currently in the beginning stages of conducting outcome research that will test our predictions about the effects of using RC with both staff and patients.

In the meantime, it is important to note that many of the basic concepts that RC draws upon (the role of the therapeutic relationship, psychoeducation, empowerment, meaning-making, and the effects of the work on the worker) have theoretical and empirical support.

Risking Connection is based on the premise that the therapeutic relationship is the foundation for psychological growth and change. This concept is drawn from a considerable body of literature, which theorizes that the quality of the therapeutic relationship is paramount to successful treatment (Messer, 1988; Chessick, 1993).

Empirical findings support this theory. Research has demonstrated that although the concept of the therapeutic alliance has its roots in the psychoanalytic literature, it is an essential component of all types of therapy. A meta-analysis of 24 different research studies conducted on the therapeutic alliance found that the client's perception of the quality of the alliance was the best predictor of success in treatment, independent of the type of therapy (Horvath & Symonds, 1991). Interestingly, the client's perception of the alliance was a better predictor of success than the therapist's perception of the alliance, providing support for another aspect of the RC approach—the importance of identifying and working from the client's perspective on his/her problems, goals, and treatment.

RC speaks to the particular challenge of maintaining safe and trusting alliances with individuals who have been repeatedly hurt within the context of significant relationships. While others have suggested that facilitating a safe and trusting therapeutic environment is necessary in all therapies (Foreman et al., 1985), it is particularly relevant with survivors of trauma for whom themes of safety and trust typically emerge in the

therapeutic process (Briere, 1996; Courtois, 1988; Herman, 1992; McCann & Pearlman, 1990; Olio & Cornell, 1993). Research with trauma survivors has found that building a therapeutic alliance is related to the ability to trust others (other-trust), while sustaining an alliance over time requires developing positive feelings about others (other-esteem) (Nicastro, 1997). *Risking Connection* frames the therapeutic alliance as the basis for developing a secure attachment, without which techniques would be unsuccessful. Themes such as trust and safety are well served in relational approaches such as *Risking Connection,* which emphasize the importance of establishing trust and mutuality in the therapeutic relationship.

Further elaboration of some of the ideas presented in RC in regard to the importance of relationship and connection may be found in the writings of the Stone Center (e.g. Surrey, 1991; Miller & Stiver, 1993).We agree with their theory that a primary goal of psychological development is to move toward mutuality rather than separation. This goal is then reflected in the therapy process where a context of trust, mutual empathy, and empowerment must be established in order for growth to take place.

The components of such a therapeutic relationship are described in RC as RICH (Respect, Information, Connection, and Hope). These are also the ingredients of empowerment (Kalinowski and Penney, 1998), and a small body of research has recently emerged which supports the role of empowerment in psychological healing. Ozer and Bandura (1990) found that empowering individuals with the ability to exercise control increases their feelings of personal safety. There is additional research demonstrating the efficacy of psychoeducation, or providing information (the "I" in RICH) to clients about their problems, prognosis, community resources, etc., in reducing symptoms among survivors of trauma. For example, a recent study showed that the use of psychoeducation in a women's trauma group increased self-care (Talbot, Houghtalen, Cyrulik, Betz, Barkun, Duberstein and Wynne, 1998). Psychoeducation was also successfully used in a case study with a trauma survivor to decrease health concerns (Nayak, Resnick, and Holmes, 1999).

Meaning-making, a further component of the *Risking Connection* approach, has also been theoretically and empirically connected to trauma recovery. For example, Jim Lantz (1992) writes about Logotherapy, an existential approach to trauma treatment in which the meaning of one's experience is emphasized. The efficacy of articulating meaningful aspects of one's experience within trauma recovery has been illustrated by case examples (Lantz, 1996; Lantz and Greenlee, 1990). Posttraumatic Growth theory and research also supports the notion that finding meaning within traumatic experiences and incorporating such meaning into treatment can lead to growth and healing. One study found that persons who had recently experienced a major stressor and had reported symptoms of psychological distress did not differ from their controls in regard to evaluations of the world as predictable, safe, and controllable. The authors suggest that the participants'metaphysical beliefs allowed for effective coping with the trauma (Overcash, Calhoun, Cann, and Tedeschi, 1996).

Lastly, we would like to mention the theoretical and empirical support for RC found in the Dialectical Behavior Therapy (DBT) model. Originally developed as a treatment model for Borderline Personality Disorder (BPD), DBT has been used with various other disorders, as well as with trauma survivors. Like RC, DBT emphasizes strategies for acceptance, validation, and for developing feelings skills—skills that are important for the survivor client. Linehan, Heard, and Armstrong (1993) found that women with BPD and a history of parasuicidal behavior who received DBT demonstrated, among other things, less parasuicidal or self-injury behaviors than did their controls in the treatment-as-usual group. We hypothesize that our RC model, which shares some important characteristics with DBT, would also be effective in decreasing self-injury behaviors, a common symptom among trauma survivors. In addition, DBT emphasizes support for the therapist, thereby offering further endorsement of RC's focus on vicarious traumatization and caring for the caregivers.

In summary, a small, but growing body of empirical research exists that supports the foundation of the RC approach: the critical importance of relationships—particularly the therapeutic alliance—in psychological healing. Two specific components of the RICH relationship, respect and information, are also supported in the empowerment and psychoeducation literature. And the component of hope is supported in literature that speaks to meaning-making. RC's emphasis on developing feelings skills has also found empirical support. Other critical components of RC, such as understanding symptoms as adaptations and working to acknowledge and minimize the effects of vicarious traumatization, have good theoretical support and clinical acceptance (e.g. van der Kolk, 1987; Chu, 1998; Herman, 1992; Courtois, 1999) although research to empirically assess these concepts has yet to be conducted. It is our hope and prediction that as more agencies and organizations begin adopting the RC approach, and more outcome data are gathered, we will be able to demonstrate empirically that utilizing a RICH™ relationship, understanding symptoms as adaptations, and acknowledging and tending to the effects of the work on the workers all contribute to enhanced healing for clients and greater job satisfaction and morale for workers. We invite interested colleagues to consider collecting data to assess the effectiveness of the *Risking Connection* approach.

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