PAIR THERAPY FOR SURVIVORS OF TRAUMA

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In the 1980s, a number of us found ourselves working with more and more patients with histories of developmental sexual trauma. At this time childhood sexual abuse was not openly discussed and survivors tended to feel particularly isolated and stigmatised. This seemed to make it all the more difficult to shift disabling feelings of shame and blame. Several patients asked us to put them in touch with other survivors so that they might begin to shift their sense of being alone and a being "a misfit".

Therefore, we developed an 18-session CBT out-patient programme for survivors of childhood trauma* with the aims of making CBT more widely available and of providing a therapy milieu where patients might feel less isolated and less shameful. The programme proved popular, we had many referrals, ran it twice a year, had good feedback (in that patients reported finding it helpful and their mental state improved). In particular, patients described their sense of shame and blame diminishing.

So far so good – except we soon hit a few road blocks. Very early on we learnt that we had to screen carefully for group membership. It was a focused, skills-based programme and members needed to be socially able enough to contribute and learn, they needed to be stable enough to tolerate the changes that the programme might bring about, they needed to feel connected to the other members. This meant that we had to turn away some patients – those who clearly would not benefit from the group setting and programme because of their social anxieties, or because their personal fragility meant that they needed closer attention than we could offer in a group, or because their strong personality traits might undermine their ability to be empathic and focussed, or because they asked to join a group that represented their sexual orientation or their gender and we could not fulfil their request. Some people simply missed the boat – they were perfect candidates for the group programme but referred a week or two too late – it seemed wrong to put them on a waiting list that could exceed half a year.

As a compromise, we began to offer the programme as a one-to-one intervention and this satisfied the needs of those who just wanted to be taken through a structured course of therapy. For example, one person had a diagnosis of borderline personality disorder, she struggled to empathise and she generally felt discomforted around people, so would not have contributed to the group and would have found it difficult to learn vicariously from others. However, she did well with the one-to-one approach as this put her under no social pressure, enabled interventions to be more "bespoke" so that she could relate to the models and strategies that we shared and – perhaps relevant for other patients with similar presentations – she said that the overt structure of the programme compensated for the "chaos that is inside my head".

But what about those who did want to meet and work with other survivors? We were still left with that dilemma and this is when the idea of "pair therapy" emerged to resolve the issue.

**"Recovering from Childhood Abuse". More information about training to use this programme can be found on the OCTC website.*

What is Pair Therapy?

Pair therapy was intended to offer a "mini group" setting where patients might still benefit from a shared experience. A pair comprises two patients with a similar history, in our work this meant that they had experienced developmental trauma of a similar type and duration. Interestingly we found that their current circumstances did not need to be so closely matched, that the shared past experiences were far more relevant than shared recent experiences.

A single therapist would take the pair through the 18-session programme in the same way that two therapists would take a group through the programme, although sessions were 75 minutes rather than 90 minutes long. Norris (1995) gives a detailed account of two women's experiences in this form of pair therapy.

Subjective feedback from pair therapy in the initial trials indicated that patients found it rewarding and "shame-busting" (as one patient described it), while objective feedback indicated outcomes comparable with the group intervention (Kennerley, 1995). This feedback was exciting because pair work meant that we could accommodate therapy to meet more needs and, as a bonus, in our service it was more cost effective than individual therapy or small group therapy.

Clinical Examples

David and Jonas both expressed a preference to work with male patients and as it was not possible to set up a group, they were offered pair therapy. This was particularly helpful for David as he was very socially anxious and prone to panic attacks and the pair setting was less frightening for him. The two men were well resourced in that they were both quite psychologically minded, each had a stable relationship, neither was at risk of self-harm or suicide. They worked through the programme with relative ease and showed improvements in their mood and stress levels which were sustained at a three-month follow-up. Both David and Jonas also reported feeling less stigmatised by their childhood experiences and stressed the benefit of being able to explore the particular issues that arise for boys who are abused by older women.

Ronit and Adrienne were both too socially anxious to contemplate joining a group, yet each wanted to be able to share their past and their recovery with a fellow survivor of developmental trauma. Pair therapy was the obvious solution. They found the content and the structure of the programme suited them and because working with a single other person was socially tolerable, they worked through it without having significant problems. Not only could they share their traumatic experiences within an intimate and safe setting, but they also shared the particular difficulties of those who develop extreme social anxiety. In doing so, they ameliorated the shame they associated with both their abuse and their acute shyness. Furthermore (and this would not have been possible in a one-to-one setting) they were able to partner each other in role playing and practising working through some of their social fears. They both reported increased social confidence and said that using each other in this practice gave the exercises more authenticity than they would have had with a therapist or a stooge as a partner.

Lilly and Dagmar each had a diagnosis of borderline personality disorder and each struggled with interpersonal issues. It would have been challenging to take them though the group programme as they had particular needs that would probably require additional attention that would then detract from the group programme and from other members. Both had difficulty trusting appropriately, tended towards subjugation of their own needs, resorted to self-injurious behaviour at times of elevated stress and each experienced traumatic intrusions. Thus, not only did they have in common a history of sexual abuse, but they struggled with ongoing emotional and behavioural problems that were similar. The course of therapy was likely to be more fraught than that of David and Jonas but the thematic similarity in their ongoing difficulties enabled the work to stay focussed on key issues.

The course of therapy was indeed challenging – they each experienced elevated fears and stress at the beginning of the programme which exacerbated intrusions, which in turn fuelled self-harm. However, within the more intimate and flexible setting of pair work, this could be accommodated and because it was successfully addressed it was an affirming experience for the women. In their case a one-month and a three-month follow-up appointment was offered as their progress at the end of the course was not as robust as that of David and Jonas. By the final session, they were both reporting continued progress and commented that they no longer felt marginalised and stigmatise by the label "borderline personality disorder". Their close work together had taken them beyond the label and they had seen human strengths and needs in each other that were understandable and ultimately manageable.

Francis and Sion had a shared history of emotional abuse in the form of chronic bullying and now both had anger-related problems. At that time, there were insufficient patients with anger problems related to their childhood abuse for us to be able to offer a therapy group just for them and within a mixed group there was the risk of an angry outburst undermining the group's sense of safety and acceptance. Again, pair therapy seemed to be a reasonable solution to the problem. Francis and Sion quickly related to each other's difficulties and were initially co-operative in therapy. Later, there were episodes of verbal attack and passive aggression. In the small unit of two patients, this could be managed and formulated and understood by a single therapist and both Francis and Sion said that witnessing someone else losing their temper and being abusive had been a great learning opportunity because what they saw had shocked them and helped them to see how unproductive angry tirades and manipulation were. In a mixed group, not only could these outbursts have undermined the confidence and harmony of the group but less time would have been available for proper resolution and debriefing of anger per se.

OCTC continues to run training workshops for the 18-session programme and this particular intervention is now employed nationally. However, in principle, the benefits of **Pair Therapy** might not be limited to a setting that focuses on recovery from childhood trauma and neglect. This co-operative and de-stigmatising approach might well be suited to other psychological disorders, particularly those with an element of embarrassment or shame.

Kennerley, H. (1995) Presentation at BABCP annual conference, Lancaster.

Norris, R. (1995) *Pair therapy with adult survivors of sexual abuse.* Thesis submitted for MSc in Clinical Psychology, University of Derby.