Developmental Couple Therapy for Complex Trauma: Preliminary Results of a Pilot Study

Heather B. MacIntosh Ph.D.
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heather.macintosh@mcgill.ca

Why do we need a Trauma informed couple Treatment?

- Couples and trauma:
  - High levels of distress & dissatisfaction
  - Significant impacts of trauma on relationships
  - Partners feeling left out of healing process
- Direct Impacts of PTSD--Symptoms
- Indirect Impacts of Complex Trauma—Skills
  - Emotion regulation
  - Mentalizing
- Insecure Attachment
- Assortative Mating-Vicarious trauma
- Limitations of current models

Where do “traditional” models fall short for trauma survivors?

- Frequently avoid working with survivors
- Assumption of certain self capacities
  - Assume that participants can regulate emotions
  - Tolerate and integrate the perceptions of others
  - Develop therapeutic relationship with some ease

DCTCT

- Integrates understanding of the specific challenges in couple therapy with trauma survivors
- Intervening at the level of developmental deficit:
  - Improve process and outcomes in couple therapy, &
  - Decrease individual trauma symptoms and attachment hypervigilance.
- Mentalizing & emotion dysregulation as baseline skills

Developmental Couple Therapy for Complex Trauma

- Emphasizes Interventions to promote mentalizing
  - Based on understanding of the development of self and interpersonal capacities and how this development is impacted by CT
  - Affect regulation
  - Empathy
  - Perspective taking
  - Does not move into process focused interventions until the final stage

- Stage One – Establishing Context
  - Establishing Safety, Therapeutic Alliance
  - Psychoeducation (Creating a common goal)
    - Trauma and Relationships
    - Trauma and Attachment
    - Trauma and Sexuality
    - Shame
    - The Negative Cycle and Dyadic Traumatic Reenactment
    - What is Mentalizing?
    - What is Emotion Regulation?
  - Containing Conflict

- Stage Two – Capacity Building in the Attachment Relationship Context
  - Building Mentalizing Capacities
  - Building Emotion Regulation Capacities

- Stage Three – Attachment-focused Dyadic Processing
  - Attachment Histories Living in the Present
  - Dyadic Traumatic Reenactment
  - Disclosure – Telling the Stories
  - Trauma Processing in a Dyadic Context
  - Sex and Sexuality

- Stage Four – Consolidation
  - Consolidation

Stage One: Establishing Context

- Working on therapeutic relationship
- Beginning psychoeducation
- Containing Conflict

Psychoeducation

- Trauma and Relationships
- Trauma and Attachment
- Trauma and Sexuality
- Shame
- The Negative Cycle and Dyadic Traumatic Reenactment
- What is Mentalizing?
- What is Emotion Regulation?

- This happens in the context of relationship building, containing conflict and an ongoing process of assessment
- Handouts are provided on each topic
  - Working through the handouts with the couple's own stories and framing this in the context of emotion regulation and mentalizing

TRAUMA AND ATTACHMENT

WHAT DO WE MEAN BY ATTACHMENT?

The term attachment relates to the relationships we have with significant others in our lives. In particular, we are referring to the relationship between an infant and their primary caregiver and the relationship between romantic partners.

There are different ways of being attached. The majority of people (70%) had mostly positive experiences of closeness with their primary caregivers in infancy and childhood and these people, called securely attached, came to believe that people would be there for them in their distress and that they, themselves, were worthy of care and comfort from others. A smaller percentage of people experienced relationships with their primary caregivers that caused them to feel insecure about whether they, themselves, were worthy of consistent care and to be unsure about whether people would be there for them.

Research with couples has demonstrated that attachment security/insecurity is quite consistent from childhood to adulthood. This research has also demonstrated that the needs for closeness, safety and a “secure base” are lifelong needs. This tells us that if someone has a secure attachment in childhood, they will likely have a secure attachment also with their romantic partner.

HOW DOES CHILDHOOD TRAUMA IMPACT ATTACHMENT?

Childhood trauma may have a significant impact on attachment. The earlier in your life that the trauma happens and the closer the relationship you have with your abuser, the more significant is the impact of the trauma on your attachment security.

The majority of childhood trauma survivors do experience some insecurity in their attachment relationships.

For those who have experienced sexual abuse, attachment insecurity can be even more complicated. For instance, while you may really long for connection and closeness with others, that very same closeness and connection may feel very dangerous. This can lead to difficulties with maintaining close relationships and a tendency to jump in relationships quickly but become overwhelmed and frightened and then run away.

WHERE DO YOU SEE YOURSELF IN THESE DESCRIPTIONS?

Do you tend to be anxious about whether others will let you down or abandon you?

Do you tend to avoid closeness with others and fear that they will hurt you if you let yourself get close?

How has this affected your relationship?

How do you understand the origins of these feelings?

Containing Conflict

- Working on Emotion Regulation capacities to decrease ongoing conflict
- Assessing IPV to determine suitability for treatment

Stage Two: Capacity Building

- Mentalizing
- Emotion Regulation

Mentalizing

- “Thinking about thinking”,
- Interpretation of behaviour in terms of intentional mental states,
- Relies upon secure attachment for development,
- Necessary for empathy, affect regulation,
- Fundamental for navigating social relationships

Characteristics of Good Mentalizing

- Security of mental exploration
- Curiosity
- Perspective taking
- Empathy
- Self reflection
- Comfortable with uncertainty
- Acknowledgement of opaque nature of mental states
- Acknowledgement of changeability of mental states
- Playful, engaged, flexible & not stuck
    - Adapted from * Luyten, P., Fonagy, P., Lowyck, B., & Vermote, M., (2012).

Characteristics of Bad Mentalizing

- Unreflective
- Rigid adherence to own perspective
- Unjustified certainty about self or other
- Automatic
- Distorted
- Overly focused on Internal of External factors
- Lack of interest in mental states
- Defensive attempts to avoid mentalizing
- Inability to regulate distress in relation to others
  - * Luyten, P., Fonagy, P., Lowyck, B., & Vermote, M., (2012).

Therapeutic Process

- Therapeutic Stance:
  - Mentalize the relationship
    - Both partners and together
  - Model mentalizing
    - Include yourself in this dialogue where appropriate
  - Challenge mentalizing limitations
    - Push the limits of rigidity to build flexibility
    - Challenge and explore assumptions
    - Help the couple develop curiosity
  - Practice mentalizing
    - Take apart the “small” issues of daily life
    - Scaffold these into the more challenging issues over time
  - Help the couple hold past, present and future in mind as they explore their own expectations and assumptions
  - Keep trauma in context of current relationship issues

Question that prompt mentalizing

- How do you think you partner would feel about situation X?
- What do you imagine was your part in that argument?
- How do you imagine your partner is feeling right now?
- When you look back over the past week, what do you think your partner would say had gone well?
- How do you imagine your partner would know that you were feeling upset?
- If this happened again, could you imagine trying something different?
  - What might that be?

Camille: I run out of milk and suddenly, oops I can’t eat breakfast any more. He doesn't even notice.
Therapist: Do you drink milk?
Chris: No.
Therapist: Why would he notice?
Camille: Because he opens the fridge all the time.
Therapist: He doesn't drink milk; why would he notice?
Camille: I notice things if they are missing.
Therapist: Right, that is the thing…you notice everything.
Camille: I expect him to notice.
Therapist: You expect him to notice.
Camille: He just looks through his tunnel, tunnel vision. (makes a tunnel with her hands)

Therapist: How do you know he's not sincere? What are you basing that interpretation on?
Camille: Because his apology just sounded too much like a throw off. I feel like you can tell when somebody actually cares and is actually sincere and I feel like he actually didn't care. I know he wasn’t sincere!

Therapist: We are always making those choices. On the one hand you might *want* to do one thing but you might *need* to do another thing. Every choice involves choosing one thing and not getting something else.
Chris: Yeah, my friends were at the bar and I… sometimes it's hard to say no to my friends, to hanging out with them.
Therapist: But, you did make a choice to be with Camille when she needed you. You made the choice to not go with your friends to be with Camille when she hurt her back, to be with her and take care of her physical needs but it sounds like you didn't quite get there psychologically, you weren't entirely present anywhere but you went to be with her.
Chris: Yeah, I guess so.
Therapist: Change takes a long time. It sounds like this was a very positive change and that you really *held Camille in mind* and tried to make a decision about something in your life, something where she really needed and wants care from you and *you were able to hear her, understand her need* and respond. That's positive change! But you weren't quite at the place where you could do that and also be really emotionally present.
Chris: Yeah, *I did want to be there but I also didn't want to be there*. Does that make sense?
Therapist: Right! That's the kind of self-reflection that builds a healthy relationship. You were able to *hold those two desires in mind, and hold Camille in mind*, and make a decision to care for your partner. Sometimes you don't do something you want to do but *you can tolerate the conflict inside of yourself and not dissociate or shut down*. And sometimes we stay home and do the dishes instead of going to a party right?

Building Emotion Regulation in Couples

- Therapeutic Process Versus Exercises
  - Therapeutic Window
    - Titrating arousal
    - Slow down
    - Work with dissociation in the moment
  - Exploring triggers
    - Rewind, scaffold, try again
  - Managing frustrations
  - Working to tolerate and regulate emotions directly in the session
- Specific Exercises
  - Naming feelings
  - Exploring learned relationships
  - Dyadic breathing exercises
  - Dyadic emotional coping

Dyadic Emotional Coping Exercise

The purpose of this exercise is to explore repetitive emotional responses or patterns that lead to conflict and emotional distress in your relationship.

1. Using a situation that has occurred recently and lead to conflict between you and your partner, fill in this log.
2. Identify how this situation relates to ongoing and repetitive patterns of distress in your relationship.
3. Share your log with your partner and discuss the similarities and differences between your responses.
4. Discuss possible alternatives to current ways of responding
5. The next time you and your partner find yourselves in this repetitive pattern again, try out the alternatives you have thought up in step four.

Situation
Feelings Thoughts
Relationship to Repetitive Pattern in Relationship
Response
Alternative

Stage 3
Attachment Focused Dyadic Processing

- Attachment histories living in the present,
- Disclosure,
- Trauma processing in a dyadic context,
- Sex and Sexuality and,
- Working through the Dyadic Traumatic Reenactment.

Stage 4: Consolidation

- Consolidate mentalizing and emotion regulation
- Consolidate shifts in attachment security enhancing behaviours
  - Explore gradual shifting towards attachment security in couple
- Gradual decrease in frequency of sessions

Pilot-Feasibility Study

- Seven couples recruited
  - Two couples did not complete
    - IPV & Severe Delusion
  - 5 couples completed X sessions
    - range
- Case series design
  - Pre and post AAI
  - Pre and post measures
  - Measurement of mentalizing in sessions
- Exploring feasibility of model and adapting manual as appropriate
  - Feasibility of long term treatment in most settings
  - How can we condense interventions for long term issues

Characteristics of Couples

- 5 couples completed
  - 3 cisgender heterosexual couples
  - 2 couples w/transgender partner
  - Sexual abuse in at least one partner in all couples
  - Average age 32.5 (SD 5.3)
  - Average length of relationship 6.5 years (range 1-14)
- One partner in 1 couple did not complete the post treatment questionnaires
- Average number of sessions completed 24 (range 17-31)

Change over time

- Due to small sample size, examining clinical change using the reliable change index
  - Moving out of the clinical range
  - Improvement of greater than 1SD
- Couple Satisfaction (DAS)
- Trauma Symptoms (ICD)
- Emotion Regulation (DERS)
- Attachment (ECR-R)
- Mentalization (RF Scale)

Couple Satisfaction

- DAS
  - Mean at Pre-Treatment 89.8 = Distressed Range
    - Range 44-108
  - Mean at Post-Treatment 81.5
    - Range 37-110

- Not clear—
  - 2 couples became more distressed, 3 couples became less distressed
  - No couples left the clinical range
  - No couple improved or deteriorated more than 1 SD

Trauma

- Sum of PTSD Symptoms (ICD)
  - Mean at Pre-treatment 68
  - Mean at Post-Treatment 41
- PTSD Dx
  - 7 of 10 participants met criteria at beginning of treatment
    - Only 2 participants of 10 were not identified as CT survivors
  - 6 of 7 participants moved out of the diagnostic range
- CPTSD
  - 7 of 10 participants met criteria for CPTSD
  - 2 of 7 moved out of the diagnostic range
- BPD
  - 4 of 10 participants met criteria for BPD
  - 2 of 4 moved out of the clinical range
  - 1 of 6 moved into the clinical range

Emotion Regulation

- DERS Mean at Pre-Treatment 103 (SD 26.9) (+70 is clinical)
- DERS Mean at Post-Treatment 85.8
  - All participants were in the clinical range at pre-treatment
  - 2 participants moved out of the clinical range
  - 4 participants improved more than 1 SD

Attachment

- Attachment Avoidance
  - Mean Avoidance of Partner at Pre-Treatment 2.8 (SD 1.8)
  - Mean Avoidance of Partner at Post-Treatment 2.6 (SD 1.1)
  - 2 Participants decreased levels of avoidance more than 1 SD
- Attachment Anxiety
  - Mean Anxiety at Pre-Treatment 2.8 (SD 2)
  - Mean Anxiety at Post-Treatment 2.7 (SD 1.8)
  - 3 participant decreased levels of anxiety by more than 1 SD
  - 1 participant increased level of anxiety by more than 1 SD

Mentalizing

Participant	Pre Self	Pre Other	Pre Global	Post Self	Post Other	Post Global
2f	5	5	5	3	2	3
2O	2	4	2	1	0	1
3F	5	5	5	6	6	6
3M	3	3	3	4	3	4
4F	2	3	3	2	1	2
4M	3	3	3	4	3	3
5F	4	5	4	-	-	-
5O	4	2	4	2	1	2
6F	1	0	0	2	1	2
6M	1	1	1	2	1	2

Ongoing analysis

- Continuing to collect data
- Developing method of coding mentalizing within sessions
  - Using RF coding strategies
  - Selecting out “demand” type questions in sessions
  - Rating 150+/- word segments
- Considering methodological issues in working with highly vulnerable populations

Important considerations

- Most couples completed Stage Two but even with over 30 sessions, only one couple complete Stage Three
  - Feasibility issues
  - Methodological issues with long term treatments
- Measurement of outcome "success"
  - Issues in research with highly traumatized populations
  - Use of clinical change scores rather than group means
    - Huge differences between couples
    - Some couples making improvements while others deteriorating
    - Necessity of working with small number of couples over longer treatment periods
  - What does it mean to have a positive outcome?
    - Ending relationships can be positive
    - Building new skills

Future Directions

- Multiple baseline study
  - RCT not appropriate or feasible
    - Long term treatment necessary
    - Challenging population
    - Ethical issues with providing treatments that are not trauma focused
    - There may even be ethical issues with asking distressed trauma survivors to wait before starting treatment…
- Developing mechanisms for assessing fidelity and treatment integrity
- Validating mentalizing coding method
- Developing a series of training videos and materials as we go for training new therapists