THE PROMISE OF ATTACHMENT-BASED COUPLE INTERVENTIONS FOR INDIVIDUALS LIVING WITH CPTSD

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ABSTRACT

Complex Post Traumatic Stress Disorder (CPTSD) is a leading mental health concern, which is known to be the most prevalent and functionally impairing form of traumatic stress diagnosis. CPTSD results from prolonged and repeated forms of interpersonal trauma, such as physical, sexual, mental, or emotional abuse. CPTSD includes PTSD symptoms in addition to a cluster of symptoms indicating a Disorganized Sense of Self (DSO), which includes pervasive disturbances in relationships. CPTSD symptomology is known to have a degenerating impact on intimate relationships; however, the mechanisms are yet to be explored within the population itself. Further, prior research exploring how couples experience and manage CPTSD symptoms is limited. Empirical research on systemic family therapy and traumatology identify the potential fit of expanding attachment-based relational interventions for CPTSD populations—most notably, Emotionally Focused Therapy (EFT) with couples. For this study, couples active in EFT treatment, and where at least one partner met the criteria for CPTSD, were recruited to participate in a joint semi-structured qualitative interview. Framework analysis was used to analyze the data for two separate studies. Study one explored couples' joint experience of CPTSD symptomology present within the relationship. Participants' experiences of symptoms and their perceptions of how CPTSD impacted their relationship along with their methods of coping were described. Study two examined couples' experiences of EFT in the context of CPTSD symptoms, and it analyzed participants' perspectives regarding the fit and acceptability of EFT for treating interpersonal trauma-related distress within their relationships. Implications for future research and clinical recommendations are discussed.

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This dissertation is dedicated to all survivors of interpersonal trauma who do the hardest and most important work there is, and despite all odds, strive to create a truly safe and loving space in the world for themselves and others.

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1: INTRODUCTION TO THE STUDY

Statement of the Problem

Science indicates that close and fulfilling human relationships are a critical factor in survival, health, longevity, and well-being (Fyvie et al., 2019; Gerge, 2020; Mahoney et al., 2019; Matheson & Weightman, 2020). However, for individuals who have been exposed to severe and prolonged interpersonal trauma, close human relationships coexist as both necessary and damaging (Hyland et al., 2017b; Matheson & Weightman, 2020; Stadtmann et al., 2018). Clinical symptomology that develops from such trauma, Complex Post Traumatic Stress Disorder (CPTSD), is rooted in prolonged and repeated interpersonal traumas such as adverse childhood experiences (ACES), childhood sexual abuse, emotional abuse, and prolonged domestic violence (Knefel, 2019; Melton et al., 2020). Unfortunately, these types of trauma are extremely common worldwide (Hyland et al., 2017a), and according to recent prevalence studies, so is CPTSD (Karatzias et al., 2017; Redican et al., 2022b). Overwhelmingly, research shows that the prolonged effects of CPTSD are devastating (Karatzias et al., 2018a; Mahoney et al., 2019; Matheson & Weightman, 2020; Ogawa et al., 1997). CPTSD has a severe and detrimental impact on well-being, relationships, psychological health, physical health, and mortality for millions of people globally (Cloitre, 2021; Hyland et al., 2017a; Karatzias et al., 2017; 2019a). As a result, CPTSD has become a leading epidemiological concern for professionals in mental health-related fields, including at the World Health Organization (Hyland et al., 2017b).

The primary focus in the traumatology field at this time lies in addressing the critical empirical gap in evidence-based interventions for CPTSD (Cloitre, 2021; Karatzias et al., 2019b). Existing traumatic stress interventions were developed for and have been empirically tested to treat Post Traumatic Stress Disorder (PTSD), which, though related and serious, is now

known to be categorically distinct from CPTSD (Herman, 1992; Hyland et al., 2017a). Research shows that evidence-based interventions for PTSD do not adequately address the therapeutic needs of CPTSD populations (Matheson & Weightman, 2020; Monson et al., 2022; Karatzias et al., 2019c). Though by definition, the CPTSD diagnosis includes PTSD symptomology, there are three additional symptom clusters defined as Disturbances in Self Organization (DSO) that intensify and alter the traumatic stress response (Herman, 1992; Hyland et al., 2017b). DSO symptoms consist of emotion-regulation difficulties, negative self-concept, and disturbances in relationships (Cloitre, et al., 2018). These symptoms set CPTSD apart from the traditional understanding of traumatic stress response and identify the inherent and severe fractures in interpersonal attachment that are present for CPTSD populations (Karatzias et al., 2018b).

Individuals with CPTSD suffer from a disorganized ability to regulate emotions and positively relate to themselves and others (Karatzias et al., 2018a; 2018b; Knefel et al., 2019). This makes relationships extremely distressing and leaves those with CPTSD in a perpetual cycle of re-traumatization (Alexander, 2012; Karatzias et al., 2019a). Therefore, current calls for research acknowledge that "one size does not fit all" in terms of trauma intervention (Fyvie et al., 2019; Gerge, 2020). Clinical observation from both the couple therapy and the traumatology fields have recognized the importance of expanding current CPTSD interventions to include relational interventions, but the two fields have been largely operating in isolation (Brewin, 2020; MacIntosh, 2018). Researchers recognize the need for a better understanding of what individuals with CPTSD experience in relationships and how to tailor interventions to best address the devastating impact of CPTSD's specific symptomology (Karatzias & Cloitre, 2019; Karatzias et al., 2019b; Matheson & Weightman, 2020).

Importance of Categorizing CPTSD as a Distinct Diagnosis

Defining CPTSD as a distinct disorder. The mental health field has long recognized the negative impact of traumatic stress response on individuals exposed to trauma (Herman, 1992; Melton et al., 2020). For over forty years, PTSD has been the primary traumatic stress diagnosis from which clinicians and researchers operate to test and develop effective therapeutic interventions (Cloitre et al., 2011; Melton et al., 2020). The PTSD diagnosis itself consists of three core symptoms, which include reexperiencing, hypervigilance, and avoidance (Hyland et al., 2017b). As operationalized by the International Classification of Diseases, eleventh edition (ICD-11), DSO symptom clusters—which, in addition to PTSD symptomology make up the CPTSD diagnosis—include emotion regulation difficulties, disturbances in relationships, and negative self-concept (Cloitre et al., 2018; Hyland et al., 2017; McLaughlin et al., 2015).

CPTSD impact and outcomes. The impact of untreated CPTSD is severe. In 1992, Herman determined "three broad areas of disturbance which transcend simple PTSD" that remain salient today (p. 379). These areas of disturbance include**,** first, symptoms that are now classified as DSO; second, categorical differences of the impact of trauma type on "deformations of relatedness and identity," and third, CPTSD survivors' vulnerability to revictimization (Herman, 1992, p. 379). Recent studies have explored Herman's clinical observations and found that persons with CPTSD are at a higher risk for revictimization than those with PTSD or the general population (Knefel et al., 2019). The cycle of revictimization, and the ongoing symptomology of hyperactivation and psychological burden, are known to have a deteriorating effect on brain structure and individual relational capacities, along with mental and physical health (Alexander, 2012; Harricharan et al., 2016). CPTSD and associated interpersonal traumas are highly correlated with early death and great psychological distress during one's lifetime

(Hyland et al., 2017a). Further, CPTSD is heavily linked to negative health and interpersonal outcomes, including a wide range of comorbidities including severe dissociation, chronic illness, functional impairment, job loss, domestic violence, sexual assault, suicidality, and relational distress (Brenner et al., 2019).

CPTSD and intimate relationships. Studies reflect the degenerative effects of CPTSD on intimate relationships (Courtois & Ford, 2012; Herman, 1992; Hyland et al., 2017a; 2017b). Due to engrained attachment patterns and neurobiological changes in the brain resulting from severe and/or accumulated interpersonal traumas, individuals with CPTSD struggle with intimate relationships above and beyond those individuals with PTSD alone (Courtois & Ford, 2012; Dugal et al., 2020). As discussed, the differentiation in trauma type and resulting symptomology are the primary cause for classifying CPTSD disorder, and across studies, the severity of the relational impact of CPTSD is at the forefront (Baldwin, 2013). Intimate relationships experience severe strain in the context of CPTSD and are more likely to result in divorce, separation, or long-term distress compared to PTSD and general populations (Aloni et al., 2020; Hyland et al., 2017a, 2017b; 2018).

CPTSD is a challenging disorder for individuals and has a severe life impact. In this study, I explored the impact of CPTSD on intimate relationships. Next, I will turn to theory to show its importance for understanding the relationship between trauma and interpersonal relationships.

Theoretical Framework

An important consideration in this study is the use of two theoretical frameworks, attachment theory and polyvagal theory, which will provide a scaffolding for the analysis of this study (Bowlby, 1988; Porges & Furman, 2011). Each of these theories are well aligned with the

interpersonal trauma literature, and they are important foundations for CPTSD research and intervention efforts.

Attachment theory. Developed by psychiatrist John Bowlby (1988), attachment theory examines the universal and biological necessity of bonding throughout human development. Initially focused on child development and more recently expanded to adults (Aloni et al., 2020; Hazan & Shaver, 1987; Nivison et al., 2022), attachment theory maintains that attachments, which are defined as close intimate bonds with attachment figures (i.e., parents, caregivers, intimate partners, and close others), function to protect and support individuals during times of need or stress. Attachment figures provide a safe and "secure base" from which individuals can "explore their environment effectively" (Alexander, 1992, p. 185). The mechanisms of attachment theory address how humans encode patterns of interaction and bond with current and future attachment figures based on the relational signals they receive over the course of development (Cassidy & Mohr, 2001). Stemming from the intrapsychic encoding of relational patterns, Bowlby identified four attachment styles: secure attachment, anxious attachment, avoidant attachment, and disorganized attachment (Alexander, 1992; Bowlby, 1988).

Secure attachment is characterized as a way of relating to others that reflects an encoded sense of interpersonal security in which an individual can seek proximity to others who are close and can feel assured that overall, their emotional and physical needs will be met (Atkinson, 1997). Conversely, anxious attachment reflects an encoded pattern of expecting forms of neglect or abandonment from otherwise secure attachment figures, which is exhibited by hypervigilance and excessively seeking emotional proximity due to a fear of loss in close relationships. Avoidant attachment is characterized by the conscious and subconscious avoidance of emotional closeness and proximity in attachment relationships due to expectations of emotional or physical

harm. Finally, disorganized attachment is understood to be a way of relating that integrates both anxious and avoidant attachment and a stern emotional disengagement from others due to encoded patterns of neglect or abandonment in which attachment figures are not otherwise trustworthy, safe, or secure (Alexander, 1992; Atkinson, 1997; Bowlby, 1988; Hazan & Shafer, 1987).

Attachment and CPTSD. Due to a pervasive pattern of interpersonal trauma, individuals with CPTSD possess a multiplex of attachment wounds that are connected to intrusive reexperiencing (of traumatic memories), avoidance, and the hypervigilance features of PTSD. Simultaneously, those with CPTSD have difficulty regulating emotions, they struggle with self-defeating negative appraisals and beliefs about themselves, and they have difficulties establishing a secure base in relationships. As outlined by Liotti (2004), relationally traumatized individuals often develop an internal polarization of attachment-related phobias, which are characterized as the phobia of attachment and the phobia of attachment loss. These attachment mechanisms leave individuals with CPTSD in a revolving state of "unresolvable fear" and relational distress with no clear path toward relief. Both individual autonomy and secure bonds with others are undermined by conflicting attachment patterns, making even the most positive intimate relationships psychologically distressing and difficult to maintain. Disorganized attachment related to interpersonal traumas leave an individual managing "nonintegrated mental states," characterized by seemingly unsolvable relational exchanges, and no safe place to land internally or externally (Liotti, 2013, p. 1136).

Polyvagal theory. Porges' polyvagal theory (2009), which is supported by other studies on the neurobiological factors of neuroception, describes the process by which individuals physiologically appraise risk and safety in their environments (Baldwin, 2013). Dependent upon

neurobiological appraisals, individuals experience a state of calm relatedness to others in their environment, or hyperactivation within the autonomic nervous system. As noted by Gerge (2020), the relational capacities of the prefrontal cortex dim amidst a perceived sense of threat, and the brain, along with the body, slips into a defensive state of fight, flight, freeze, or fawn response patterns. Studies show that individuals who exhibit severe insecure attachment or CPTSD, and who have been exposed to related accumulative traumas, tend to experience ongoing distrust, distance, and distress in relationships even once they are safe from harm (Baldwin, 2013). The cycle of dissociation and hyperactivation persists due to physical changes in the hippocampus and amygdala that impair an individual's ability to accurately appraise safety in relationships. These mismatched appraisals lead to either an over- or under-assessment of risk in the context of relationships, causing either undue distress, fear, and defensiveness, or an elevated and unrealistic sense of calm amidst danger (Porges, 2009). Furthermore, these changes in the hippocampus impair an individual's ability to connect to their own internal experience, making it difficult to understand or communicate what is happening (Gerge, 2020). Therefore, when bonding is disorganized and overwhelmed by conflicting intrapsychic and autonomic signals of danger, individuals struggle to reap the protective benefits of close relationships, even despite their best efforts (Stadtmann, 2017; 2018).

Gaps in the Literature

Current state of CPTSD interventions. Due to the complex relational nature of CPTSD, researchers and clinicians suggest phase-based relational treatments (Cloitre et al., 2011; Courtois, & Ford 2012) that integrate family members as social supports (Monson et al., 2022; Stadtmann et al., 2017; 2018). The recommendation of phase-based treatments comes from the collective recognition from both clinicians (Cloitre et al., 2011) and researchers

(Karatzias et al., 2019b) that individuals with CPTSD do not reach a point of recovery after one form or method of treatment (Mahoney et al., 2019). Due to the multifaceted impact of symptoms, treatment recommendations for individuals with CPTSD hypothesize that interventions should address individualized needs in a sequenced manner to increase acceptability and effectiveness in the long and short term (Cloitre et al., 2011; 2020a, 2020b). For example, this theory suggests that initial sequences or phases of treatment should target stabilization and safety, if not already present, and then move toward interventions such as emotion or memory processing (Cloitre et al., 2011). Overall, the idea is to address issues first that will allow treatment to progress (e.g., stabilization and safety), and then continue to address other needed aspects of treatment which include intrapsychic memory processing to alter their fear-based relationship to the trauma stimulus, in the case of CPTSD, interpersonal relationships. Further, CPTSD clinicians and researchers highlight the importance of treating the disturbances in relationships component of the DSO cluster due to its ability to undermine progress in all other areas and its ability to secure an individual's sense of safety both within and outside of therapy (Cloitre, 2021; Coleman et al., 2021). In this sense, integrating family or meaningful social supports using a relational framework of care is recommended and shows great promise for this population (Cloitre et al., 2020b; Matheson & Weightman, 2020; Stadtmann, 2017; 2018). However, phase-based treatments stand as a theoretical recommendation, and no current studies have tested the use of these treatments. Furthermore, many questions remain regarding the best ways to sequence treatments (Cloitre et al., 2020). Researchers hypothesize that the breach in safety within close relationships both leads to and exacerbates other mental health symptoms and must be addressed to spark lasting clinical change (Hyland, 2017; Johnson, 2019; Matheson & Weightman, 2020; Stadtmann et al., 2018). Despite this understanding, the

relational component is an understudied area of CPTSD research, leaving a dearth of literature on the subject of how individuals with CPTSD experience the disorder, relationships, and interventions (Karatzias et al., 2019b. Interpersonal factors are at the helm of CPTSD development and symptomology; therefore, to move interventions forward for CPTSD populations, questions about the impact of CPTSD on relationships and relationships on CPTSD must be explored (Courtois & Ford, 2012; Stadtmann, 2017; 2018).

Empirical evidence in CPTSD treatment. The current standard of care for trauma relies most heavily on exposure-based or trauma-informed cognitive behavioral interventions intended to treat the three clusters of PTSD symptomology (De Jongh et al., 2016; Karatzias et al., 2019). These traditional interventions for traumatic stress are not as effective for CPTSD and leave many without effective or lasting care (Matheson & Weightman, 2020; Melton et al., 2020). Empirical evidence suggests that current traumatic stress interventions fall short due to their lack of capacity to address DSO symptomology either in addition to or prior to targeting PTSD symptoms, which usually consists of traumatic memory processing or skills training (Cloitre et al., 2020). Such interventions can pose too much of a burden on CPTSD populations without providing them with the proper amount of intrapsychic and interpersonal support, which is usually fragile due to ongoing DSO symptoms.

A recent meta-analysis by Mahoney et al. (2019) provided an in-depth review of treatment effects and outcomes for symptoms and trauma types associated with CPTSD. The review included studies that address CPTSD sequela that were deemed rigorous in terms of methodology and approach (2019). This analysis found that trauma memory processing was significantly effective in reducing trauma symptoms compared to usual care; however, other aspects of trauma interventions, such as psychoeducation and emotion regulation skills training,

were nonconclusive (Mahoney et al., 2019). Importantly, this review also determined the initial effectiveness of group interventions that incorporate social support but noted the necessity for further scientific inquiry in this area.

Relational interventions for traumatic stress. Couple interventions have shown promise in treating individual mental health disorders such as depression, anxiety, obsessive compulsive disorder, eating disorders, schizophrenia, substance abuse, and post-traumatic stress (Baucom, et al., 1998; 2012; 2014; Doss et al., 2022). In one review, Fisher et al. (2016) found that couple interventions can be as effective as individual therapy, with the added benefit of increased relationship functioning. For example, a randomized control trial conducted by Wittenborn et al. (2018) found that a leading attachment-based couples' intervention (i.e., Emotionally Focused Therapy) was significantly more effective than usual care in treating individual depression and relationship satisfaction. In the context of traumatic stress, a recent review found that couple therapy can be effective in lowering trauma symptoms for individuals with PTSD (Suomi et al., 2019).

Developing support indicates that dyadic intervention for traumatic stress is effective in treating relational functioning and trauma symptoms for trauma-exposed populations (Monson et al., 2022; Oseland et al., 2016). Dyadic or couple interventions for traumatic stress have four current domains, which include disorder-specific couple therapy, partner-assisted interventions, general couple therapy, and psychoeducation and family engagement in therapy (Monson et al., 2022). Each type of couple intervention for traumatic stress involves various models of therapy (Monson et al., 2022); however, common factors of care include an awareness of the systemic impact of trauma within the couple relationships (Nelson Goff & Smith 2005; Oseland et al., 2016). The couple adaptation to traumatic stress (CATS) model developed by Nelson Goff and

Smith (2005) highlights the systemic impact of traumatic stress within couple relationships. According to the CATS model, acute individual functioning in response to trauma symptoms for survivors and their partners interacts with predisposing factors, and couple functioning factors such as attachment and stability indicate how couples adapt to traumatic stress symptomology. Oseland et al. (2016) used the CATS model to identify key clinical components of couple interventions with trauma-exposed couples across models. Findings from this study indicated four essential clinical components of a traumatic stress intervention with couples: individual safety and stability, couple safety and stability, conjoint trauma processing, and connection between partners. These core clinical components were believed to support recovery for trauma survivors across couple therapy models (Oseland et al., 2016). Furthermore, the involvement of partners in trauma treatment can support sustainable outcomes by treating trauma within the context of the system rather than isolating treatment to the individual (Baucom et al., 1998; 2012; 2014; Blow et al., 2020).

Overall, the inclusion of intimate partners in treatment acknowledges the reality that clients and their symptoms do not operate in isolation but rather exist within a relational system (Banford Witting & Busby, 2019; Baucom et al., 1998; 2014; Doss et al., 2022; Kozlowska, 2020). Couple therapy for individual disorders enables clinical interventionists to leverage the intimate relationship as a mechanism of change by establishing mutual support and a secure base from which partners can explore new patterns of interacting, process past wounds, and adapt new mental/emotional skillsets (McRae et al., 2014). Areas of growth in couple therapy for individual disorders include determining fit and acceptability of couple treatments for specific individual disorders like CPTSD, and determining salient mechanisms of change (Baucom et al., 1998; 2014; Blow et al., 2020; Costa-Ramalho et al., 2017; Johnson, 2003).

Emotionally focused Couple Therapy. The systemic family therapy field has identified an inherent value of systemic conceptualization and intervention for traumatic stress response (MacIntosh & Whiffen, 2005; Macintosh & Johnson, 2008; MacIntosh, 2018; Monson et al., 2022). Further, the systemic approach in this sense is especially salient for those with accumulated interpersonal trauma histories and ongoing distress in relationships captured by CPTSD (MacIntosh, 2018; Roundy, 2017; Suomi et al., 2019; Vaillancourt-Morel et al., 2019). Much of the work in this area has been explored with Emotionally Focused Couple therapy (EFT) with promising preliminary evidence (Dalton et al., 2013; Johnson, 2019; Roundy, 2017). EFT is an experiential and attachment-based intervention that harnesses present process and emotional enactments to establish new emotional connections and patterns between partners (Johnson, 2003; 2019). Studies on EFT maintain that mechanisms of change are contingent upon this experiential process that enables partners to develop emotional attunement and a safe and secure attachment (Wiebe & Johnson, 2016).

The bulk of empirical and clinical support for using EFT to treat PTSD/CPTSD exists in the form of case examples (Johnson, 2002; MacIntosh, 2008), extensive theoretical discussions on the proposed fit of EFT for CPTSD (Johnson, 2002; Roundy, 2017), and one randomized clinical trial with adult survivors of childhood sexual assault, which is highly linked to CPTSD (Dalton et al., 2013). These studies have emphasized the clinical perspectives of therapists who worked with severely interpersonally traumatized clients, clients who struggle with "relationship trauma and terminal relational distress" and who experience significant change from EFT (Johnson, 2002, p. 65). Theoretical discussions of EFT for interpersonal trauma survivors have been especially notable, as multiple studies and texts define in detail how the attachment-based mechanisms of EFT target insecure attachment and resulting mental health symptomology

caused by severe interpersonal trauma (Roundy, 2017; Wiebe & Johnson, 2016; Wiebe et al., 2017). Some preliminary studies have been conducted with populations with a wide range of traumas (Dalton et al., 2013; MacIntosh, 2014). However, these studies were not conducted with a CPTSD-specific population, and more evidence is needed to determine the true fit of EFT for CPTSD as a distinct diagnosis.

Though there is a promising body of literature pointing to the fit and utility of further testing the EFT intervention for CPTSD populations, this literature also acknowledges that CPTSD symptoms can also make it difficult for survivors to fully engage in the EFT process (MacIntosh & Johnson, 2008). Therefore, some recommend adaptations to EFT for CPTSD populations, including a longer duration of treatment and increased assessment (Johnson, 2002). However, these recommendations come from a clinical perspective, and there is no information in the literature examining how individuals with CPTSD experience components of the EFT intervention, or what changes to the EFT protocol are best suited to CPTSD populations.

The need for qualitative inquiry into candidate CPTSD interventions. With the recent definitive diagnostic criteria from the ICD-11, current studies acknowledge the importance of developing a comprehensive understanding of how individuals with CPTSD experience the disorder so the mental health field can appropriately adapt effective interventions (Melton et al., 2020; Stadtmann, 2017; 2018). As noted, current evidence-based treatments for traumatic stress were developed for PTSD, which does not account for the more severe and relational nature of the DSO symptom clusters and root trauma triggers. The main gap is that current traumatic stress approaches for CPTSD "rely heavily on clinical experience and theory, and there is usually sparse empirical evidence in terms of effects, and acceptability from the patient or therapist perspective" (Chouliara & Narang, 2017, p. 3).

Despite the clear connection between CPTSD and interpersonal functioning, little is known about how individuals with CPTSD and their partners experience, interpret, and manage the disorder. Nonetheless, it is known that in addition to the underlying attachment and neurobiological factors of CPTSD, studies on interpersonal trauma types reveal that intimate partner relationships trigger unresolved interpersonal traumas (Barawi et al., 2020). Therefore, calls for future research collectively address the need for deeper inquiry using qualitative methods to determine the lived experience of CPTSD populations in addition to learning their perspective on the potential fit, acceptability, and adaptation of treatments that directly target the underlying intrapersonal and interpersonal factors of CPTSD (Cloitre et al., 2011, 2020a, 2020b; Karatzias & Levendosky, 2019, Melton et al. 2020).

Present Study

Empirical investigation into CPTSD intervention at this time requires a more comprehensive understanding of the interpersonal impact and lived experience of CPTSD populations and their families (Melton et al. 2020). This knowledge can expand on the current literature, which has identified the potential fit for using relational interventions for CPTSD (Cloitre & Karatzias, 2019; Matheson & Weightman, 2020). The purpose of this study is twofold. First, it seeks to explore how couples in the context of CPTSD experience interpersonal related trauma symptoms in their relationships. Second, despite promising evidence that highlights the potential effectiveness of using EFT with CPTSD couples, it is important to determine the fit and acceptability of this treatment from a client perspective (Roundy, 2017; Stadtmann et al., 2018). Therefore, the proposed study will explore the following research questions:

Research questions.

R1) How do individuals with CPTSD and their partners experience, manage, and perceive the impact of CPTSD-specific symptomology (i.e., reexperiencing, hypervigilance, avoidance, disturbances in relationships, emotion regulation difficulties, and negative self-concept) within the context of their intimate relationship?

R2) How do individuals with CPTSD and their partners experience EFT and perceive the acceptability of EFT in treating their relationship difficulties; i.e., what do they describe as especially helpful or difficult about participating in EFT?

CHAPTER 2: LITERATURE REVIEW

Introduction

Trauma type and classification. The origin of psychoanalysis, rooted in the work of Sigmund Freud, is what many believe to be the early scientific study of complex interpersonal trauma response (Herman, 1992; Matheson & Weightman, 2020). One of the key hallmarks of Freud's work was the connection he made between early interpersonal violations, such as childhood sexual abuse (CSA), and the resulting symptomology of what was then termed 'hysteria' in adults (Freud, 1953). The mental health field has since worked to distinguish between trauma type and response and therefore classify diagnoses that can adequately encapsulate the variation of traumatic stress response (Herman, 1992; Hyland et al., 2017a; Loitti, 2013).

For decades, the PTSD diagnosis has been used to distinguish traumatic stress response from other mental health diagnoses such as depression and anxiety by classifying reexperiencing, hypervigilance, and avoidance as core trauma-related symptomology (Hyland et al. 2017a). However, these symptoms fail to address a range of trauma-related symptoms that are more prevalent in clinical populations and more closely related to the earlier conceptualizations of traumatic stress response (i.e., difficulty regulating emotions, fear in interpersonal relationships, and a deteriorated view of oneself) (Courtois & Ford, 2012).

Herman (1992) originally summarized the consistent reports in clinical literature describing an expanded conceptualization of PTSD. The key issue she and others addressed are the apparent distinctions between the type of symptomology that develops in response to traumatic stress and how these symptoms are predicted by the amount and type of trauma experienced. Specifically, individuals who have experienced single event, or non-relational

traumas characterized as “circumscribed traumatic events”—which can include combat, a car accident, or a natural disaster—tend to develop PTSD (Herman, 1992, p. 377). However, those who have experienced prolonged, repeated, and relationally based traumas (i.e., those perpetrated by close others, attachment figures, or individuals/systems with prolonged control over one’s survival) tend to develop what is now classified as CPTSD (Palic et al., 2016). The types of trauma that are most likely to develop into CPTSD are those that leave individuals with “damaging experiences of relationships with others so as to change catastrophically their view of themselves, other people, and the wider world” (Matheson, 2016, p 333). Therefore, causes of CPTSD include interpersonal trauma with prolonged exposures that vary in nature, are repeated, and occur in situations that are difficult to escape. For example, forms of childhood abuse, interpersonal abuse, and systemic cultural traumas (e.g., war, displacement, and cultural oppression) (Hyland et al., 2017).

Terminology. The origin of the newly classified CPTSD diagnosis is derived from many years of development within the mental health field and its collective concern regarding the negative impacts of accumulated traumatic experiences (Courtois & Ford, 2012; Karatzias & Levendosky, 2019b). Prior diagnostic proposals for CPTSD sequela have all focused on the relational origin of interpersonal trauma and point toward multiple broken attachment bonds over time that create a fragmented sense of self that primarily impacts individual well-being and close relationships (Ogawa et al. 1997). In efforts to determine a concrete diagnosis, there have been several prior labels that sought to identify these phenomena. The prior terms have included PTSD, Disorders of Extreme Stress Not Otherwise Specified, Developmental Trauma, Betrayal Trauma, and Interpersonal Trauma (Chouliara & Narang, 2017; Gomez et al., 2016; Luxenberg et al., 2001).

The factor that serves as a common thread throughout all of these terms is that they acknowledge the presence of accumulated negative experiences with close others that breach the boundaries of interpersonal safety (i.e., forms of emotional or physical abandonment, severe or chronic mis-attunement, lack of availability [neglect], and/or mistreatment) (Hyland et al., 2017a). However, a common thread of this trauma typology is that CPTSD sequela are often interwoven with positive relational experiences within the same context, leaving a disorganized pattern of relating to others and oneself (Liotti, 2004; Pearlman et al., 2005). Relational traumas are typically nuanced and therefore tricky to address as they also leave behind a complex constellation of symptoms (Luxenberg, et al. 2001). In addition to impairing PTSD symptoms, individuals with CPTSD manage "persistent and pervasive impairments in self and relational functioning, including difficulties in emotion regulation, beliefs about oneself as diminished, defeated or worthless, and difficulties in sustaining relationships" (Maercker, et al., 2013, p. 200).

Measurement. The six-factor model of the CPTSD diagnosis, which includes the three core PTSD symptoms and three Disorganized Sense of Self (DSO) symptoms, has been validated across studies and global populations (Cloitre, 2018; Tay et al., 2018). The validity of the six-factor structure supports the clinical utility of differentiating between PTSD and CPTSD as distinct disorders (Karatzias et al., 2018a; Tay et al., 2018). The International Trauma Questionnaire (ITQ) (Cloitre et al., 2018) was developed to measures levels of PTSD and CPTSD symptomology based on the presence of PTSD and DSO symptoms. To qualify for CPTSD, individuals must meet the clinical cutoff for PTSD, at least one DSO symptom, and they must experience symptoms as persistent, intrusive, and impairing in daily life (Cloitre et al., 2018; Karatzias et al., 2018a).

Prevalence and risk of CPTSD. Risk factors that predict CPTSD class membership include being female, experiences of poverty, revictimization, and accumulated interpersonal trauma (Hyland et al., 2017; Redican et al., 2022a). Moderators for CPTSD include social support and emotion regulation skills (Karatzias et al., 2018b; 2019a; Knefel et al., 2019). A recent population-based study in the United States found that of a nationally representative sample, 3.8% met the criteria for CPTSD, which is similar to results from preliminary studies in other countries (Cloitre et al., 2019). Additionally, a key finding is that CPTSD prevalence is higher than PTSD across populations (Karatzias et al., 2017a; Redican et al., 2022b). Furthermore, the prevalence for CPTSD is extremely high in trauma-exposed and treatment-seeking populations, ranging between 13% and 80% (Hyland et al., 2018b; Letica-Crepulja et al., 2020). Across studies, interpersonal trauma and resulting CPTSD symptomology are each viewed as the greatest risk factors for mental, physical, and interpersonal health outcomes (Benjet et al., 2016; Brenner et al., 2019; Cloitre et al., 2019; Hyland et al., 2018b; Karatzias et al., 2017a, 2018b, 2019a; Knefel et al,, 2019; Letica-Crepulja et al., 2020). Furthermore, studies assessing risk and protective factors for CPTSD and interpersonal trauma recommend that mental health resources should be dedicated to victims of interpersonal trauma due to the severity of associated risks and the call for family-based interventions that can address relational issues specific to interpersonal trauma populations (Benjet et al., 2016).

Purpose and aims of differentiating between PTSD and CPTSD. The recent updates to the ICD-11 (Brewin, 2020) offer a new way of classifying trauma response in order to address two aims: (1) to more accurately define the distinct presentations of trauma symptomology between simple PTSD and complex PTSD, and (2) to determine and adapt interventions to address the specific therapeutic needs of CPTSD populations (Cloitre et al., 2019). The first aim

acknowledges the clinical reality that therapists and mental health practitioners have encountered for decades in terms of the variation in traumatic stress response (Cloitre et al., 2011), which has now been defined by the ICD-11. In combination with definitive diagnostic criteria from the ICD-11, current empirical literature has collectively acknowledged the necessity of developing a comprehensive understanding of how individuals with CPTSD experience the disorder so that the mental health field can appropriately adapt effective interventions (Melton et al., 2020; Stadtmann et al., 2017; 2018). This leads to the second aim, which highlights the clinical gap in effective CPTSD interventions. As noted, current evidence-based treatments for traumatic stress were developed for PTSD, which does not account for the more severe and relational nature of the DSO symptom clusters and attachment -based trauma triggers.

Theoretical Framework of CPTSD

Attachment framework for CPTSD. Attachment theory is a commonly used framework for trauma in general and for interpersonal trauma specifically (Pearlman & Courtois 2005). Atkinson (1997) maintained that Attachment Theory is the theory of trauma due to the internal working model of oneself and others based on attachment and trauma experiences.

From an evolutionary and developmental perspective, attachment theory is founded on the principal that bonding with others is "the most intrinsic essential survival strategy for human beings" (Johnson, 2019, p. 6). Empirical evidence provides ample support for this theory, replicating the findings over and over that span across human development, from cradle to grave (Bowlby, 1988), social support and connection in close relationships are essential to survival and produce positive mental and physical health outcomes (Nelson & Wampler, 2002). Conversely, fractures in interpersonal, social, and intrapsychic attachment systems pose a great risk for individual outcomes (Özcan et al., 2016). Furthermore, the encoded sense of threat for those with

CPTSD and cumulative attachment-based traumas are activated in the context of close relationships.

Individuals develop a secure attachment when they experience attachment figures as reliably accessible, responsive, and emotionally attuned to their needs. A secure attachment enables individuals to experience "emotional balance," which promotes the "development of a grounded, positive, and integrated sense of self and the ability to organize inner experience into a congruent whole" (Johnson, 2019, p. 7). Conversely, insecure attachment styles develop when attachment figures, for one reason or another, are not reliably accessible, responsive, and attuned. A mismatch of attunement can create a sense of neglect, rejection, abuse, and betrayal known as "attachment wounds" (Johnson, 2003). Some negative experiences are inevitable in human relationships; however, the accumulation of many and/or severe attachment wounds leads to an experience of instability and distrust in close relationships, resulting in an insecure attachment style.

Attachment theory maintains that how an individual perceives attachment wounds manifests into the type of attachment style they develop (Bowlby, 1988). For example, anxious attachment occurs when an individual perceives a pattern of abandonment or betrayal from an attachment figure, either emotionally or physically. This attachment style manifests for individuals as an internal working model of how close relationships operate (Bretherton & Munholland, 1999), with an ever-present fear of losing attachment figures or losing trust and security with attachment figures. Similarly, avoidant attachment develops from the intrapsychic and interactional experience of one's needs or emotions being dismissed by attachment figures, resulting in an avoidance of vulnerability in close relationships. Finally, disorganized attachment is rooted in the pervasive pattern of experiencing both forms of attachment wounds.

Disorganized attachment is exhibited by individuals who anxiously seek proximity while also maintaining emotional distance and distrust of others. Due to the accumulation and severity of attachment wounds at the root of disorganized attachment, some researchers prefer the term traumatic attachment over disorganized attachment to better describe the origin and presentation of this attachment style (Matheson & Weightman, 2020, p. 333). This connection is relevant given the CPTSD diagnosis, which also defines similar sequela based on related traumatic attachment experiences.

It is important to acknowledge that each insecure attachment style is underscored by a fear-based response due to the internal working model of what to expect from close relationships; constantly managing the fear and belief that what happened before will happen again. The ongoing presence of fear in close relationships results in difficulties in emotion regulation evidenced by hyper- or hypo-arousal and persistent patterns of relational distress in existing and future relationships (Karatzias et al., 2018a).

Adult attachment. The growing body of research on adult attachment illustrates the process of how attachment style serves as a "script" for future relationships (Atkinson, 1997; Hazan & Shaver, 1987; Nivison et al., 2022). As children grow into adults, their primary attachment figures and needs shift from parents and caregivers to intimate partners and close others with whom they can enjoy reciprocal and emotionally connected relationships (Aloni et al., 2020; Bretherton & Munholland, 1999; Hazan & Shaver, 1987). Based on attachment scripts, adults who developed a given attachment style in childhood are likely to attach the same way to intimate partners in adulthood (i.e., secure, anxious, avoidant, or disorganized) (Nivison et al., 2022). Attachment style is also impacted by relationships in adulthood, and individual attachment styles are not necessarily fixed (Cassidy & Mohr, 2001; Makinen & Johnson, 2006).

Attachment can evolve and become either more secure or insecure depending on the characteristics and quality of ongoing experiences in close relationships. Despite the relative flexibility of attachment, it is also well understood that the more engrained an attachment style, the harder it can be to change (Hazan & Shaver, 1987; Nasim & Nadan, 2013). Attachment styles and relational scripts are powerful in dictating what individuals are accustomed to in close relationships, including what they will accept and expect in terms of ongoing proximity, accessibility, and emotional attunement from intimate partners (Cassidy & Mohr, 2001).

Changes in attachment. Theorists and clinicians believe that individuals with past experiences of accumulated interpersonal trauma and severe fractures in attachment can shift toward secure attachment and a felt sense of safety in relationships (Smith & Stover, 2016; Volgin & Bates, 2016). Change in attachment style is based on accumulated experiences of security with current attachment figures that portray a felt sense of accessibility, attunement, and safety. As outlined by polyvagal theory (Porges, 2009) and supported by neurobiological studies on trauma populations, it can be difficult for those with a trauma history in relationships to experience emotional connection, even amidst a safe relationship due to physical changes in the brain that alter an individual's ability to appraise for safety (Baldwin, 2013; Gerg, 2020; Lanius et al., 2010). Therefore, it is imperative that clinical interventions for these populations target relational and attachment processes in a way that emphasizes safety and establishes a secure base for clients (Chouliara & Narang, 2017; Liotti, 2004). Studies on adults with interpersonal trauma relay the importance of attachment-based interventions due to the high rates at which insecure attachment transmits to children and how difficult it is to develop a secure attachment without intervention (Aloni et al., 2020; Cassidy & Mohr, 2001). In this sense, interventions that can

effectively harness attachment mechanisms may serve as a key intervention point to support lasting outcomes for clinical populations.

For many with PTSD, traumatic stimuli can include cars, highways, loud noises, or enclosed spaces. However, for those with CPTSD, such stimuli typically include an array of characteristics found in close relationships. These processes can make it difficult for CPTSD populations to adequately discern how to navigate intimate relationships, which is especially important given the reciprocal nature of how close relationships impact mental health (Baucom et al., 2012; Courtois & Ford, 2012). This pattern is also clinically challenging because CPTSD populations struggle "to understand when they are actually safe" (Gerge, 2020, p. 3), and they face difficulties establishing safe emotional boundaries and lasting security in their most intimate relationships. Existing literature emphasizes that CPTSD serves as an ongoing barrier to protective mechanisms of human connection (Barawi et al., 2020), and it stresses that future intervention research must address DSO-specific symptomology of disturbances in relationships and explore the integration of family and attachment-based therapies (Blow et al., 2020; Courtois, & Ford 2012; Fyvie et al., 2019; Stadtmann et al., 2017; 2018).

Intervention

Current state of intervention. The current standard of CPTSD intervention relies on three pillars of treatment: (1) clinical experience and expertise from mental health professionals, (2) current evidence-based PTSD interventions, and (3) exploratory treatments that have been tested for CPTSD-related symptomology and/or related populations (Karatzias et al., 2019). The operational diagnosis for CPTSD, along with the International Trauma Questionnaire (ITQ) measurement tool, are new to the mental health field, and therefore, solid empirical support for effective CPTSD treatment is scarce (Cloitre et al., 2018). Current research for CPTSD

intervention is in an exploratory phase, but there is growing evidence that highlights the promise of integrating social support and phase-based treatments that can address not only PTSD symptomology but also more intrusive and degenerative DSO symptomology (Cloitre et al., 2020; Courtois & Ford, 2011; Karatzias et al., 2018a; Melton et al., 2020).

Empirical evidence in CPTSD treatment. Traditional trauma interventions rely most heavily on exposure-based or trauma-informed cognitive behavioral interventions intended to treat the three clusters of PTSD symptomology (De Jongh et al., 2016; Karatzias et al., 2019). Specifically, an evidence-based trauma exposure therapy, Eye Movement Desensitization and Reprocessing (EMDR) Therapy, and forms of Cognitive Behavioral Therapy (CBT) are common treatments for traumatic stress response. These traditional interventions for traumatic stress are not as effective for CPTSD-specific DSO symptomology and leave many without effective or lasting care (Dorsey et al., 2016; Matheson & Weightman, 2020).

Melton et al. (2020) conducted a rigorous mixed-methods meta-analysis that included a quantitative review of 104 studies, primarily randomized control trials, measuring the effectiveness of interventions for CPTSD-related symptomology across interpersonal trauma subgroups. Existing interventions that met the inclusion criteria for the study were either individual or group-based trauma-informed cognitive behavioral therapies, exposure therapies, and pharmacological and somatic interventions for CPTSD sequalae and trauma types (e.g., childhood sexual abuse, domestic violence, refugee status, and veterans). Compared with control groups across studies, evidence-based trauma therapies were effective in lowering PTSD-specific symptoms; however, they were less effective for more severely traumatized subgroups, especially veterans, and they were not effective in treating DSO symptomology. Authors also detailed concerns related to the lack of evidence on the long-term effectiveness of these

treatments, the presence of bias in a large portion of the studies, and the exclusion of diverse presentations of comorbidities in the studies (Melton et al., 2020).

In addition to effectiveness, the acceptability of proposed interventions from CPTSD populations is another key issue that is largely unknown at this time due to the dearth of studies that address this question. Melton et al. (2020) concluded that based on their meta-analysis, exposure and group-based therapies were deemed acceptable to this population. This finding was based on lower client dropout rates for those forms of therapy, which show initial promise for these types of interventions for CPTSD; however, further information is needed and should include perspectives from the population itself to identify how and why they benefited from these therapies.

These gaps are especially concerning due to three critical issues. First, there is a high prevalence of comorbidities in CPTSD populations (Hyland et al., 2017a; 2018b). Second, these analyses quantified a known and overarching issue in CPTSD intervention, which is that there are limited evidence-based treatments that effectively lower DSO symptoms (Karatzias et al., 2019). Finally, the meta-analysis revealed that effective interventions for treating PTSD-specific symptomology do not adequately measure long-term effects (Melton et al., 2020). Based on their analysis, Melton et al. (2020) argue that future directions of research must work to identify "candidate psychological" treatments for the CPTSD populations (p. xxix). Preliminary studies have made similar arguments and recommend future research should incorporate known mechanisms of change in trauma therapy with promising approaches that can target the interpersonal nature of underlying DSO symptomology, including integrating close social/familial supports into therapy (Stadtmann et al., 2017; 2018)

CPTSD population perspectives. In addition to clinical and empirical recommendations, CPTSD survivors' perspectives are viewed as a necessary ingredient to develop effective and acceptable interventions for this population; however, very few researchers have studied this topic by obtaining the voices of this group directly (Chouliara et al., 2020; Stadtmann et al., 2017). Some related studies have addressed interpersonal trauma survivors' perspectives of therapy prior to the current diagnostic criteria from the ICD-11 (Chouliara et al., 2012; Van der Linde & Edwards, 2013), and more recently, a few preliminary studies have started to scratch the surface and explore various perspectives of small samples of individuals with CPTSD (Chouliara et al., 2020; Matheson & Weightman, 2020; Stadtmann et al., 2018).

A study by Chouliara et al. (2012) specifically reviewed adult survivors of child sexual assault (CSA) and sought their perspectives on clinical services in a thematic synthesis of existing literature across nine studies. The analysis explored survivors' positive and negative experiences of psychotherapy and counseling treatment, along with their experience of disclosing their trauma in therapy and their perception of the effectiveness of treatment overall. Out of the nine studies reviewed, the methodological quality was deemed poor to moderate, which the authors recognized could have influenced the results of some studies leaning toward the possibility of positive researcher bias. The thematic synthesis did, however, reveal both positive and negative experiences of therapy on behalf of the population that provided helpful information for clinical care for survivors of CSA. For example, an important finding noted that CSA survivors attributed positive experiences in therapy and lasting clinical change to the quality of safety they felt within the therapeutic setting, including factors such as respect, equal power, participation, and flexibility. Therapist attunement and ability to address mistakes and misappraisals in therapy were also important. Furthermore, a notable positive factor was

therapist competence in addressing interpersonal abuse and trauma, especially with regard to attunement and pacing with the client's emotional needs (Chouliara et al., 2012). In this sense, collaborative care with the client played a key role in a client's sense of safety with the therapist and resulted in positive perceptions of therapy and therapeutic change. These findings are consistent with other studies, such as one conducted by Melton et al. that noted, "phased treatments that first start with helping people to feel safe before focusing on trauma symptoms might be beneficial for both post-traumatic stress disorder and additional psychological symptoms" (Melton et al., 2020, p. xxvii).

Conversely, negative experiences in therapy resulted from imbalances in power and control and a therapist's inability to adequately diagnose and treat interpersonal trauma, which led to distrust and the mishandling of clinical care for this already vulnerable population (Chouliara et al., 2012). One of the underlying themes from this synthesis addressed the felt tension between a medical model and social models of psychotherapy care. Survivors felt power and control issues were more prevalent in the medical model and did not respond well to the focus on pharmacological solutions, seeming to prefer a social model of treatment. From this analysis, Chouliara et al. (2012) determined that across studies, the negative themes were not investigated as systematically as the positive themes, which leaves room for a more in-depth understanding of negative experiences in clinical care for survivors of CSA and interpersonal trauma.

Mechanisms of change in CPTSD interventions. Despite a lack of empirical evidence recognizing specific interventions for CPTSD, the large body of traumatic stress literature has synthesized some of the underlying processes in effective treatment for traumatic stress related to accumulated interpersonal trauma types (Fyvie et al., 2019; Karatzias et al., 2018a). Across

studies, a foundational element in effective trauma intervention lies in the success of neurobiologically overriding a disturbing experience by connecting formerly traumatic stimuli to a new safe/neutral experience (Gerge, 2020; Karatzias et al., 2019; Mahoney et al., 2019; Melton et al., 2020). This process lessens the salience of traumatic memories that activate trauma response in the nervous system, and research notes that experiential therapies are useful in achieving this goal (Cloitre et al., 2011; De Jongh et al., 2016; Khalfa & Touzet, 2017). There is also an emphasis on the importance of shifting "attitudes and values" (Van Der Linde & Edwards, 2013, p. 28) of the interpersonally traumatized person from feeling chronically fearful, to establishing safety and confidence in their ability to establish close bonds with others (Dugal et al., 2020).

Despite the perceived benefits of individual trauma intervention, trauma processing is also known to be extremely burdensome on clients with high rates of client drop out. In one case example, a CPTSD client described the process by saying, "it is like uprooting trees, taking them out with roots and all" (Van Der Linde & Edwards, 2013, p. 24). Studies on existing therapies reveal that current individual interventions for traumatic stress are not as effective and can pose severe harm, especially when individuals still live within a setting that chronically activates or triggers past trauma (Karatizias et al., 2019b). Therefore, the consensus from clinicians and empirical research relays the added difficulty in treating CPTSD due to the nature of traumatic stimuli as it is much less containable than circumscribed trauma and is generally interwoven into close human relationships (Stadtmann et al., 2017; 2018). An additional gap in treatment lies in the fact that dealing with complex interpersonal trauma is clinically challenging, and many therapists are underprepared to work from a systemic conceptualization either in individual or dyadic treatment (Kozlowska, 2020). Theoretical and empirical studies hypothesize that

interventions that integrate safety and positive social support can mediate this effect and therefore show great promise in the field of CPTSD intervention (Cloitre et al., 2011; Karatizias et al., 2019).

Another recent qualitative analysis by Chouliara et al. (2020) explored the perceived mechanisms of change in group-based therapies for interpersonal trauma populations from the perspective of clients and therapists. This study expanded on the current knowledge as to why group-based interventions are often used for people with accumulated interpersonal trauma histories, noting the added stabilization effect of the social environment in therapy. Findings from this study suggest that a patient-centered relational framework is most acceptable and effective for interpersonal trauma and CPTSD populations. Specific findings from this study suggest that mechanisms of change for this population are related to a person-centered humanistic therapeutic framework that focuses on a present process rather than content. These findings are consistent with common factors that support change in therapy (Johansson & Høglend, 2007) but seem to be especially important for more vulnerable CPTSD populations (Herman, 1992; Mahoney et al., 2019). It is believed that the relational nature of group therapy not only stabilizes participants but also contributes to what Chouliara et al. (2020) refer to as a reorganization of self-concept, which is a core component of CPTSD treatment (Hyland et al., 2017a).

Based on current gaps in the literature, researchers have recommended that in-depth qualitative studies are needed to collect perspectives from both CPTSD persons and their families to better inform and tailor future intervention adaptations (Stadtmann et al., 2017; 2018). Some of this work has begun, and results from a recent qualitative study by Matheson and Weightman indicates that individuals with CPTSD believed that interventions should focus more

on relational safety and trust with close others, including the therapist but extending to others in the context of the client (2020).

Expanding CPTSD treatment to relational interventions

Systemic therapy. The field of systemic family therapy operates from an ecological perspective of care and regards family as the core system from which therapeutic interventions can effectively address the biopsychosocial components of mental health diagnoses (Baucom et al., 1998; 2012; 2014; Doss et al., 2022). Family systems theory maintains that individual psychopathology results from interpersonal interactional patterns that are dysfunctional and either directly influence individual disorders and/or allow unresolved issues to persist (Baucom et al., 2014). Therefore, systemic family therapy aims to treat the family system as the target of intervention rather than seeking to produce substantial and sustainable therapeutic outcomes at the individual level.

The purpose of using relational interventions to treat individual diagnoses like CPTSD is twofold. First, the systemic approach is an acknowledgement that all individuals, and, therefore, individual dysfunctions, exist within a larger social/family system, and treatment that does not shift the status quo of the system will not be sustainable for the individual (Baucom, et al., 1998; 2012; 2014; Doss et al., 2022). From this stance, individualized treatment is believed to place a great deal of burden on persons within a system to not only maintain intrapsychic gains made in therapy without adequate support but to also shift the status quo within their family system singlehandedly. Furthermore, the systemic conceptualization holds that individual symptoms, such as those found in traumatic stress, extend to the system (Nelson Goff & Smith, 2005). This is especially relevant with intimate partners in the context of traumatic stress exemplified by the CATS Model (Nelson Goff & Smith, 2005; Oseland et al., 2016), which outlines how individual

traumatic stress affects the system of the couple relationship. The CATS model defines how one partner's individual factors, such as individual functioning and individual predisposing factors (trauma and resources), interact within the dyad to create the couple's model of functioning, impacting attachment, satisfaction, roles, and conflict. In this way, the systemic approach to treatment "emphasizes the interdependence of individuals within a family system" (Baucom et al., 2014, p. 445). This idea extends beyond the ecological perspective that individuals are influenced by their particular system and details the way in which humans as a social species develop and change based on iterative and reciprocal interactions with those closest to them.

Baucom et al. (2014) argued that despite the fact that individual therapy can be effective for certain individuals and certain diagnoses, there is a great deal of evidence suggesting that individual treatments are lacking. This study further suggests that relationally based therapies offer a missing component to the current standard of individualized mental health care. Longitudinal research supports this theory in that individual treatment can be hindered by relational issues. Furthermore, relational distress itself greatly enhances the likelihood of remission for disorders such as depression, anxiety, gambling, and PTSD both during and after treatment (Baucom et al., 2014; Lee, 2015). Therefore, the benefit of relational therapies that include an individual's family system lies in the systemic approach, which not only accounts for preexisting relational distress but also actively works to support relational distress that can occur throughout therapy. An added benefit of systemic therapies is the way in which relational skills and bonds are deepened within the context of therapy, which is believed to support positive outcomes in individual diagnoses (Baucom et al., 2014; Doss et al., 2022; Johnson 2003; 2019).

The second purpose of using relational interventions to treat individual diagnoses is to integrate family as a social support that is not only active in clinical change as a system but that

also acts as a buffer against the known burden of treatment (Baucom et al., 2014; Choularia et al, 2012; Cloitre, 2015; Matheson, 2016). Relational models of therapy meaningfully integrate family members to address symptoms that impact the system as a whole, establishing a shared experience and supportive environment, which is key in traumatic stress intervention (Chouliara, 2012). This is a stark shift from the medical model of care, which has been linked to client dropout, especially in CPTSD populations (Chouliara, 2012). Client dropout rates for CPTSD are also high in individual psychotherapy treatment, which some researchers attribute to a lack of proper "emotional support outside" of the therapeutic environment (Matheson 2016, p. 340). Researchers theorize that therapies that can effectively and meaningfully integrate family into treatment can greatly mediate against client burnout and thus lower drop out (Matheson & Weightman, 2020). Cloitre (2015) argued that one size does not fit all in traumatic stress intervention, which especially applies to the differentiation between treating circumscribed trauma and PTSD compared to accumulated interpersonal trauma and CPTSD. Across studies, researchers maintain that the mental health field should not be satisfied with the status quo of traumatic stress intervention for CPTSD, which relies on non-relational medical models of care (Karatzias et al., 2019a)

Emotionally focused couple therapy as a candidate CPTSD treatment. The current interventions recommended for CPTSD focus on establishing safety in therapy and close relationships, attachment-based and relational interventions, and traumatic memory reprocessing (Matheson & Weightman, 2020; Mahoney et al., 2019). EFT, an attachment-based couple intervention (Johnson, 2003; 2019), shows promise in treating the underlying interpersonal components of this complex disorder (MacIntosh, 2018; Roundy, 2017). Prior research has argued that EFT is "ideally suited" (Blow et al., 2015, p. 261) for treating traumatic stress

symptomology and relational disturbances for couples who face trauma (Greenman & Johnson, 2012; McRae et al., 2014; Wiebe & Johnson, 2016). Furthermore, EFT has exhibited success in treating interpersonal trauma populations with related trauma types and sequela to CPTSD, including adult survivors of childhood sexual abuse (Dalton et al., 2013) and veterans (Weissman et al., 2017).

EFT is a leading evidence-based couples intervention founded on the principles of adult attachment-theory and a humanistic philosophical stance, which emphasizes present process in therapy (Johnson, 2003; 2019). The relational setting via the inclusion of intimate partners and attachment framework, along with the emphasis on present process and a humanistic stance, are all proposed to be necessary components for effective CPTSD interventions that are also acceptable to this population (Chouliara et al., 2020). Furthermore, a primary takeaway from the existing traumatic stress intervention literature for CPTSD is the necessity of establishing safety within the therapeutic environment (Karatzias et al., 2019a; Stadtmann et al., 2018; Van der Linde & Edwards, 2013), which is a core component of the EFT intervention that begins in the de-escalation stage of the model (Welch et al., 2019). Establishing emotional safety between partners and within the therapeutic relationship is central in EFT, occurring through therapist attunement with clients and then expanding to partners throughout the three phases of treatment (Welch et al., 2019).

The literature continues to address the mechanisms of change in adult attachment targeted by EFT that can be effective for interpersonal trauma populations (Blow et al., 2015; Dalton et al., 2019; Johnson 2005; MacIntosh & Johnson, 2008). Roundy (2017) has provided a comprehensive comparison of EFT's three treatment phases to the recommended three stages of phase-based relational treatments proposed for effective CPTSD intervention (Cloitre et al.,

2011; Courtois & Ford, 2012). Specifically, the EFT model consists of three phases which seek to: (1) deescalate and alter the negative interactional cycle between partners, (2) repair attachment wounds and rewrite attachment scripts though corrective enactments between partners, and (3) consolidate and integrate a restored internal working model of relationships by establishing a secure base between partners (Johnson, 2019; Roundy, 2017). Over the course of treatment, EFT aims to treat negative interpersonal cycles and negative beliefs of self and others in the context of close relationships, and it establishes secure bonds through experiential enactments (Johnson 2019).

A secure intimate partner relationship is a strong moderator against negative outcomes for CPTSD populations (Vaillancourt-Morel et al., 2019; Volgin & Bates, 2016). Therefore, EFT is a compelling candidate intervention for CPTSD because it seeks to target and repair the attachment system by first establishing genuine interpersonal safety and it then leverages the intimate partner relationship as an active ingredient for rewriting emotional experiences via emotional enactments between partners (Johnson, 2002; 2019). These components are key for treating DSO symptomology (Matheson & Weightman (2020) and are known to be effective for PTSD symptoms (Blow et al., 2020; MacIntosh & Johnson, 2008; Paivio & Niewenhuis, 2001), which has been difficult to capture in a single intervention.

CHAPTER 3: METHODOLOGY

Research Design

The research questions for this study will guide the search for a deeper understanding of how couples experience the impact of CPTSD on their intimate relationships. In addition, they will guide the exploration of client perspectives about the acceptability of EFT for partners with accumulated interpersonal trauma histories. To achieve this aim, I used qualitative methods and employed framework analysis, a subtype of thematic analysis, to uncover salient and in-depth descriptions from couples within the context of the CPTSD diagnosis and EFT treatment. To answer the research questions of this study, qualitative data were generated from semi-structured interviews with 10 couples who were currently participating in EFT. At least one partner in each couple met the diagnostic criteria for CPTSD at the time of the interview.

Theoretical Framework

The proposed study used a phenomenological approach and use a constructivist paradigm to examine responses to research questions (Leavy, 2022). Framework analysis, as outlined by Gale et al. (2013) and Parkinson et al. (2016), was used to analyze themes under each branch of inquiry. The phenomenological orientation in qualitative research seeks to uncover how a given population experiences the phenomena under investigation (Leavy, 2017). This approach centers participants' perspectives and language around a specific topic, which can then inform future directions for research, theory, and treatment adaptations. Qualitative interview methods are considered a gold standard in exploring emergent themes and uncovering the lived experiences from participants in phenomenological studies (Creswell & Poth, 2018; Leavy, 2022). Therefore, a phenomenological design was ideal for achieving the goals of this study to gain rich and in-depth descriptions from couples who experience CPTSD symptomology in their relationships

and to examine if, how, and in what ways they believed EFT treatment is effective in light of their personal histories of accumulated interpersonal trauma.

The constructivist paradigm maintains that knowledge is constructed though the iteration and interaction of individuals, and it explicitly acknowledges the co-construction of meaning that occurs using phenomenological methodology (Creswell & Poth, 2018; Leavy, 2022). In this sense, the phenomenological methodology helped to make sense of the meaning constructed by and between the couple. The constructivist orientation also recognizes the researcher as a co-constructor of findings in qualitative research in that the researcher plays a role in the analysis of data and brings their biases to this process. In this study, empirical findings were co-constructed through iterative interactions with study participants, EFT therapists during treatment and recruitment, myself as the interviewer/researcher, and the research guidance committee.

As a form of thematic analysis, framework analysis details a systematic process in qualitative methodology that determines thematic categories by integrating a priori concerns from theoretical and empirical literature in combination with "emergent issues" from the present study (Parkinson et al., 2016, p. 116). For this reason, framework analysis is useful when research questions, like those in the present study, seek to address distinct goals that are "contextual" and "evaluative" (i.e., capturing the lived experience of couples in the context of CPTSD, and evaluate client perspectives of an intervention for a specific psychological concern (Parkinson et al., 2016, p. 113).

Methodological Rationale

Researchers collectively recognize the clinical utility afforded by the new conceptualization and measurement of CPTSD and highlight the necessity of qualitative analysis that involves CPTSD populations at this current juncture in treatment development (Cloitre et al.,

2020a; 2020b). Working with traumatic stress "in the context of the couples' relationship is highly promising"; however, due to the vulnerability of the population, the expansion of relational interventions for traumatic stress "should not occur in a haphazard manner, but rather with caution and an abundance of planning" (Blow et al., 2020, p. 241). It is in this attitude that I approached this study, prioritizing the lived experiences, perspectives, and opinions of individuals living with CPTSD and their partners to detail how the disorder impacts their relationships and how they experience the EFT intervention.

The stage of clinical research this study proposes is what Onkin et al. (2014) view as Stage 0 in clinical intervention research. This stage is key in intervention development and asks basic questions to help understand mechanisms of change along with the mediators or the moderator of the intervention. Stage 0 can occur at any point within intervention development if there is key information needed to support the further development of effective interventions for a specific goal. A goal of the current study was to add to the existing literature and "facilitate the creation of ever more potent and implementable interventions" (Onkin et al., 2014, p. 28)—in this case, using an attachment-based couple intervention, EFT, for CPTSD. Based on the research questions, this study seeks to identify if certain aspects of EFT are especially important for CPTSD populations as facilitators of barriers to engagement in treatment and clinical change. Additionally, this research sought to explore if and how the intervention should be adapted to address heightened emotion regulation difficulties or disassociation that is typical for CPTSD.

Sampling

The consensus from the qualitative methodological literature for phenomenological studies maintains that 8 to 20 total participants in a specific sample with shared characteristics will enable a phenomenological study to reach data saturation (Creswell & Poth, 2018; Francis et

al., 2010; Monson et al., 2020; Stadtmann et al, 2017). Therefore, the sample for this study included 10 couples (20 individuals) who were currently active in EFT treatment, where at least one partner met the diagnostic criteria for CPTSD and has a history of interpersonal trauma. This study used purposive, convenience, and snowball sampling by recruiting participants from experienced EFT therapists within the researcher's professional clinical networks who work with couples that have accumulated interpersonal trauma histories and ongoing CPTSD symptomology (Leavy, 2017). The goal of purposeful sampling is to collect data from information-rich cases. In this case, EFT therapists were the first point of contact for the study and helped direct participants to the study.

Intervention

EFT is a three-phase treatment that includes de-escalation, partner softening and reengagement, and consolidation (Johnson, 2003; 2019). To capture the most salient responses of participants' experiences of EFT treatment, I interviewed participants who had been in EFT therapy for at least eight weeks to ensure they were adequately exposed to the core components of EFT and/or are well into or past stage one of the EFT treatment model.

Interventionists and fidelity. I recruited therapists who were either certified in EFT or actively gaining certification and thus receiving ongoing EFT supervision by an EFT trainer. To obtain certification in EFT, therapists must either be a master's level licensed mental health professional or under the supervision of a licensed mental health professional in either marriage and family therapy, social work, or licensed professional counseling.

Procedures

Recruitment. *Community engaged recruitment.* Prior to conducting this study, all procedures were approved by the Michigan State University Internal Review Board. Recruitment for the current study took place in two ongoing stages across the open recruitment period of November 2021 to June 2022. The first stage involved a community-engaged approach, during which I actively recruited advanced EFT therapists as recruitment "liaisons" and "gatekeepers" to clinical participant couples for the study (Archibald & Munce, 2015, p. 35). A key component of a community-engaged recruitment methodology highlights characteristics of the study recruiter, which are central to successful recruitment (Archibald & Munce, 2015).

As an EFT therapist and researcher, I embedded myself in each of EFT training networks beginning in 2019, several years prior to the study. Researcher embeddedness within the EFT therapist community was a key component to the recruitment of this study to build rapport with therapists who in turn shared the study information with their clients. In addition to advanced training within these EFT networks, the majority of the therapist networks over the past several years of my involvement have included consultation around implementing EFT with couple populations that report interpersonal trauma histories and struggles with resulting trauma symptoms within the context of their relationship. This knowledge supported the feasibility of recruitment for a population that would be otherwise difficult to access.

Stage one. The first stage of recruitment for this study involved actively recruiting EFT therapists to participate as liaisons in the study by sharing the study information with broader EFT networks and individuals. Interested EFT therapists were asked to take an EFT therapist eligibility survey using Qualtrics survey software, which briefly screened to determine their level of training and fidelity to the EFT model in working with couple clients. Eligible therapist

liaisons reported to completing at a minimum of core skills 2 with active ongoing EFT supervision up through certification and reported that they used EFT core components with couple clients. Participating recruitment therapists had completed advanced EFT training, with 24 who had completed core skills 4 and five who completed certification in EFT.

After the screening, eligible therapists were offered additional information about the aim, scope, and structure of the study, along with study recruitment materials, including the study flyer (Appendix A) and a link to the couple screening Qualtrics survey. Studies that involve gatekeepers benefit when those involved "have a thorough understanding of the study purpose and eligibility criteria" (Archibald & Munce, 2015, p. 35). Therefore, as the study organizer, I worked closely with therapists and offered online informational meetings to help better inform therapist liaisons about the study's recruitment process, which greatly supported effective recruitment.

Stage two. The second stage of recruitment took place after establishing EFT therapists as participating liaisons for the study on a rolling basis between November 2021 and May 2022. Participating therapists emailed study information (study flyer, Appendix A) to their couple clients and/or posted a printed flyer in their offices. Therapists were asked to clarify that the study was not required, and it was completely separate from their therapeutic environment. The recruitment materials directed clients to the study website, which included more detailed information about the study format, which entailed a joint Zoom interview with couples and a link to the client screening survey. Recruitment for this study took place over an eight-month period and ended once the study reached 10 couples and qualitative data indicated saturation.

Screening and eligibility. Screening for this study included multiple layers, which first involved screening for therapist eligibility when unknown and then screening for client couple

eligibility. The couple client screening involved five key considerations based on eligibility: (1) couples had to be in a committed relationship of at least six months, and each above 18 years of age, (2) participating couples had to be active in EFT treatment with an eligible EFT therapist over the course of at least eight weeks prior to participating in the study to sufficiently speak to their experience of EFT, (3) participants had to pair with their partner, who also filled out the screening survey as indicated by matching names provided (their own and their partner's), emails (their own and their partner's), location, EFT therapist, and duration of treatment, (4) one or both partners had to meet the criteria for CPTSD as per the ITQ, and (5) both partners had to indicate that they wanted to participate in the joint interview. At the end of the recruitment period, a total of 33 individuals completed the initial screening survey. Once participants passed the first screening, they were sent a second survey that asked for demographic information and a final confirmation allowing me to jointly email the couple to send their informed consent forms and schedule the two-hour interview. A total of 24 individuals completed the second screening survey. When couples did not meet all of the above criteria based on the online screening protocol, they were excluded from the study.

Measures.

Demographics. The demographic screening (see Appendix D) was standard and asked participants general questions regarding their age, gender, race and ethnicity, level of education, SES, relationship status, length of time in their current relationship, number of children, and their length of time in EFT. The demographic results are summarized in Table 1.

International Trauma Questionnaire. The ITQ (Appendix F) was developed for the ICD-11 as the only reliable and valid measure that differentiates between PTSD and CPTSD as distinct disorders (Cloitre et al., 2018). The ITQ consists of 18 Likert style questions that assess

for both PTSD and CPTSD as distinct diagnoses. The ITQ factor structures have been independently validated to support the measure's accuracy in diagnosing likely CPTSD and PTSD across populations (Cloitre et al., 2018; Tay et al., 2018). The ITQ has also been validated across the globe with diverse populations ranging between age groups, geographic locations, and trauma types (Fernández-Fillol et al., 2020; Haselgruber et al. 2019). The ITQ is appropriate for the study population as the only current and valid measure that can assess for CPTSD. The ITQ was administered as part of the initial online Qualtrics screening survey. If at least one member of the couple did not meet the clinical cutoff for CPTSD, they were excluded from the study. The clinical cutoff for CPTSD class membership is sixteen out of a possible seventy-two. The ITQ is scored by individual scores equal or greater than two. A moderate score for each PTSD symptom (avoidance, hypervigilance, and reexperiencing) and DSO symptom (emotion regulation difficulties, negative self-concept, and disturbances in relationships), along with moderate levels of functional impairment for each were required for a CPTSD diagnosis.

Enrollment. Once participants met study inclusion criteria based on the screening materials, they were offered the informed consent for the study (Appendix B). After participants had filled out the informed consent, they were considered enrolled in the study.

Sample. Resulting from the screening process, 12 couples (24 participants) met the inclusion criteria for the study; however, two couples opted out of participating in the joint interview due to scheduling constraints. Therefore, the total sample included ten couples (20 participants). The final sample included (n=19) participants meeting the full criteria for a CPTSD diagnosis as per the ITQ and one participant who indicated trauma symptomology, but did not meet the cut off for PTSD or CPTSD. Interestingly, this led to a sample of predominately dual

trauma couples for this study. Participant scores indicating PTSD, DSO, and total scores for each participant are summarized in Table 2.

Participant demographics. A final count of 10 couples, or 20 individuals, participated in this study (Table 1), including 40% males (n=8) and 60% females (n=12). The participants indicated ages between 25 and 65+ years old. A majority of participants (80%) were married (n=16), while the remaining 10% were in a dating relationship (n=2), and 10% were in a dating relationship after their divorce (n=2). The average relationship length was 17 years, ranging from 3 to 42 years. A majority of participants (95%) had children within the span of their relationship. A majority of participants (80%) identified as White/Caucasian (n=18), whereas 10% identified as Hispanic or Latino (n=2). Participants' sexual orientation varied, with 75% identifying as heterosexual (n=15), 10% identifying as queer (n=2), 5% identifying as lesbian, (n=1), 5% identifying as bisexual (n=1), and 5% identifying as pansexual (n=1). All participants lived within the United States, with 50% in the Northeast (n=10), 20% in the Southwest (n=4), 20% in the West (n=4), and 10% in the Midwest (n=2). This sample overall experienced high SES, with the majority of participants (65%) reporting a gross income of $100,000 or higher (n=13), 20% making $80,000–$99,000 (n=4), 10% making $60,000–$79,000 (n=2), and 5% making $40,000–$59,000 (n=1). Participants' education also varied, with 5% having earned a doctorate degree (n=1), 45% completing a graduate or master's degree (n=9), 40% with a bachelor's degree (n=8), 5% completing some college (n=1), and 5% completing technical school (n=1). A majority of participants (75%) were employed full time (n=15), with 15% employed part-time (n=3), and 10% retired (n=2).

Almost the entire sample met the criteria for CPTSD (n=19) based on the scores from the self-report ITQ in their screening (Table 2), which indicated an average score of 38 (range=22–

61). These score indicate that the sample overall scored moderate to high in terms of the severity of their CPTSD symptomology. Further, couple participants scored relatively close together at an average of 10 points apart (range= 2-22), which informs this study not only as dual trauma participant couple, but couples who share a similar level of CPTSD symptom severity.

Table 1

Participant Demographics

Participant couple	Participant Pseudonym	Gender	Sexual Orientation	Age	Relationship Status	Current Relationship	EFT Sessions	Children	Employment	Education	Annual household income	Ethnicity
1	Erin	Female	Queer	25-34	Married	9 years	25-51	1 child	Full-time	Graduate/ Master's Degree	US$100,000 or higher	White / Caucasian
	Amy	Cis-Female	Queer	25-34	Married	9 years	25-51	1 child	Full-time	Doctorate Degree	US$100,000 or higher	White / Caucasian
2	Sarah	Female	Heterosexual	35-44	Married	23 years	17-24	1 child	Full-time	College Degree	US$60,000 - US$79,000	Hispanic or Latino
	Evan	Male	Heterosexual	35-44	Married	20 years	17-24	1 child	Full-time	Some college	US$60,000 - US$79,000	Hispanic or Latino
3	Erica	Female	Heterosexual	45-54	Divorced, In a committed relationship	3 years	8-16	2-3 children	Full-time	Graduate/ Master's Degree	US$100,000 or higher	White / Caucasian
	Adam	Cis-Male	Heterosexual	45-54	Separated, In a committed relationship	3 Years	8-16	None	Part-time	College Degree	US$40,000 - US$59,000	White / Caucasian
4	Monica	Female	Heterosexual	45-54	Married, Divorced	7 years	8-16	4-5 children	Full-time	College Degree	US$100,000 or higher	White / Caucasian
	Brent	Male	Heterosexual	45-54	Married, Divorced	6 years	8-16	2-3 children	Full-time	Graduate/ Master's Degree	US$100,000 or higher	White / Caucasian

Table 1 (cont'd)

	Kirsten	Female	Heterosexual	35-44	Married	16 years	17-24	2-3 children	Unemployed/ retired	Graduate/ Master's Degree	US$100,000 or higher	White / Caucasian
5												
	Mitchell	Male	Hetero sexual	45-54	Married, Widowed	17 years	17-24	2-3 children	Full-time	Graduate/ Master's Degree	US$100,000 or higher	White / Caucasian
	Brittney	Female	Heterosexual	35-44	Married	12 years	17-24	2-3 children	Part-time	College Degree	US$100,000 or higher	White / Caucasian
6												
	Ryan	Male	Heterosexual	35-44	Married, Divorced	12 years	17-24	2-3 children	Full-time	Technical school	US$80,000 - US$99,000	White / Caucasian
	Matthew	Male	Heterosexual	55-64	Divorced, in a committed relationship	22+ years	8-16	2-3 children	Full-time	College Degree	US$80,000 - US$99,000	White / Caucasian
7												
	Annette	Female	Heterosexual	45-54	Divorced, in a committed relationship	22 years	8-16	2-3 children	Full-time	College Degree	US$100,000 or higher	White / Caucasian
	John	Male	Heterosexual	65+	Married	46 years	52 or more	2-3 children	Unemployed/ retired	Graduate/ Master's Degree	US$100,000 or higher	White / Caucasian
8												
	Gina	Female	heterosexual	65+	Married	46 years	52 or more	2-3 children	Part-time	Graduate/ Master's Degree	US$100,000 or higher	White / Caucasian

Table 1 (cont'd)

9	Cathy	Gender Fluid	Lesbian	45-54	Married, Divorced	20 years	52 or more	2-3 children	Full-time	Graduate/ Master's Degree	US$100,000 or higher	White / Caucasian
	Janet	Female	Pansexual	55-64	Married	20 years	52 or more	2-3 children	Full-time	College Degree	US$100,000 or higher	White / Caucasian
10	Rachel	Female	Heterosexual	45-54	Married, Divorced	11 years	25-51	1 child	Full-time	Graduate/ Master's Degree	US$80,000 - US$99,000	White / Caucasian
	Harry	Male	Heterosexual	45-54	Married	10 years	25-51	1 child	Full-time	College Degree	US$80,000 - US$99,000	White / Caucasian

Table 2

Participant ITQ Scores

Participant Couple	Participant pseudonym	PTSD Score	PTSD FI	Meets PTSD Diagnostic Criteria	DSO Score	DSO FI Score	Meets CPTSD Diagnostic Criteria	Total Score
1	Amy	19	5	Yes	11	5	Yes	40
	Erin	6	5	Yes	8	3	Yes	22
2	Sarah	7	10	Yes	14	11	Yes	42
	Evan	8	5	Yes	14	4	Yes	31
3	Adam	6	3	Yes	18	4	Yes	31
	Erica	10	5	Yes	8	6	Yes	29
4	Monica	9	7	Yes	21	10	Yes	47
	Brent	10	4	Yes	7	4	Yes	25
5	Kirsten	13	6	Yes	21	9	Yes	49
	Mitchell	14	6	Yes	11	6	Yes	37
6	Brittney	11	5	Yes	12	3	Yes	31
	Ryan	12	3	Yes	18	6	Yes	39
7	Annette	19	11	Yes	21	10	Yes	61
	Matthew	20	12	Yes	7	11	Yes	50
8	Gina	15	3	Yes	8	2	Yes	28
	John	16	0	No	8	0	No	24

Table 2 (cont'd)

9	Cathy	17	7	Yes	14	7	Yes	45
	Janet	18	6	Yes	8	6	Yes	38
10	Rachel	21	7	Yes	18	7	Yes	53
	Harry	22	4	Yes	11	5	Yes	42

Notes: The PTSD diagnoses is designated by a minimum PTSD score greater than or equal to six (maximum 24) with a PTSD FI score greater or equal to two (maximum twelve). The CPTSD diagnoses is designated by meeting the full criteria for the PTSD diagnosis plus a minimum DSO score greater than or equal to six (maximum 24) with a DSO FI score greater or equal to two (maximum twelve) as per (Cloitre et al., 2018).

The sufficiency of this sample size is supported by qualitative methodological literature for phenomenological studies that maintain that 8 to 20 total participants in a specific sample with shared characteristics can enable a study to reach data saturation (Creswell & Poth, 2018; Francis et al., 2010; Manson, 2010; Stadtmann et al, 2017). The sample for this study included 10 couples who were currently active in EFT treatment where at least one partner met the diagnostic criteria for CPTSD and had a history of interpersonal trauma.

Interview procedure. Qualifying participant couples were interviewed using a semi-structured interview guide (Appendix G). Interviews, which took place online, were recorded using HIPPA-compliant Zoom meeting session software. Prior to starting the interview, as the researcher and interviewer for the study, I verbally reviewed the informed consent with participants, provided an overview of the study's purpose and questions, reviewed risks and benefits of the study, and then informed participants that they may elect to skip any questions or end their participation in the study at any time. Once participants provided their final verbal consent for the study, the interviews commenced.

Interview. The content of the interview (Appendix G) did not inquire about details regarding past trauma in the screening survey or otherwise but acknowledged participant histories of past accumulated trauma and ongoing CPTSD symptomology. In this way, the interview questions did not involve any discussion of past traumas but rather focused on current experiences of trauma symptomology within the relationship to address the first research question. Then, couples were asked questions regarding their experience of the EFT intervention, to reflect on their therapy progress and experience, and finally to discuss what they found to be both useful and difficult about the model, addressing the second research question. Interview

questions were asked of partners in an alternating fashion to give both partners the opportunity to respond first equally.

Data collection. Qualitative interviews averaged two hours per participant couple and ranged between 78 and 134 minutes. My data collection, therefore, resulted in approximately 20 hours of joint in-depth descriptions from participant couples regarding their experience of the ways in which each distinct CPTSD symptom impacts their relationship (chapter 4), and their experience of EFT in the context of those symptoms (chapter 5). Clinical couples were interviewed together to ensure complete and salient responses regarding their dyadic experiences, with equal time allotted to both partners. All interviews were voice recorded via Zoom video conferencing software. Recordings were also electronically encoded and double password protected. Interviews were transcribed verbatim and transferred to Word files that were stored under the same electronic protection standards as the audio files.

Data Analysis. For the analysis of this qualitative study, I employed framework analysis outlined by Ritchie and Spencer (1994) and expanded on by Gale et al. (2013). Framework analysis methodology involves seven procedural stages of analysis: (1) transcription/data organization, (2) familiarizing, (3) coding, (4) developing an analytical framework, (5) applying an analytical framework, (6) charting data into framework matrix, and (7) interpreting the data (Gale et al., 2013).

Transcription. As noted, participant interviews were transcribed verbatim. At the time of transcription, I assigned participants pseudonym codes, and all participant information was de-identified, including participant names, identifying information, and therapist information. Data were stored digitally in Microsoft Word files with an encrypted passcode to ensure secure storage. I used a codebook that included categories for terms, emerging themes, and notes, which

I maintained to organize initial categories and accessible information during later stages of analysis. Computer Assisted Qualitative Data Analysis Software (CAQDAS) is considered useful for this form of research due to the magnitude of data collected, and therefore, the study design was modeled under the guidelines of prior studies using the MaxQDA qualitative coding software (Parkinson et al., 2016; Ward et al., 2013).

Familiarizing. The second stage of framework analysis included an iterative and immersive process of reading all interviews in their entirety multiple times, paired with memo taking (Creswell & Poth, 2018; Gale et al., 2013). This process allowed me to develop a "sense of the data as a whole without getting caught up in the details of coding" (Creswell & Poth 2018, p. 148). This process spanned across six months between the first and final interviews. Consistent familiarization (reading, listening, and memoing) of each case and across cases enabled me to develop an overarching understanding of what participants communicated during the interview process, which supported the initial coding framework for emergent themes. Memoing also serves a vital role as an "audit trail" (Creswell & Poth, 2018, p. 149) to support the development of codes throughout the process of analysis. This information was shared in detail with my advisor in ongoing analysis meetings in which we developed the emergent framework based on memos, which included key phrases, concepts, and themes from the data. The emergent framework consisted of a moderate number (i.e., less than 10) of general categories of information per research question, and that were consistently supported by the data, which served as an initial guide for in-depth systematic analysis.

Coding. The next phase of analysis involved line-by-line open coding in MaxQDA to further identify emergent themes that were inductive and that defined "particular behaviors, incidents, or structures" in the data, such as pervasive expressions, experiences, or emotions

(Gale et al. 2013, p. 4). Open coding elaborated upon and determined more specific themes in the data based on the emergent framework in the prior section. At this stage, I built "detailed descriptions, appl[ied] codes, develop[ed] themes or dimensions, and provide[d] an interpretation in light of . . . the literature" (Creswell & Poth, 2018, p. 151). Coding in this stage involved aggregating the data to develop "small categories of information" that was used to compare codes across cases (Creswell & Poth, 2018, p. 151). Once all categories were determined, they were designated with a specific name, a description of each category, and a code, in addition to a designated example of the code from the data itself.

Developing an analytical framework. To develop a working analytical framework, the research team, consisting of myself and my advisor, met in order to categorize and define codes by integrating emergent themes and prior categories based on CPTSD symptomology and attachment theory. This was an iterative process that took place after the initial coding of the first three transcripts, and it continued until each transcript had been fully coded. Furthermore, the data were interpreted considering the a priori concerns within the current traumatic stress and systemic therapy literature regarding CPTSD symptomology, adult attachment, and mechanisms of change for CPTSD interventions. To support the trustworthiness of the study findings (Braun & Clarke, 2006; Pelias, 2019), once the analytical framework was initially identified by the research team, study participants had the opportunity to review categories and offer approval or input for adjustment. Responding participants (n=12) overarchingly agreed with the content of the framework and provided feedback about certain elements that they felt needed to be highlighted—for example, the essential nature of validation in therapy and between partners in the context of past trauma, and the need for therapists to direct clients toward their core emotions and away from content.

Applying analytical framework. The application of the analytical framework began directly following the initial iterations of framework development prior to completing coding for all transcripts. The framework was then applied by indexing remaining transcripts using the framework for existing categories and codes based on a priori concerns and emergent themes. The application was also an iterative process that took place amongst coding and framework development as new themes arose (Gale et al., 2013). This process of applying the framework was assisted by MaxQDA, which supported the process of cross-checking between researchers in the next stage and aided in clarity as well as organization for a research team where I led the primary coding process (Gale et al., 2013; Parkinson et al., 2016).

Charting data into framework matrix. A key element of framework analysis involved charting the data into a matrix to clearly organize and reduce "voluminous" data (Gale et al, 2013, p. 5). This is a useful method for qualitative health research with large data sets, consisting of multiple hours of interviews across cases. The framework matrix made it easier to "identify relevant data extracts to illustrate themes and to check whether there is sufficient evidence for a proposed theme" while also providing an "audit trail from original raw data to final themes, including the illustrative quotes" (Gale, 2013, p. 6). Early in this stage, it was important to address trustworthiness in qualitative interpretation in order to compare and contrast summarizing across the research team, which was done in an iterative process as interviews were completed. Charting into the framework matrix supported the summarization of data within the context of each participant couple case as recommended by Gale et al. (2013), which aided the organization of "complex meaning and understanding" by using "each participant's own subjective frames" (Gale et al., 2013, p. 5). This process helped to ensure transparency in the

coding process from charting to interpretation between the research team. The final framework matrices are listed in Appendix H and Appendix I.

Interpreting the data. After all the interviews were coded in MaxQDA and then charted into the framework matrix, a data summary was added for each category and participant in each RQ domain. At this stage, the research team—my adviser and myself, who are both clinician researchers with varying degrees of experience—explored the data categories and themes and compared interpretations. This process allowed for a critical look at our interpretation of participants' experiences from various perspectives and bolstered our confidence in the robustness of our analysis and findings. We each brought both unique and convergent perspectives to the analysis. As traumatic stress researchers and clinicians, we drew from our familiarity with the theoretical and empirical literature along with our clinical experience with trauma exposed couples. Being responsible for the collection of data, including qualitative interviews, I was more intimately aware of each participant couple's experience, while my research advisor was able to challenge my interpretations in the light of prior research. Compilation of the data led to a final iteration of interpretation, which led to a further refinement of themes, increasing our confidence in the robustness of our analysis and its ability to relay and summarize the experience of couples in the context of CPTSD and EFT treatment.

Following the completion of the framework analysis, data were written up in two distinct manuscripts that separated findings between CPTSD couples experiences' of symptomology in their relationship and their perspectives and experiences of the EFT intervention.

Trustworthiness. An essential element of qualitative research is establishing credibility though rigorous methodology (Creswell & Poth, 2018). For this study, I acted as the primary researcher, interviewer, and qualitative coder. Because I performed multiple roles in this study, I

built in several stages of cross-checking and member-checking to support the confirmability and dependability of the study findings. Cross-checking for this study involved my advisor as an expert in the field of couples therapy, EFT, qualitative data analysis, and trauma in couple relationships. Furthermore, I elected to use a study design and audit trail that prioritized an organization and transparency with those involved in cross-checking with my research committee. Additionally, the dependability of the results was supported by member-checking, as outlined by a similar study (Dansby Olufowote et al., 2020), which offered participant involvement that provided commentary on the findings during the initial theme coding stage.

Reflexivity

Qualitative methodology acknowledges the role of the researcher as an active ingredient in the study design, analysis, and interpretation (Creswell & Poth, 2018). Pelias (2019) maintains that in all research, especially qualitative methodology, it is essential that researchers are both "ethically and politically self-aware, (and) make themselves part of their own inquiry" (p. 662). As the primary researcher of this study, I recognize my positionality as a Caucasian American, cis-gendered female in my early thirties. I am also a couple and family therapist and researcher with ten years of experience in the field. I have been trained in several systemic therapy and trauma therapy models with a special emphasis on Eye Movement Desensitization and Reprocessing Trauma Therapy (EMDR) and EFT. I practice from an attachment and trauma-informed lens, and my work is influenced by social justice and feminist theories. Furthermore, I acknowledge the presence of my own attachment, interpersonal trauma, and relational experiences and their impact on my worldview as a researcher in addition to my preexisting clinical and empirical conceptualizations of CPTSD and EFT.

Through the awareness of my own positionality, I pledged to privilege the voices, perspectives, and interpretations of the study participants. As the primary researcher for this study, I maintained a reflexive stance and consistently met with my study advisor to discuss how my prior training, clinical experiences, and prior research in systemic and trauma-informed therapies influenced my conceptualization and interpretation of the results. Additionally, to avoid marginalizing participants' perspectives, the research process was conducted as an interactive co-construction between the researcher and participants. Once core themes were determined, study participants had the option to review and provide input into preliminary findings.

Feasibility, Ethics, and Limitations

It was essential that the therapists included as recruitment liaisons clinically practice out of the EFT paradigm and routinely participate in ongoing education in the model, which entails gaining client consent for filming sessions. This engagement showed promise for the feasibility of the study due to a population of therapists and clients who displayed a preexisting willingness to participate in actions that further research and best practices in EFT. Furthermore, from the participating sample of EFT therapists, there were 47 therapists who all maintain full clinical caseloads, which therefore included over 1,500 clinical couples.

In terms of feasibility and ethics, it was my belief as a trauma researcher and clinician that couples could engage in this research and benefit from the insight into their experiences by participating in this study, which was supported by research with similar populations (Chouliara et al., 2012; Matheson & Weightman, 2020; Stadtmann, 2017). As a trauma-informed researcher, psychological safety is a foundational element of this study. Therefore, I took all possible measures to establish an ethical methodology in this study, including acknowledging I would end or redirect an interview when participants or I deemed that proceeding could cause any

psychological or relational harm. This did not occur; however, participants were informed of this procedure. A key limitation of this study is that it recruited couples who were extremely open to share about their experience in a joint interview and who were actively seeking treatment for their relational issues. Therefore, this sample did not represent the full scope of CPTSD impacted couples but rather focused on a subset of the study population.

Summary

Empirical literature investigating foundational components for CPTSD intervention overwhelmingly recognizes the need to expand relational treatments for CPTSD that can focus on the "rebuilding of relationships based on trust (as) an active mechanism of change" (Matheson & Weightman, 2020, p. 1). Current findings from both the traumatology and systemic family therapy literature recognize the inherent value of systemic conceptualization and treatment for those with accumulated interpersonal trauma (Suomi et al., 2019; Vaillancourt-Morel et al., 2019). Much of the work in this area for adults has been explored with Emotionally Focused Couple therapy(EFT) with promising preliminary evidence (Dalton et al., 2013; Johnson, 2019; Roundy, 2017). The phenomenological approach for this study advantaged the current state of the literature for CPTSD by revealing the perceived acceptability and impact of EFT for couples who experience the impact of CPTSD in their relationship in addition to giving voice to the CPTSD's effect on intimate partner relationships. A strength of the proposed study is that it sought to integrate two siloed empirical fields of study that each investigate effective interventions for CPTSD and interpersonal trauma. This study merged developing theories and clinical perspectives from EFT, systemic family therapy, and complex trauma literature by using a bottom-up approach to privilege the perspectives of the population itself to inform future research.

CHAPTER 4: STUDY ONE—COUPLES' EXPERIENCES OF CPTSD SYMPTOMATOLOGY

Abstract

Complex Post Traumatic Stress Disorder (CPTSD) has been designated as the most functionally impairing form of traumatic stress response. CPTSD is distinct from PTSD in both the type of trauma exposure that leads to CPTSD and in symptom presentation. The CPTSD diagnosis includes a cluster of symptoms designated as a Disorganized Sense of Self (DSO) in addition to PTSD symptomology. The types of trauma exposures that lead to CPTSD are repeated forms of interpersonal trauma that are typically experienced within the context of close attachment relationships such as childhood sexual abuse, intimate partner violence, emotional abuse, and adverse childhood experiences. Due to the interpersonal nature of trauma exposures related to CPTSD and the severity of symptoms, close interpersonal relationships, especially intimate partner relationships, are greatly affected. However, little is known about how individuals and their partners experience, manage, and understand the impact of CPTSD-specific symptomology within their relationships. Therefore, the current study used a qualitative approach informed by framework analysis to explore ten client couples' experiences of CPTSD symptomology within the context of their relationships. Findings revealed the immensity of symptom burden for couples and the degenerative impact of CPTSD symptomology on their relationship in addition to the meaningful ways couples were able to jointly manage and cope with symptoms. Clinical implications and directions for future research are discussed.

Introduction

Empirical literature has identified the critical importance of close and fulfilling relationships in human survival, well-being, longevity, and physical health (Fyvie et al., 2019; Gerge, 2020; Mahoney et al., 2019; Matheson, & Weightman, 2020). Conversely, exposure to prolonged and repeated interpersonal trauma can create a cascade of harmful symptomology attached to trauma-related stimuli in the context of relationships, which hinders their protective factors (Hyland et al., 2017b; Matheson, & Weightman, 2020; Stadtmann et al., 2018). Complex Post Traumatic Stress Disorder (CPTSD) has been identified as a traumatic stress disorder, distinct from PTSD, which develops from exposures to trauma and abuse within close relationships (Cloitre et al., 2018; Herman, 1997; Hyland et al., 2017b). Untreated CPTSD symptomology has a degenerative impact on all aspects of human life, including mental health, relationships, physical health, and mortality (Cloitre et al., 2019; Hyland et al., 2017a; Karatzias et al., 2016; 2017; 2019). Consequently, a number of organizations around the world, most prominently, the World Health Organization (Hyland et al., 2017b), have classified it as an epidemiological issue of great concern.

CPTSD as a Distinct Traumatic Stress Disorder

For decades, PTSD has been the primary traumatic stress diagnosis from which clinicians and researchers operate to develop effective therapeutic interventions for trauma (Cloitre et al., 2011). PTSD criteria include three core symptoms: avoidance, hypervigilance, and reexperiencing (Hyland et al., 2017b). The eleventh edition of the International Classification of Diseases (ICD-11) operationalized an additional cluster of symptoms that are a component of the CPTSD diagnosis that are referred to as a disorganized sense of self (DSO) (Cloitre et al., 2018; Hyland et al., 2017; ICD-11). The DSO symptom clusters include emotion regulation difficulties,

negative self-concept, and disturbances in relationships, which, in addition to PTSD symptomology, make up the CPTSD diagnosis (Cloitre et al., 2018; ICD-11; Shevlin et al., 2018). Critically, empirical research recognizes the severity of, and functionally impairing nature of CPTSD symptomology compared to PTSD alone (Herman, 1992; Hyland et al., 2017b). It is believed that the deeply rooted interpersonal nature of CPTSD trauma symptoms and exposure intensify the experience and frequency of symptomology because the trauma stimulus—relationships—are complex and serve as a commonplace experience necessary for survival (Chouliara & Narang, 2017; Cloitre, 2015; Herman, 1997).

Trauma type. The empirical literature has identified the importance of trauma type as a predisposing factor for how individuals develop a traumatic stress response (Maercker et al., 2013; 2022). Known interpersonal trauma exposures, which predict CPTSD diagnosis, include adverse childhood experiences (ACES), childhood sexual abuse, emotional abuse, prolonged domestic violence, institutional abuse, and refugee status (Knefel, 2019; Melton et al., 2020). Exposure to these types of interpersonal trauma is prevalent in every community worldwide (Hyland et al., 2017a). Furthermore, prevalence studies indicate CPTSD is more prevalent than PTSD in general among trauma-exposed and treatment-seeking populations globally (Karatzias et al., 2017; Redican et al., 2022).

Attachment and CPTSD. CPTSD and related interpersonal trauma research has begun to make the connection between the underlying mechanisms of trauma experienced within relationships and Bowlby's theory of attachment (Bowlby, 1988; Bretherton & Munholland, 1999; Dansby Olufowote et al., 2020; Linder et al., 2022a). Attachment theory maintains that human connection is a core feature of survival. Therefore, when interpersonal and/or emotional proximity, responsiveness, and safety is violated, this creates an attachment wound and incites an

insecure attachment style or way of relating to others (Aloni et al., 2020; Bowlby, 1988). Insecure attachment styles—including avoidant attachment, anxious attachment, or disorganized attachment—all stem from pervasive attachment wounds with caregivers or close others, and they result in subsequent fear-based beliefs and patterns of relating to others in close relationships (Alexander, 1992; 2012). In relation to CPTSD, pervasive patterns of interpersonal trauma are viewed in the light of attachment wounds, which can impact individuals' ability to feel safe and secure in close relationships (Atkinson, 1997; Liotti, 2013). The underlying attachment-based mechanisms of CPTSD promote a state of fearfulness and distress, especially within the context of close relationships (Liotti, 2013). The impact of these symptoms is most notable for adults in their intimate relationships with romantic partners, which has generated increased interest in the study of adult attachment and its interplay with relationship functioning in couple therapy (Cassidy & Mohr, 2001; Nivison et al., 2022). Research indicates that individuals with CPTSD-related sequela struggle in relationships due to untreated or unaddressed attachment-related traumas (Atkinson, 1997; Lotti, 2013). Furthermore, the adult attachment literature underscores the importance of establishing a secure attachment between partners in the context of attachment-based relational distress (Cassidy & Mohr, 2001; Dansby Olufowote et al., 2020; Linder et al., 2022a, 2022b; Nivison et al., 2022). Additionally, initial empirical research supports the expansion of attachment-based conceptualizations for CPTSD, which can support intervention research using attachment-based models (Aloni et al., 2020; Fyvie et al., 2019; Johnson, 2019; Karatzias et al., 2018b; Pearlman et al., 2005)

CPTSD treatment gap. Due to the differences in trauma response and the relatively new classification of CPTSD as a distinct disorder, empirical research on effective treatments for CPTSD is lacking (Brewin, 2020; Bryant, 2022; Forbes et al., 2020). Addressing the critical

CPTSD treatment gap in evidence-based interventions is a primary concern of the traumatology field at this time (Karatzias et al., 2019b). Empirical literature supports the effectiveness of evidence-based traumatic stress interventions for PTSD-specific symptomology; however, this support is limited to only effectively treating PTSD symptoms (Herman, 1992; Hyland et al., 2017a). Outcome research indicates that standard traumatic stress interventions, such as trauma-focused CBT and exposure therapies, do not adequately address the full scope of CPTSD symptomology (Karatzias et al., 2019c; Matheson & Weightman, 2020; Monson et al., 2022).

Those who suffer from CPTSD often have a disorganized ability to regulate emotions. Consequently, they have difficulties relating to themselves and others (Karatzias et al., 2018a; 2018b; Knefel et al., 2019). Because of these difficulties, those with CPTSD often find that relationships can be extremely distressing and, unfortunately, they can become trapped in a perpetual cycle of re-traumatization (Alexander, 2012; Karatzias et al., 2019a). As researchers learn more about CPTSD, it is becoming more clear that, due to the nature and intricacies of CPTSD, a one-size-fits-all approach to trauma intervention is not working (Fyvie et al., 2019; Gerge, 2020). Clinical observations suggest that current interventions need to be expanded to include relational interventions (Cloitre et al., 2011; Fyvie et al., 2019). The fields of traumatology and couple therapy, however, largely operate in isolation (Brewin, 2020; MacIntosh, 2018). More specifically, there is a great need for research that provides information about the ways in which individuals with CPTSD experience relationships and how practitioners can tailor interventions to impact those experiencing CPTSD symptomology (Cloitre & Karatzias, 2019; Karatzias et al., 2019b; Matheson & Weightman, 2020).

Inquiry into candidate CPTSD interventions. Current studies acknowledge the importance of continuing the development of comprehensive understanding, as well as effective

interventions, on the ways individuals with CPTSD experience the disorder (Melton et al., 2020; Stadtmann, 2017; 2018). The current evidence-based interventions for traumatic symptomology were developed specifically for PTSD, which does not account for the more severe DSO symptom clusters and root interpersonal trauma stimuli (Bryant, 2022; Karatzias et al., 2019b; Mahoney et al., 2019). In order to bridge the gap between the current trauma interventions and efficacious approaches for CPTSD treatment, interventionists currently "rely heavily on clinical experience and theory," despite the fact that "there is usually sparse empirical evidence in terms of effects, and acceptability from the patient or therapist perspective" (Chouliara et al., 2017, p. 3).

Despite evident overlaps between interpersonal functioning and CPTSD, there has been relatively little research concerning how couples that include at least one individual with CPTSD experience, think about, and manage the disorder. This is the case even though we know that along with CPTSD's attachment and neurobiological factors, research into interpersonal trauma types has shown that relationships between intimate partners can trigger interpersonal traumas that have not yet been resolved (Barawi et al., 2019).

Consequently, there is a need for further inquiries that use qualitative methods for determining the lived experiences of people with CPTSD. Additionally, research should address these individuals' perspectives concerning the potential fit, acceptability, and adaptation of treatments targeting CPTSD's underlying intrapersonal and interpersonal factors (Boullier et al., 2018; Cloitre et al., 2011; Karatzias & Levendosky, 2019).

Present Study

A deeper and more comprehensive understanding of CPTSD interventions is greatly needed at this time in order to better support those who experience CPTSD as well as their families

(Melton et al. 2020). This knowledge will add to the current scholarly literature on the subject, which has demonstrated the potential effectiveness of relational interventions in treating CPTSD (Cloitre & Karatzias, 2019; Matheson & Weightman, 2020). This study seeks to explore the ways that couples—in which one or both of them has experienced CPTSD—experience interpersonal-related trauma symptoms in their relationship. The proposed study explores the following question:

> How do individuals with CPTSD and their partners experience, manage, and perceive the impact of CPTSD-specific symptomology (i.e., reexperiencing, hypervigilance, avoidance, disturbances in relationships, emotion regulation difficulties, and negative self-concept) within the context of their intimate relationship?

Method

Recruitment. All study procedures were approved by Michigan State University's Internal Review Board. Recruitment for the current study took place over two ongoing stages across the open recruitment period of November 2021 and June 2022. This study's first stage of recruitment involved using community engaged, purposive, convenience, and snowball sampling methodology with EFT couple therapists who had access to couples seeking treatment for interpersonal-trauma-related relationship distress. Participating therapists acted as recruitment liaisons (Archibald & Munce, 2015). Stage two of the recruitment process involved therapists posting the study flyer (Appendix A) in their offices and/or providing the study flyer directly to couple clients who had reported exposures of interpersonal trauma. Therapists were asked to clarify that the study was not required and that it was completely separate from their therapeutic work. The recruitment materials directed clients to the study website, where participants could find more information about the study's format, which entailed a joint Zoom interview with

couples, and a link to the client screening survey. Recruitment for this study took place over an eight-month period and ended once the study reached 10 couples and qualitative data indicated saturation.

Screening and eligibility. There were multiple levels of screening in this study. First, the study screened the eligibility of recruitment therapists. To meet this eligibility criteria, therapists had to be licensed, and meet a minimum training requirement of completing the four-day EFT externship, and the two additional twelve-hour EFT core skills courses (core skills 1 and 2) (Appendix E). Then, the screening processes determined eligibility of the participating EFT therapists' client couples who elected to take the screening survey. The client screening process entailed four primary eligibility considerations: (1) couples had to be involved in a committed relationship with each other for a least six months, and they both had to be at least 18 years old, (2) they had to currently be involved in EFT treatment—with an eligible EFT therapist—for a minimum of eight weeks prior to their participation in the study to ensure they could speak to their experiences with EFT, (3) each partner had to fill out the screening survey, providing matching names (their own and their partner's), emails, locations, EFT therapists, and their time in treatment, (4) at least one of the partners had to meet the criteria for CPTSD, as measured by the International Trauma Questionnaire (ITQ) (Appendix F), and (5) both participating partners had to willfully take part in the joint interview. A follow-up survey—which asked about demographic information and included an informed consent form and a scheduling form for the interview—was sent to those participants who passed the initial screening.

Measures.

Demographics. This study used a standard demographic screening that asked general questions about potential participants' age, gender, race and ethnicity, level of education,

socioeconomic status, relationship status, the amount of time of their current relationship, number of children, and the length of time they had been involved with EFT (Appendix, D).

International Trauma Questionnaire. The International Trauma Questionnaire (Appendix F) is the only valid, reliable tool that can help distinguish PTSD and CPTSD as distinct disorders (Cloitre et al., 2018; Shevlin et al., 2018). The questionnaire includes 18 questions that all use the Likert scale. In order to support the ITQ's ability to diagnose likely CPTSD and PTSD, the questionnaire has been validated independently (McElroy et al., 2018). It has also been validated by being administered to diverse populations with varying ages, location, and types of trauma (Fernández-Fillol et al., 2020; Haselgruber et al., 2019). Because it is currently the only tool that can validly measure and assess CPTSD, the ITQ is an appropriate tool for this study.

In this study, participants received the questionnaire with the first Qualtrics screening survey. If either member of the couple did not meet the clinical requirements of CPTSD—16 out of a possible 72—they could not participate in the study. Questionnaire scores are derived from individual scores that are equal or greater than two, which is a moderate score for each symptom of PTSD (avoidance, hypervigilance, and reexperiencing) and DSO (emotion regulation difficulties, negative self-concept, and disturbances in relationships). Additionally, a CPTSD diagnosis must involve moderate levels of functional impairment indicated by a score of two or higher for functional impairment in each of the PTSD and DSO categories. Participant scores indicating PTSD, DSO, functional impairment, and the total scores for each participant are summarized in Table 2. Based on ITQ scoring, the overwhelming majority of the sample met the criteria for CPTSD (n=19) as per their self-report scores of 16 or above across the PTSD, DSO, and functional impairment scoring categories from the ITQ in the screening survey (Appendix C, and F). Participants had an average score of 38 out of a possible 72 (range=22–61). Notably,

participants scored relatively high for CPTSD, indicating the severity of symptoms across the sample. Additionally, partner's scores within each participant couple ranged somewhat close together with the average difference of 10 points between partners (range=2-22).

Enrollment. Participants with screening materials who met the study's inclusion criteria were then offered the study's informed consent form (Appendix B). They were considered as officially enrolled in the study when they completed this form.

Sample. After the screening process, a total of 12 couples (24 participants) fulfilled the study's inclusion criteria. Two couples, however, later chose not to participate in the joint interview because of scheduling conflicts. As a result, the total sample size was 10 couples (20 participants).

Participant demographics. Participants for this study included 10 couples, or 20 total individuals. Overall, participants in the sample consisted of 40% males (n=8) and 60% females (n=12). Participants' ages ranged between 25 and 65+ years old. Most participants (80%) were married (n=16), while 10% reported being in a committed relationship (n=2), and 10% reported being in a committed dating relationship after their divorce (n=2). The length of relationships ranged between 3 and 42 years, with an average of 17 years. Participants' sexual orientation varied, with 75% identifying as heterosexual (n=15), 10% identifying as queer (n=2), 5% identifying as lesbian, (n=1), 5% identifying as bisexual (n=1), and 5% identifying as pansexual (n=1). All participants lived within the United States, with 50% in the Northeast (n=10), 20% in the Southwest (n=4), 20% in the West (n=4), and 10% in the Midwest (n=2). This was an sample with relatively high SES; the majority of participants (65%) reported a gross income of $100,000 or higher (n=13), 20% making $80,000–$99,000 (n=4), 10% making $60,000–$79,000 (n=2), and 5% making $40,000–$59,000 (n=1).

Interview procedure. After screening, the qualifying couples were interviewed using a semi-structured interview guide (Appendix G). The interviews occurred online and were recorded using HIPPA-compliant Zoom meeting session software. Before the interview began, I orally went over the informed consent, reviewed the study's goals and questions, summarized the study's benefits and risks, and informed the participants that they could choose to skip questions or end their participation in the study at any point. Once the participating couples provided final verbal consent, the interviews began.

Interview. The interview (Appendix G) did not ask about any details concerning participants' past trauma that had been reported either in the screening survey or through another source. It did, however, acknowledge participants' experiences of past trauma and ongoing CPTSD symptomology. As a result, the questions did not pertain to any past traumas but instead solely focused on the participants' current lived experiences of trauma symptomology within their relationship. Partners were asked questions in an alternating format, which gave both of them an equal opportunity to respond.

Data collection. The qualitative interviews with the couples ranged between 78 and 134 minutes and were an average of 120 minutes in length. The interview data resulted in rich descriptions of participant couples' experiences of each PTSD and DSO symptom and the subsequent impact of these symptoms on their relationship. The interviews were recorded on Zoom video conferencing software and then password protected and stored electronically. Once transcribed, interviews were stored in Word files and kept under the same electronic password protection standards as the audio files.

Data analysis. Framework analysis, a subset of thematic analysis outlined by Ritchie and Spencer (1994) and expanded by Gale et al. (2013), was used to analyze the large qualitative data

set for this study. As Gale et al. suggest, this methodology includes seven steps of analysis: (1) the transcription and organization of data, (2) data familiarization, (3) coding, (4) creating a framework for analysis, (5) applying the framework, (6) placing data into the framework matrix, and (7) data interpretation (2013).

Following the methods outlined above, participant interviews were transcribed verbatim, de-identified, and each participant was assigned a pseudonym code. Transcription data were stored with an encrypted passcode to ensure secure storage digitally in Microsoft Word files. As the interviewer and lead researcher for this study, I kept track of initial categories for terms, emerging themes, and notes after each interview in a codebook, which supported organization in early stages of analysis. As standard for large datasets in framework analysis studies, I used a Computer Assisted Qualitative Data Analysis Software (CAQDAS), MaxQDA (Parkinson et al., 2016; Ward et al., 2013). The next stage of analysis, spanned across six months (i.e., between the first and last interview), and involved a continual process of reviewing each interview in depth multiple times while taking notes and memos in each iteration of familiarization (Creswell & Poth, 2018; Gale et al., 2013). From this, I developed an intimate understanding of the overall themes that participants relayed within and across interviews (Creswell & Poth 2018). The information from this stage was saved in the initial codebook as an audit trail (Creswell & Poth, 2018), which I shared in detail with my advisor as we worked over time to develop the emergent analytic framework for the study.

Once we developed the initial coding categories based on key themes within the data and a priori concerns, I began line-by-line open coding in MaxQDA to further classify emergent themes that were inductive and that portrayed “particular behaviors, incidents, or structures” in the data across cases (Gale et al. 2013, p. 4). From this stage, the we worked to develop a core

analytical framework which involved defining coding categories and in an iterative fashion with the completion of each interview. As an important aspect of this analysis, this stage to incorporated study participants perspectives of the analytical framework (Braun & Clarke, 2006; Pelias, 2019). The responding study participants (n=12) provided feedback about certain elements that they felt were important within the framework, which included: validation between partners in the context of past trauma, and interpersonal healing and the development towards understanding their own and each other's symptoms.

The next stage was to apply analytical framework, which involved indexing each interview transcript codes into the matrix to compare existing categories and codes across cases. The application stage was again, an iterative process, which developed amongst coding and framework development as new themes evolved and as we received feedback from participants (Gale et al., 2013). The next essential stage of analysis was charting data into framework matrix. The charting stage included organizing the data by reducing it from lengthy sets of codes across cases from "each participant's own subjective frames" (Gale et al., 2013, p. 5), into salient summaries of each theme. Once all of the data was fully charted within the analytic framework categories, I met with my advisor repeatedly to cross-check and compare interpretations of each code category and theme. Through this iterative interpretation process, we determined six categories based on each CPTSD symptom each with a subset of themes related to how couples experienced CPTSD symptomology within the relationship, how they coped, and the relational impact of each symptom (Appendix H).

Trustworthiness. Central to the trustworthiness of qualitative research is the creditability and confirmability of the analysis (Creswell & Poth, 2018). In the current study, I held multiple roles in this study, as the primary researcher, interviewer, and qualitative coder. Therefore, I built

in multiple layers of both cross-checking and member-checking to support the confirmability and dependability of the study findings. Cross checking for this study primarily involved my research advisor who is experienced in the field of couples therapy, trauma in couple relationships, EFT, qualitative data analysis. Importantly, the confirmability of the analysis is supported by member-checking, which was used in similar study (Dansby Olufowote et al., 2020). Member-checking in this framework solicited participant involvement and requested their input on the initial analytical framework, theme categories and summaries. Their feedback supported the direction of what they, as participants, found the most important in based on their experience as couples in the context of CPTSD symptomology.

Results

The findings from the current study outline couples' experiences of each distinct CPTSD symptom (hypervigilance, avoidance, reexperiencing, negative self-concept, emotion regulation difficulties, and disturbances in relationships). The findings further identify couples' perceptions of the impact CPTSD symptoms have on their relationship and their process of coping with symptomology over time.

PTSD: Avoidance.

Experience of avoidance: Couples consistently avoided relational trauma stimuli within their relationship. Participants in the current study described their experience of avoidance in depth and distinguished between intentional versus unconscious avoidance and how these symptoms were directly related to past interpersonal traumas. They also described the relational impact of both forms of avoidance, their journey to identify and understand this symptom in the context of past trauma, and their attempts to manage it within their current relationship.

Avoidance for participants in the sample was a deeply ingrained and consistent symptom. This was the case individually—"I became an expert at avoiding, you know, now that I'm thinking about it is probably one of my best go-tos" (Cathy)—but it was also the case within their intimate relationship as a way to avoid conflict—"we have a well-ingrained habits of avoiding, you know, all those sorts of raw spots that we have from our childhoods and from, you know, our early relationship when things were less stable" (Gina). In this way, participants within the sample described avoidance as a coping mechanism that was in some ways intentional and protective—"I mean, there are certain things about the trauma that I've experienced that I know there are certain situations that will bring that up for me and I avoid them" (Amy). However, participants also experienced avoidance like an involuntary "preprogramed reaction" (Evan). One participant, Cathy, further described avoidance in this way:

> There's different kinds of avoidance, like the avoidance that helps protect us and to help keep us safe and healthy. . . . I think the other part of the question is avoiding things that I don't even realize I'm avoiding. And, and that does happen.

These two forms of avoidance experienced by participants played out in their relationship in both intentional and unintentional ways and with associated conscious and unconscious reactions, which affected how they encountered their relationship on a regular basis. Whether healthy or not, avoidance within the relationship served as a mechanism partners could use to create space and feel safe from distressing stimuli, including either their own or their partner's difficult emotions (which is related to emotion regulation difficulties and reexperiencing). As Cathy explained:

> Sometimes [my partner] recognizes [my avoidance] . . . she'll say that I'm distant . . . but I don't even recognize it when I'm emotionally avoidant. So, in the past, I didn't even

> know what [my partner was] talking about. Then I would become really defensive and irritable because I'm distant for a reason. Like, I just don't want you to bother me. I don't want anybody to bug me kind of thing.

Participants further relayed how these forms of avoidance were intended to prevent negative interactions in their relationships (disturbance in relationships) related to painful emotional states (emotion regulation difficulties) or sensitive situations connected to past trauma (reexperiencing), or fears of attachment loss within the current relationship (hypervigilance, negative self-concept). Participant Amy revealed, "I do avoid conflict with [my partner] a lot of the time because it brings up, like, bad emotional feelings and bad memories for me about conflicts that I've had in the past." Participant Brent further detailed the role of avoidance as a stabilization tool amidst overwhelming stimuli in his personal experience and relationship:

> I think I spent several years avoiding internal feelings and thoughts related to my own trauma. I've done a lot of work . . . to sort of face those things, but I still do it. I mean, there's certain things I don't want to think about or put myself in a position, and I will definitely avoid things that might trigger [my partner], I guess. So, I'm still very aware of that kind of stuff. . . . I guess I've got sort of a PhD in sensing when things are about to explode or get scary.

His partner, Monica, then responded, "(my partner) is very attuned to, like, my triggers, and maybe he's had to be that way."

Experience of avoidance: Withdrawal and disassociation led to distance and disconnection between partners. Participants described the impact of avoidance symptoms on their relationship. Partners relayed that their external responses took the form of emotional disconnection via withdrawal. For example, one participant, Brent, noted, "I see it in myself, if I

feel something familiar [to past trauma] in my marriage, my go-to coping mechanism is to withdraw." Brent's partner, Rachel, noted how her external response took the form of disassociation: "the question [of avoidance] is a little bit difficult for me because I dissociate regularly, it's not conscious I'm avoiding [my partner]."

Relational impact of avoidance: Mutual activation of avoidance symptoms between partners. The pattern of withdrawal and disassociation rooted in trauma avoidance proved difficult for couples. Participants described a mutually activating cycle related to avoidance and systemic triggering of issues in partners: "If I sense my partner's avoidance, I completely cut off [from him] . . . it's my fear of abandonment" (Erica). Another explained her reaction to her partner's avoidance based in the fear of attachment loss (related to hypervigilance) and disconnection:

> When he shuts down or, like, if he's cold and distant to me, then it triggers something inside me . . . [when] he was very distant to me. Like my behaviors would ramp up. I would subconsciously, like, pick a fight or, like, text him a thousand times. Yeah. And he would make him *even more* distant. And I didn't realize what I was doing was just, you know, trying to get his attention. (Brittney)

The result of this mutually activating cycle surrounding partner avoidance, perceived as emotional distance, plays out further in couples' experiences of the other five CPTSD symptoms (see below). In this way, avoidance-related constructs within participants' relationships triggered frustration, anger, and constant arguments (emotion regulation difficulties), the replaying of past traumatic experiences in the present (reexperiencing), a heightened sense of fear and threat within the relationship (hypervigilance), feelings of being unloved and emotionally cut off from one's partner (negative self-concept), and an unreliable attachment bond between the partner

(disturbances in relationships). These are detailed within each symptom category below. Avoidance seemed to play the role of preserving the relationship at times, or it kept a partner's difficult emotional states at bay, but it also kicked off a mutually activating cycle that triggered other symptoms, which also stirred up relationship difficulties.

Relational impact of avoidance: Avoidance of emotional and sexual intimacy. In terms of the relational impact, an emergent theme was the way in which couples' sexual relationships were impacted by traumatic stress-related avoidance. As one participant, Kirsten, noted, "our sexual relationship is impacted because I will get to a certain point and then I get triggered." Within the sample of this particular study, partners displayed compassion for their partners' experiences, recognizing that "sexual activity is, is different for us than if (my partner) hadn't had some things in her childhood" (Harry). In this case and in others, participants displayed a sense of empathy for their partner's experience and yet described a lack of intimacy, pervasive sexual issues, or a lack of sexual frequency as core problems in their relationship. This was also met with a key realization from one participant (Janet), who noted that greater physical and emotional intimacy within her relationship was perceived as a heightened risk and, therefore, something to avoid due to her interpersonal trauma history:

> We started to see [a therapist because] of sexual issues that were related to [my partner's] trauma and my needing to understand it, it was helpful to me to understand the issues in our relationship, but in order to do that, I had to understand the trauma history and how that, how that changed everything. Because the closer we got and the longer we were together . . . the more truly intimate we were, the more she got scared. (Janet)

Managing and coping with avoidance: Lack of resolution. When asked how they manage these symptoms within their relationship, several participants responded by recognizing the

burden it had on their relationship. They noted their struggle to find a solution, but for many, they just learned to live with the lack of resolution. For example, "I don't think we do manage. . . . I'm fight, [my partner is] flight. We need to find a new way" (Mitchell), or, "I've made clumsy attempts . . . but it hasn't always been going well" (Adam).

A process toward discovery and understanding. Conversely, some participants described a discovery phase and progression toward mutually managing the avoidance-response pattern as it related to their own and their partner's avoidance. Participants described their experience, and their management of avoidance symptoms within the relationship, as a continual progression toward learning about the symptom in context and how to respond. This process was, at times, a confusing barrier and a painful reminder for partners, revealing the automatic and subconscious nature of their avoidance related to past interpersonal trauma and its pervasive impact on their current relationship.

Within this process, participants described how long periods of conflict (reactivity) or emotional distance (emotional constriction) related to avoidance propelled partners to recognize the issue: "things got pretty explosive and that was damaging our relationship and we had to get help" (Monica). This course of discovery and the subsequent adaptive coping strategies for couples was heavily supported by extensive resources, primarily years of individual therapy, and in the case of this sample, Emotionally Focused Couple Therapy. Over time, learning the root cause of avoidance, and "becoming vulnerable with and holding space for each other" (Sarah) was notably beneficial for partners to find a new way of responding and understanding the rationale behind a partner's avoidance symptoms within the relationship. As one participant, Janet, explained:

> I didn't understand it because there were things she was afraid to talk to me about, and [she was] afraid that I would be judgmental about. Once we finally do start talking about our past trauma [related to emotional avoidance] and sharing, I had the opposite reaction. I'm really genuinely amazed [by my partner], but it takes a really long time because if you don't wanna think about it yourself, you sure as hell don't wanna talk about it.

As participant Amy noted, this process was "something that we had to learn and develop through a very long course of, of discovery."

PTSD: Hypervigilance

Experience of hypervigilance: A way of being in relationship. When asked about the symptom of hypervigilance, participants described the experience of "being watchful, jumpy, on guard, and super alert as if something bad is about to happen," not as a "symptom" like others, but more as "a way of being" (Amy). Participants explained, "I live my life like that" (Ryan), and, "it's hard to notice because it's more" (Amy). Participants also described the experience of hypervigilance in their couple relationship as a hyperaware activated state between partners: "we're always ready to rock and roll . . . it's a real struggle and a constant experience. Like, I think we're always, we're hyperaware of each other's physical expressions and definitely the verbal expressions" (Evan).

Participants described two categories of hypervigilance. The first relates to a general state of being "very aware of (the surrounding) environment . . . it impacts our sleep and we cannot rest, it is very prevalent for us" (Evan). This can also include abrupt experiences of extreme fearfulness and an activated sense of threat. As participant Monica detailed, "I can be a very logical 46-year-old, and then all of the sudden, I think I'm going to be killed." These forms of

hypervigilance were functionally impairing for participants in terms of their ability to relax and move freely in their environment.

Second, partners recognized the relational component of this individual experience. One participant, Matthew, noted: "She's always waiting for something bad to happen. I understand where that comes from with what she's been through . . . it's always been that way and it got real, real, real, real stressful for her." However, the burden of symptom management still had an impact on participants' ability to engage with their partners. Participant Erica described the impact of symptom burden on the relationship: "I am constantly doing so much to keep myself calm and functional that I don't have a lot of resources left over for [my partner]."

Experience of hypervigilance: Pervasive fear and distress within the relationship. The second and more prominent form of hypervigilance discussed by participants was the experience of a pervasive sense of threat related to their intimate relationship, which proved more complex. The sense of threat related to participants' ability to feel secure in their relationships took the form of fearing loss, abandonment, or disconnection from their partner; it is "a constant evaluation of my relationship. At every moment I am on guard about it" (Erica). This process can be mutually triggering because, "we both have the fear of abandonment" (Erica); however, participants also emphasized, "we do *not* do well when we are disconnected" (Monica). Another participant described the overwhelming fear of relational disconnection: "I get fearful of (my partner) leaving or dying, which I can regulate myself from, but if I feel that he doesn't trust me, I get really afraid" (Brittney). Hypervigilance within the relationship was experienced as a symptom on the opposite end of the spectrum from avoidance, and yet it had a similar automatic response pattern:

> As soon as I get a little spark of a thought, I think about it, right. Then I give that energy and it kind of grows in my mind and I don't wanna do it, and I feel bad about doing it. And I, like, know I shouldn't be doing it, but there's this part of me that, like, does it anyway. And then I start trying to connect little dots of things that happen, something to, like, almost, like, find the problem when there is no problem in order to ensure that there is no danger in a way (Mitchell).

Partners described the struggle to process and manage their partner's relational hypervigilance: "I mean, I often forget that [hypervigilance] is a way that [my partner] tends to experience things. And to me, it seems to manifest as kind of like a controlling tendency . . . judgment, criticism, controlling" (Adam).

Relational impact of hypervigilance: Defensiveness, fear, and being on guard toward partners and the relationship. Participants described how their relational hypervigilance led to a turning away from their partner and created a relational culture of fear and distrust despite the existence of security and no overt relational threats. As one participant, Amy, noted, "I always think the worst when it comes to [our relationship] like he's purposely trying to hurt me. . . . I think that's understood that he's not . . . But I really believe in that moment." This fearful and relationally hypervigilant state is distressing for couples: "it is disastrous every time" (Ryan). Others stated feeling "like everything was [my partner's] fault" (Mitchell), but knowing this was also an automatic protective response inciting fear and panic: "it's like fake news in a way" (Ryan).

Recognizing the negative impact on their relationship over time and the disconnect from their perception and the present process, partners described their struggle to shift from protecting themselves and responding to their sense of threat due to the intensity of past trauma:

> I have a tendency to take any change, any change as an attack. . . . I'm also constantly on guard for change. And some changes that I fight in our relationship, I don't even care about . . . [but] I think it's just because when all those changes happened with my family, my entire world is ripped out from under me (Mitchell).

Partners reported that when their partner experienced them as a threat, this in turn activated their own relational hypervigilance, "[I get] hyper on alert because . . . I feel like . . . his brain or whatever, doesn't want him to be happy . . . he always like latches on to see . . . [I'm] not trustworthy. So, I get really, like, afraid" (Brittney).

Participant couples' inability to let down their guard or think positively in their intimate relationships was described as one of the most difficult consequences of CPTSD symptoms due to repeated and consistent traumatic experiences in primary attachment relationships throughout their lives that brought up issues in the current relationship:

> Because I never knew what to expect. You know, I never knew what was coming around the corner and I didn't have any control of that. So you just get to the point where you expect the worst, so you're not disappointed, but it really changes your thinking and your perception. . . . I get really scared (Annette).

One participant, Ryan, described how a sense of threat related to past trauma can have an invasive effect and can impact even the most positive or peaceful relational experiences:

> It could be a 70-degree day. Good food, the kids are behaving, and like everything could be right. But then it's like a drug released into my mind. The fear takes over my body. And I want to, like, start looking and searching and doing something to prevent myself from being hurt. And it feels very real. . . . I do trust [my partner] . . . but it's a battle . . . [and] it ends up hurting both of us. . . . I want her to know that I do trust her. So at some

point, I gotta let go of this defense mechanism. That's sort of like driving me crazy. It's like my mind knows it's okay, but my body doesn't.

Management and coping with hypervigilance: Mutual awareness and emotional connection. Despite the interpersonal and intrapersonal complexity of managing extreme fear related to relational hypervigilance, participants had clarity about what helped them manage burdensome individual and relational distress related to this experience. For individuals, skills related to mindful acceptance and emotional awareness, were key. "Accepting how I'd feel and accepting that I'm like afraid or scared" (Ryan) helps participants get out of a panicked or defensive state. Another participant noted, "I try to identify the core emotion and recognize if the issue is something coming up from the past or in the here and now" (Amy).

On the relational level, mutual awareness of hypervigilance and its origins directly fed into a couples' ability to redirect and reflect on what is driving fear and conflict within the relationship. Often, "[one of us] is really misreading with [the] other, you know? And we know that those things come from trauma, the way we respond to things" (Sarah). Participants across the sample relayed the progression of healing related to how they learned to respond to each other's sense of threat: "I think what we've learned over time is . . . to not try and fix each other's trauma . . . if I'm anxious, [my partner] will say, now . . . 'I can see you're anxious.' That's a difference in the way we would've handled it from before, [it's] just Empathy 101 [now]" (Gina). These participants further noted that when they would try to "fix" each other's sense of threat, it would "just feel unsatisfied, and not any better or any less anxious" (Gina). Another summarized the importance of recognizing genuine vulnerability in her partner to soften her sense of threat and facilitate the process of coping with hypervigilance within the relationship:

> I'd say the vulnerability from my partner is what immediately, I guess, puts my guard down. And it's easier to feel loved and safe, and then you're able to actually hold emotional space or compassion for the other one (Sarah).

Participants additionally recognized that the sense of threat was never just "about the content" (Gina) but rather about needing the underlying sense of fear in that moment to be understood by their partner. This point was well illustrated by a participant responding to what helped her experience lower hypervigilance and arousal related to an attachment wound from her spouse:

> I mean, it was good that you, you took responsibility and everything. I mean, that was great . . . but that's not what really won me over, you know, what won me over is that . . . you took responsibility, but then you also listened to what [the attachment wound] did to me. And that's when I felt like you were really, really hearing me. . . Empathizing, and like really getting it, like getting what it did to me. Yeah. I mean, that's where the empathy could come from was once he really got it (Rachel).

PTSD: Reexperiencing.

Experience of reexperiencing: Reexperiencing was intrusive and impaired cohesion in the relationship. Participants described reexperiencing as a pervasive and frustrating symptom that required a great deal of mutual awareness to manage individually and jointly. Reexperiencing built upon and related heavily to symptoms of avoidance and hypervigilance in that reexperiencing posed a serious burden on participants' lives and relationships, "where [reexperiencing an attachment wound from my spouse] was like every five minutes at one point" (Brittney). Another participant stated, "I've been in therapy for 40 years and at a certain stage, I was so constantly flooded with traumatic images that I had to go to the hospital" (Erica). These

participants reported how issues in the current relationship activated the wounds from past relational traumas.

Relational reexperiencing. Reexperiencing in this sample was, at times, related to intense memory recall in the form of persistent and disturbing nightmares or specific traumatic experiences of betrayal, neglect, or abuse playing over again in an intrusive manner. However, it was more often described as "not necessarily images" (Kirsten) but rather an unconscious experience that replicated "more of the feeling, [or] thoughts" (Adam) that related to interpersonally traumatic memories. One participant revealed, "I don't have images, I have crossover experiences that are so similar [to my past], it's scary, and I feel like I've been here before and I'm here again" (Mitchell). In this way, participants described how it felt like the narrative of the reexperiencing was like a "filter" (Evan) to the present moment in which they were responding to something or someone from the past: "[how] it manifests . . . sometimes, my responses to something [my partner] is doing are so heightened that I'm, like, this can't be about what's happening right now. . . . My reaction does not match what's actually happening in the moment" (Kirsten).

Relational impact of reexperiencing: The unique impact of the couple relationship as trauma stimulus. Reexperiencing within the couple relationship started as an internal individual signal that in turn impacted partner's actions and response patterns toward each other. One participant, Ryan, relayed the impact of this on his relationship: "[my partner] then feels bad because I'm responding to what was and not what is," to which his spouse responded, "I feel like a failure when he does that" (Brittney). Participants relayed that, primarily, this type of response was related to perceiving behavioral cues from their partners (i.e., passiveness, anger, avoidance, directiveness, or frustration), which spurred on emotional memories of prolonged or repeated

traumatic relational experiences. These types of traumatic relational experiences included abuse like CSA, and pervasive experiences of bystander inaction, for example:

> When [my partner] is passive, which he often is, because he is historically very emotionally avoidant and just likes to keep the peace, it feels like he is my mother, whose passiveness was, really, honestly worse than my father's abuse. I even have a special name for [my partner] when he is passive and I call him [that] when I sense that he is passive because it makes me feel desperate, like [the past trauma] is happening again (Rachel).

In this way, reexperiencing was a pervasive undercurrent in participants' lives and relationships, a phenomenon of which they were both aware and unaware. Importantly, participants revealed how their partner's noticing or being negatively impacted by the symptom illuminated their awareness of its existence and severity:

> We'd be sitting with the kids when they were little and she'd be like, you look like you're miserable and I'm like, what are you talking about? Cause in my head I'm experiencing something and I am miserable, but not consciously, right. I'd be like, what are you talking about? I'm just sitting (Mitchell).

Reexperiencing: Management and coping—process of identification and discernment between past and the present. Participants detailed their struggle to stay in the present moment and recognize reexperiencing when it was happening, and to distinguish between intrusive and emergent feelings of past traumatic situations and how those colored their view of their relationship and partner in the present. Despite a great deal of work on this symptom, participants recognized the ongoing process and how they often managed it by disassociation or by covering it up; when this happens, "I just call it getting triggered, but I feel my heart rate and

adrenaline, like, pump. . . . I certainly feel it, but I hide it a lot" (Ryan). This symptom required a lot of effort, resourcing, and support to manage:

> I will notice images or memories come up that will lead towards disassociation, so I try to catch it before it gets there with the array of tools and strategies I've developed over the years but if I don't catch it, then I'll have to go deeper in the continuum of my tools that I have for what's going on (Monica).

Due to the negative relational impact, others described how they actively made efforts to distinguish their partner and their behaviors from the past: "I have to remember that she is not my siblings bullying me" (John), or, "just because he is a man does not mean he is like my father . . . he is actually so patient" (Gina), or, "we have moved on and we are so much better off now, but it takes a lot of work to catch that. My reactiveness (related to reexperiencing) was destructive" (Ryan). As participant Brent summarized, "what I'm working on right now is to separate myself from the past trauma and recognize what's happening in the moment. Certain things can take me back to a scary place and I have to try to stop myself from going there."

The couple process of managing reexperiencing was illuminating, but it was also a road of difficulty and ongoing discovery and discernment:

> Because we've had so many blowups, we've started to recognize and know what's coming next and know that now we have the tools in couple therapy to stop from going too far and creating more damage. There are topics we can't handle on our own, and there can be constant landmines (Monica).

The discovery and management process over time led participants to be very "tuned in" (Sarah) to each other's internal processes, "I feel like we feel each other's pain now" (Sarah). As Evan described:

> I see it happening, the past coming up for [my partner] in a moment, and I know her so well that I can see, even with the way she is walking or how she is moving, I can tell what's happening for her . . . just being there and validating her when that's happening now seems to help (Evan).

For some, when struggling with reexperiencing, they reported needing to "remove myself from the situation" (Erica). Participant Amy noted, "[my partner has] learned that it's just an internal thing that I am processing." For couples overall, emotional reexperiencing was complicated and led to ongoing distress; however, "recognizing that we are *really* experiencing and stopping it before it spirals is the secret I think because from there everything gets out of control" (Brent).

Disorganized sense of self (DSO): Negative self-concept.

Experience of negative self-concept: Negative and/or defeating internal experiences of themselves in relationship to their partners. Participants struggled with the DSO symptom of negative self-concept as it related to how they experienced themselves and their relationships. This manifested often as an intrusive and deeply felt insecure attachment to partners with beliefs of either being unloved, or impending abandonment and rejection: "the way it manifests itself is that I think [my partner] doesn't love me" (Monica), or, "I get afraid that I'm not enough for [my partner" (Sarah), or, "despite everything good he does, I have to work past that bad feeling from my past, like if I trust him, then I'll inevitably be screwed over" (Annette). Another stated, "I translate my negative beliefs about myself into the marriage a lot" (Ryan). Others described recognizing their partner's struggles with negative self-concept of often feeling like a "failure" within the context of their relationship (Brittney). For some participants, this became less frequent over time; however, for others, it was again a pervasive experience: "I think every day

for me. Every day for me, I'm reassessing . . . it is a constant thing" (Erica). Participant Kirsten relayed the combined negative self-concept related to past experiences and ongoing relational difficulties:

> There was a period where I felt like a failure and part of it was how we were treating each other. And part of it was all that [interpersonal trauma] stuff coming back up for me . . . it was starting to bleed in everything in our relationship (Kirsten).

Due to this pervasive negative internal experience, participants described the impact it had on how they relate to themselves and others as they became "overly critical and harsh . . . a mistake [from others or myself] shouldn't have to be the end of the world" (Gina). Participant Annette detailed how her negative belief—"I cannot be safe to trust or get close to anyone"—was a dual experience of distrust and criticism of others and herself:

> I cannot believe I can even trust anyone . . . like, I've believed that I'll never be safe, so I'm critical of my environment, [my partner] always says "you're even too hard on yourself." And, and I am. I have a really high bar and it's not, it's not just on other people. It's, you know, I'm harder on myself than even them. And it's really hard too for me to feel like I can like myself, let alone let [my partner] in.

Relational impact of negative self-concept: Emotional distance and disconnection between partners. Participants described struggling with the pervasive Negative Self-Concept related to their ability to maintain closeness with others, which correlated to their experiences of subconscious avoidance and hypervigilance: "I mean, I feel cut off from people" (Adam), or, "I unattached" (Brittney), or, "I can very easily shut off from people" (Evan). Erica illustrated the extent of emotional cut-off she experienced due to her negative self-concept and fears that she will be rejected and abandoned:

> I have very serious object permanence problems. . . . I don't miss people; I don't remember that I miss them until I see them again. Then I'm kind of overwhelmed with a sad missing [feeling] . . . it's just kind of like a shell of protection. . . . I cannot stay connected to [my partner]. . . . It's like I don't need him, or anyone.

Relational impact of negative self-concept: Negative relational concept. In terms of the larger relational impact, participants described feeling unsafe with their partners. As Mitchell relayed to his spouse, "I believe that you were trying to hurt me. Right. And, and that comes back to my whole fight or flight thing." In a comparable way, participants described constantly needing to assess and make up for where they perceived themselves to be lacking in their relationships, which drove further symptoms of hypervigilance. One participant, Evan, described the impact of his negative self-concept on his experience within his life and marriage:

> If I have any sort of feeling that I'm not providing, which usually is [noticing my partner] not being happy, or if she makes some sort of comment about me needing to do more, or I'm not doing something enough, that is huge because I already feel that way about myself. I already feel like I need to do more or I'm not accomplishing something, or I could do better, and I'm trying to get better about it, but I rarely see anything that I've done as being something worthy. Even when I accomplish something, it's, like, never enough [in my mind]. . . . So that is a huge motivator of stress and anxiety that I'm constantly battling is being competent, being a good provider.

And another participant stated:

> I guess it just kind of manifests itself in a way that when I'm cutoff like that, when I'm just in my own world and I'm just, like, you know, I've struggled to realize my own damaging effects on my husband. The things that I do. I think what's weird—and I kind

> of came to this conclusion in the last month or two—is that when you have such a low opinion of yourself and you think so negatively about yourself, it actually has this effect that you don't even think that anything that you could do could impact anybody positively or negatively, because you think so little of yourself. So when I would be yelling at [my partner] or whatever, it never crossed my mind that he's being really hurt by me (Monica).

Relational impact of negative self-concept: A mutually activating cycle. Due to participants' engrained and deeply rooted negative self-concept, partners described how their insecurities impacted the way they related to each other: "our words are supercharged, and I think we're reacting a whole lot faster to something that the other one feels like they might be coming up short. . . . Trauma definitely has played into those for both of us. . . . That one's tough" (Evan). Participant Erica noted, "I don't respond well to his negative self-belief. And then it kind of spirals or snowballs or something like that. Or, like, cyclical, where he feels shitty about himself and then I reinforce it and then he feels shittier." When their relational insecurity cycle was triggered, it often involved misaligned bids for connection that partners experienced as reactive and alienating:

> I might really start sending really long rambling emails or texts or ramping things up to get some kind of reaction or some kind of proof that he does, in fact, love me, but it ends up just pushing him away. So then, that further triggers the whole cycle (Monica).

Negative self-concept management and coping: Extensive intentional effort and resourcing. Managing negative self-concept was a challenging task for participants. As Kirsten noted, "I spent four years working on this intensely [in therapy] because I've always had the limiting beliefs like really strongly." Participants further noted how external stressors and family

transitions worsened these symptoms, and they recognized needing partner support to manage them:

> I feel like I had made a lot of progress with my negative beliefs about myself. However, it has definitely come back more since having kids and being home. . . . I think I was so overwhelmed that I abandoned some of my tools. . . . I would like to incorporate some kind of tools that like get us [me and my partner] working together, but I'm not sure what that looks like yet (Kirsten).

Negative self-concept management and coping: Identification, partner awareness, and safety to be vulnerable. Despite the ongoing difficulty of a pervasive negative self-concept related to their identities and their relationships, participants again identified that individual and partner awareness, and the emotional safety that allowed them to be vulnerable with each other, were key in their ability to manage this distressing and invasive symptom. Participant Erin described how it helped when their partner was able to understand "the reason that I'm acting this way is because I'm feeling really insecure," and this awareness was derived from "having talked about this so many times [with my partner] . . . and having awareness of the feeling that's there."

Others described the fact that part of the management process involved a combination of giving and receiving positive messaging or support from their partners to combat intrusive negative beliefs: "I need [positive] feedback to, to feel okay" (Rachel). Participants demonstrated that they recognized their partner's struggles with negative self-concept over time and how that impacted the way they interacted within their relationship: "[my partner] will often think that the only time I'm happy with her is if she's doing something good enough or well enough and that if she doesn't do it the way that I would like, that I'd somehow not love her or she's not

worthwhile. And I see that that's a struggle for her" (Amy). In this way, participant Brent emphasized the importance of discerning the combined mechanisms of offering emotional support and emotional boundaries that come with positively managing negative self-concept within the relationship:

> I noticed that I just used everything I could to make [my partner] feel better. And now, I am just trying to support her the best I can but also realizing there's boundaries between what I can do and fix and what I can't do, and how I can help and how I can't help. So, I just try to support her. . . . I think I just try to do it healthier and less anxious (Brent).

As noted, negative self-concept was extremely difficult for couples to manage due to the deeply rooted negative belief patterns partners already carry that often mutually activate a negative belief cycle both within and between partners. However, as with other traumatic stress symptoms, emotional awareness, emotional boundaries (recognition of relational limitations), emotional safety, and vulnerability were experienced as a relief and had a neutralizing impact on relational distress. In terms of negative self-concept, "now, I share it . . . at the end of the day, [negative self-concept is] just another series of trauma-related fake news or it's another series of just my mind is like a machine that happens to produce false information because of my history" (Ryan).

DSO: Emotion regulation difficulties.

Emotion regulation difficulties experience: Reactive cycles of emotional constriction and hyperactivation. The DSO symptom of emotional dysregulation was an individual trauma symptom that was also strongly linked to partners' experiences of each other within the context of their interpretations, responses, and reactions to each other across time. Due to the intensity of prior PTSD and DSO symptoms of avoidance, hypervigilance, reexperiencing, and negative self-

concept, strong emotions related to the relationship and subsequent emotional eruptions were a common experience for couples. In this way, symptoms of fearful reactivity and anger (hyperactivation), or emotional avoidance (hypoactivation) such as emotional cutoffs and disassociation, played a significant role in couple dynamics and communication. Participants described this continuum of hyperactivation and hypoactivation in many ways, noting, "I get right in [my partner's] face a lot, I don't have a filter" (Erica), and, after an argument, "I don't feel calm for about a week" (Evan). Another described a numbing experience of emotional dysregulation and its relational impact: "I do sometimes feel like I will push away my emotions and try to be in that numb place because it's easier for me. And I, I do notice that I will not engage with [my partner]" (Amy).

Relational impact of emotion regulation difficulties: Chronic negative emotional experiences between partners. Consistent emotion-regulation difficulties within the relationship instilled a negative cycle between partners in which fearful states related to past trauma interrupted the current dynamics of the couple relationship. The impact of emotion-regulation difficulties in the context of their relationship at times reinforced interpersonal trauma beliefs related to negative self-concept and was at times retraumatizing for partners to a severe degree.

> When we split up and things got really bad, it confirmed all of my worst beliefs about myself and I, I, it's hard to say it out loud, and I've been working on it, I think I'm getting past it, but mainly, I didn't want to be on this earth anymore (Matthew).

The impact of distressing dynamics in participant's relationships was described as distressing and included long-term cycles of intense arguments or long periods of disconnection that felt like "a civil war between us [that would span across] weeks . . . and we went on for

decades like that; [it is] so painful when it's it going [on], you know, our brain takes it a certain direction and it's, it's hard. It's so hard" (Annette). Another participant noted:

> Our cycle of fighting and blow-ups felt like a trap we couldn't get out of, it was honestly really traumatizing to feel like that [constant blow-up's] was just how it is going to be for us, especially after everything we had been through before [in childhood and in our prior marriages] (Monica).

Emotion regulation difficulties: Management and coping—partners discerned and expressed needs for individual and co-regulation. Coping with strong emotions with resulting reactivity or numbing was difficult for partners to attain; however, they described how combined efforts to emotionally regulate both individually and together were key. Participant Amy illustrated how she and her partner managed and discerned how to successfully engage this process of emotion regulation and co-regulation via connection and emotional vulnerability:

> Sometimes I need to take a break, switch environments, go do something else, which can be a struggle [be]cause, as you hear, we have opposite approaches to that. Like, she wants to be together [after an argument], and I want to take some space. So I think we've, you know, learned to kind of make a balance between those two things when each other needs it. . . . If I can catch myself doing this or being in this space, I will try to do my best to reconnect with [my partner] in a way that feels meaningful, like telling her what's going on with me or like trying to confront, like, what things I'm avoiding.

Another important finding was the way participants recognized the need for support in terms of how they, as a couple, manage emotion-regulation difficulties due to how trauma adds intensity to their disagreements or negative emotions:

> I think we've had to recognize is that we've had a lot of trauma, right? We both have, and it makes things, the intensity of arguments between us very, very strong, so sometimes, I, I think it's okay to hold off and take a break on a certain issue until we can get help. That's why we found our couples therapist, we couldn't do it alone anymore, and I think we need help dealing with these intense emotions we both have, and sometimes we have to just table it until we have help (Brent).

His partner agreed and responded, "Yeah, before it damages us even more, but it is stuff we do need to address, and we're working on it" (Monica).

DSO: Disturbance in relationships.

Experience of disturbance in relationships: Trauma was a filter for how partners experienced close relationships. The experience of disturbance in relationships was, again, extensive and pervasive for each participant couple. When asked about their experience of disturbance in relationships, couples shared that it was immense. As one participant noted, "I'm sure we could go on for weeks" (Gina).

Participants relayed painful, complex, or difficult experiences within their relationship, which were linked to intrusive symptoms derived from past interpersonal trauma. For instance, participant Harry described, "there were [bad] things that happened in [my partner's] childhood that… directly affect our relationship and how we function together because of how she experiences constant triggers [being in relationship]."

Much like hypervigilance was described as "a way of being" and experiencing the world for individuals in the sample, the disturbance in relationships symptom was described as a way of relating based on past negative relational experiences with primary attachment figures, including parents, former partners, siblings, therapists, and even each other. This way of relating

mimicked attachment narratives where partners described responding to each other through the filter of how they understand close relationships, which instilled defeating patterns that remained difficult to overcome.

> I think for me, the trauma that I experience has impacted our relationship, like right from the beginning. I mean, I feel like it informed the way that I thought relationships should be and what they should look like. And therefore, I think it's affected the course of our relationship and it's been a focal point in us, like working on being together (Amy).

Another participant similarly shared his and his partner's experience of the filter of trauma in their relationship of over 40 years:

> I think our, our traumas, um, you know, obviously are the lens we see things through. . . . It's been really difficult, I think for me, to *not* in certain circumstances assume that [my partner] is behaving the way my [abusers] would. . . . It's very easy for her to see something that I do as what her [abuser] would do, right? And for, you know, for those [same] motivations. So, I think that's, that's how I see it coming into the relationship is, um, sort of viewing our partner as, you know, our, our [former] traumatic surroundings. As, you know, those [close relationships] are the situations that brought about the trauma (John).

Participants' experiences of the trauma filter were related to trauma symptom clusters like reexperiencing and negative self-concept:

> It [trauma-related disturbance in relationships] adds a filter to whatever is being said or the action[s] [between us]. So a good gesture won't get viewed as a good gesture, or a statement will get viewed as a negative statement, or one tiny little bad thing that happens

> will make the whole day or the whole week seem like it's all bad. So yeah, I think it totally affects every aspect of our relationship negatively (Evan).

Relational impact of disturbance in relationships: Interpersonal trauma as a degenerative, invasive, and harmful third entity in the relationship. The role of trauma was like a third person in the relationship that caused havoc. For one particular couple, it led to divorce. Though they regretted their divorce and were able to reconcile their relationship, participant Gina described the impact of trauma on her relationship:

> I grew up in a really chaotic home and alcoholism and, and narcissism, a lot of bad stuff…And I remember saying [to my partner when we were separated] . . . "I feel like I've been robbed of a lot in my life and you don't get it back. . . . I feel like I got short-changed and I feel like," and I remember saying to [my partner] that day in the driveway, "I just don't think it's fair that I'm still paying the price for stuff that had nothing to do with me." . . . I feel like it's—I can almost personify the trauma in my life, like it's baggage for me. And I think it's a third person in our relationship. It's a third entity in our relationship. . . . I just wanna move on. I just wanna remove that trauma piece from my life, and I know I can't ever, but I can certainly diminish it and manage it. . . . It just never goes away. . . . I really had no understanding of it [until the divorce]. I'm 54 years old, and I had no understanding of what was happening until this year.

Participants relayed how the overall impact of their trauma was deeply engrained, and therefore, many did not notice the severity of its impact on their relationship until their symptoms worsened over time.

> I think [trauma-related difficulties] always have [impacted the relationship] in various ways, right. Like from our intimacy to, like, intimacy on both levels. Right. Emotional

> intimacy versus all of it. Like, we don't have any of it. [That's] how we ended up going to therapy was all of those, all of those things playing out without us knowing it. . . Cause we were literally just fighting, like, over everything . . . that's how bad it had gotten. And I think that it was all of these things we talked about [CPTSD symptoms] playing out and we just were so in it, we weren't conscious of it. (Mitchell)

Relational impact disturbance in relationships: Polytraumatization and relational layers of complexity. Despite the fact that the interviews did not include any discussions around past trauma experiences, participants relayed that trauma experienced in differing relational contexts each had a unique impact and interaction on their overarching disturbance in relationship symptoms. For example, each participant couple, and almost all participants, acknowledged the presence of harm or abuse that occurred within the context of their families of origin. However, some also shared the additional relational complexity of past trauma experiences in former marriages, military experiences, or even in their current relationships, and they relayed how these layered traumatic experiences added complexity to ongoing disturbance in relationship symptoms within their current relationship:

> We both have experienced some trauma with past marriages, and so that adds another element to [relational distress]. . . I think the fact that it was within the previous bond of marriage somehow plays a unique role. I mean, we have trauma that's different too, but I think when you're talking about marriage and you're assessing trauma, if trauma happens within a marriage prior to a second marriage, then I think it's probably something special or different maybe.

While the interviews did not address experiences of trauma within participants' current relationships, one participant made explicit the presence of infidelity on his part—an attachment

wound within his relationship—and noted an important distinction between trauma within and outside of the current relationship. Even though this was an additional trauma for his partner, his taking responsibility also contributed to healing.

> I'll say it again right now, and I do not mind reiterating this. I am and always will be responsible for having done that to [my partner]. . . . I have, you know, I caused the trauma to [my partner] as far as that trauma is concerned. Right. Other traumas in [my partner's] childhood, I did not cause. But I think it's extremely important for . . . our connectedness, for her to know that I am and always will take responsibility for what I did . . . because that didn't happen in her childhood. It's a key difference (Harry).

The unique impact of polytraumatization and what it can look like within a couple relationship was well defined by participant Evan, who detailed the way disturbances in his relationship that showed up in his marriage were related to diverse layers of trauma that were connected to childhood experiences, coupled with military experience and loss. Evan described an innate sense of disconnection due to past trauma and relayed how the additional effort on the part of his partner was required to mitigate that within their relationship.

> I built this wall based off of childhood exposures but also the military and having several combat deployments and coworkers of mine dying and physical and traumatic brain injuries. So [my partner] knows that there's a wall that has gone up. And we have this analogy that she has to reach over the wall. Like, there's a wall that *I can't see her* and we have that analogy that she's set up before that she's reaching over the wall to, to let me know that she's still there but knowing that I can't see it because there are so many layers that go up that are just preprogrammed in me and I'm fighting trauma, but I'm

> fighting my brain being rewired through military experience to not let anything in. Like, do not let anything break or compromise you (Evan).

Disturbances in relationships: Management and coping—building mutual awareness of individual interpersonal trauma symptoms within the relationship. An emergent theme of this analysis was the way in which the couple relationship itself served as an emotional space that both continually activated partners' relational distress but also conversely facilitated partners' awareness and ability to recognize the presence of ongoing traumatic stress symptoms as they played out within the intimate relationship. Often this was related to participants recognizing the negative impact these symptoms had either on their partner, the well-being of their relationship, and/or the extent to which their own emotions were exacerbated by their prior understandings of relationships (which also related to the reexperiencing symptoms). As Gina noted:

> I think, I remember at one point, [my partner] just, we were on a trip and I was kind of freaking out . . . and he just said, . . . "I just don't want, . . . I just wonder when this is ever gonna end." . . . My anxiety was just so outta control.

Couples relayed how recognizing the presence and intensity of their emotions and consistent conflict in their relationships helped them gain awareness that past trauma and related symptoms were becoming harmful:

> A really, really emotional feeling over something that was just a very, very small statement. So, that lets me know that there's something so much deeper going on there and it's not just on her side, there's stuff that I'm dealing with, that's making this thing escalate (Evan).

Understanding and identifying trauma while developing mutual support. As with prior symptoms, partners' ability to gain a genuine understanding of their own and their partner's

trauma history and symptoms was a key ingredient to managing disturbances in their relationship. This was aided by the resource of therapy (individual and couple) and subsequent experiences of emotional safety and mutual support between partners:

> I have to understand his trauma. He has to understand my trauma and we both have to understand our own traumas and how it's affecting us. Yeah, I mean, just thinking about that right now, it seems like, you know, everything I've worked on either individually or that's been productive in couple therapy is really rooted in the past. It's, you know, how, how, uh, we developed a distorted view and distorted actions, um, and how we're sort of misapplying those to, to now. [For example], I need to really be careful if I'm feeling, if what I'm feeling is appropriate for the moment or whether it's a combination of too much of the past (Gina).

Though each couple within the sample was at a different stage of management and coping, all of them reported the importance of awareness of each other's trauma and how that stimulus plays a role in their reactions to each other while also addressing the relational issue as a team:

> We do a better job of just kind of rolling with it [the trauma reactions] and giving each other a little more grace. There's a little more benefit of that in terms of how we're managing it as a couple, we definitely could do a better job, but I think the difference now with therapy is I don't, I probably blame myself more for that more than I blame [my partner] if that makes sense. . . . I think that for a long time I blamed you [partner] and you are the problem. Instead of it was a we problem. Right. And I feel like for myself, I own more of that problem now. And I think that's because of looking at all these trauma issues together. I don't think we have a solution so far but just a better understanding maybe (Mitchell).

Participants described how understanding what was happening for their partner internally, as it related to past trauma, was what helped them cope by supporting their partner and working again as a team to process and heal:

> I think that the biggest thing that helps these issues is that you kind of have to read between the lines. It's not really what's happening [that's causing the problem] . . . it's really like the context of past traumatic experiences that both of us have had. And that when you're first in a relationship with somebody, you don't know that about them. So it's like very hard to connect and be able to like help heal each other . . . [it's a process of] learning how to, like, heal each other a little and, like, learn that like you're safe and you're okay with that person. And . . . a lot of the things for me don't happen as often as they used to, like, my genuine calm response is because like I've learned to trust her, and trust myself, and that just has happened with time and [EFT] therapy (Amy).

The role of hope and importance shifting from individual to relational coping: Developing a healing team. Despite the complex trauma histories of this sample, couples displayed hope for their relationships and pride for the work they had done in the face of their difficulties and struggles as survivors of CPTSD, at times managing severe ongoing symptomology. One participant recognized how "being emotionally close and connected with [my partner] is critically important to me and to us" (Brent). Another participant articulated:

> Just because we've been through all of this horrible stuff doesn't have to mean we have to suffer forever, and that we can't have what we want in our relationship. I'm going to be stubborn about that. We have a great relationship now, but why can't we have it all and work through this stuff together? (Janet).

This hope was fostered by individual gains in therapy in terms of self-awareness, emotional grounding strategies, and individual trauma processing along with relational gains made in EFT couple therapy, where participants described a paradigm shift from functioning in opposition to each other to functioning more as an empathetic and cohesive unit, a team standing against the trauma:

> I definitely feel like we're starting, we're, we're in, we're in that, we're down that road, you know, we're walking in, it's very slow, but we are walking down the road, you know, and we're going that way towards managing it and, like, and connecting with each other during hard times (Rachel).

Couple therapy was a central component for this sample in terms of their ability to start to manage intrusive interpersonal trauma symptomology that was rooted in individual experience but that played out within the system of their relationships:

> We both handle difficult, painful situations very differently, and it affected our relationship and was really detrimental to our relationship. And so we decided to enter couple's counseling because of that. . . . [As a result], I think that we've let each other become a part of our healing team. Like both of us are helping each other along with our own individual struggles and that's been really helpful in our relationship (Amy).

Participants in this sample reported the relevance of couple therapy for their interpersonal trauma symptomology overall, recognizing that interpersonal trauma can only be healed and addressed within the context of relationships. The couple therapy helped in this goal but required a therapist who could stay focused on this process and the uneven healing trajectory from difficult traumatic experiences:

> The therapist is to be committed, to keep focusing on the relationship and how does the trauma impact the relationship and then bringing it back to the healing. It—the healing happens within the relationship. I mean the therapist helps to facilitate that, but it is about [my partner] and I healing and, and being able to be together. So that's what the therapist has to do. And I think that's hard (Cathy).

Discussion

This study used a qualitative approach with a unique sample of ten trauma-exposed couples, where one member of the couple met criteria for a CPTSD diagnosis, to explore couple experiences of CPTSD symptomology, the impact of these symptoms on their relationships, and their approaches to coping. All twenty participants reported repeated interpersonal trauma exposures, and nineteen out of the twenty individuals met the criteria for CPTSD as per the ITQ (Cloitre et al., 2018), making this a sample of largely dual-trauma couples (Ruhlmann et al., 2017). In agreement with prior literature, our findings indicate that the depth of the CPTSD symptom burden on trauma survivors is severe, and the most distressing relationship difficulties are around disturbances in their intimate relationship caused by interpersonal trauma exposure (Hyland et al., 2017a; Karatzias et al., 2018b). Additionally, the impact of trauma on the relationship was systemic (Oseland et al., 2016), with partners adapting and responding to the whole of trauma symptoms experienced within the context of the relationship, often exacerbating individual trauma symptoms. Framework analysis for this research question revealed three thematic categories within the six CPTSD symptom domains. The findings from the current study offer an in-depth contribution to the current empirical understanding of CPTSD and couple relationships, providing concentrated attention to the themes of how couples experience, understand, and manage CPTSD-specific symptomology within their relationships.

Experience of CPTSD within the couple relationship. A unique contribution from this analysis was that all participants within the sample experienced their own and/or their partner's symptoms of CPTSD as a common and joint feature of their daily life over the course of years and decades. This process led to both ongoing distress and adaptation (Banford Witting & Busby, 2019; Oseland et al., 2016). The pervasive experience of CPTSD symptoms served to organize their ways of relating and negatively impacted the functioning of their relationship.

Furthermore, participant couples experienced these symptoms in all of the domains of CPTSD, including avoidance, hypervigilance, reexperiencing, emotion regulation difficulties, negative self-concept, and disturbances in relationships (Cloitre et al., 2018). These experiences of CPTSD were similar to what is described in the literature on PTSD and couples (Nelson Goff & Smith, 2005; Oseland et al., 2016). For example, avoidance was a way in which participants protected themselves from harm related to past traumatic experiences in relationships (Pearlman et al., 2005). However, within this sample, although a symptom like avoidance was a distinct symptom, it was related to all other CPTSD symptoms, further exacerbating the remaining CPTSD symptoms of hypervigilance, reexperiencing, emotion-regulation difficulties, negative self-concept, and disturbances in relationships (Cloitre et al., 2018; Oseland et al., 2016; Pearlman et al., 2005).

Overall, findings from this analysis revealed the relational/systemic nature of symptoms for CPTSD survivors (Costa-Ramalho et al., 2017; Pearlman et al., 2005). Participants in this sample described avoiding/pulling away from their partners at times, especially during moments of emotional closeness/potential emotional closeness in their relationship, due to emotional intimacy being the very reminder of past trauma. Because trauma was experienced within the

context of close relationships, for this sample, being close in terms of emotional intimacy was experienced and interpreted as a trauma stimulus and, therefore, unsafe.

In this same way, the symptom of hypervigilance was also distinctly distressing for couples with CPTSD, as they relayed experiencing their partner as a direct threat and being on guard against them related to past traumatic abuse, fear, and loss. This resulted in partners viewing and responding to each other and their relationship as the trauma stimulus itself. These ways of experiencing each other led partners into cycles of fear, blame, and defensiveness against and with each other, destructive relational patterns that led to increased relational distress (Smith & Stover, 2016; Stadtmann et al., 2017; 2018). Additionally, findings from this study revealed the interwoven experiences survivor couples had with reexperiencing past trauma as an intrusive overlay to their current relationship. Reexperiencing not only came in the form of images and nightmares, but also equally intrusive and elusive feelings related to prior traumas in relationships. This ever-present past impacted survivors' experiences of the relationship in the present, and it maintained diffuse internal distinctions between the unsafe/traumatic past and the present moment, which incited additional fear-based reactions between partners (Cassidy & Mohr, 2001; Stovall-McClough & Cloitre, 2006; Van der Linde & Edwards, 2013).

DSO symptomology also posed a unique strain on how survivors experienced their relationships (Cloitre, 2015; Cloitre et al., 2020a). For example, emotion-regulation difficulties perpetuated negative cycles of emotional hyperactivation and constriction between partners. Within the relationship, this took the form of explosiveness and disconnection, which is a commonly known element for couples with trauma-related sequala (Dugal et al., 2020; Karris & Caldwell, 2015; Makinen & Johnson, 2006). The symptom of negative self-concept was particularly difficult for survivor couples due to the inherent defeating beliefs about themselves

within their relationships of being unloved, worthless, unsafe, or the feeling that they would inevitably fail at their relationship. As outlined by Bryant, this type of negative belief led participants to oscillate "between intimate relations and estrangement" (2022, p. 226), further distressing the relational system. Indeed, one of the main findings from the current study was that couples in the context of CPTSD experienced the world through the lens of CPTSD symptoms, which made it difficult for partners to regulate strong emotions and discern between the state of their current relationship and intrusive past traumatic experiences.

In most cases, couples' distinct experiences of CPTSD symptoms was strained by the combined impact of PTSD and DSO symptomology for both partners, but it was also strained by the fact that each symptom itself resulted from trauma stimuli within the relationship (e.g., emotional closeness and proximity with their partner). Therefore, an important consideration of these results within the context of prior studies is that related studies measured traumatic stress using measures that did not identify or measure for DSO symptoms. Prior studies identify PTSD, and some recognize the presence of interpersonal forms of trauma exposure, most commonly childhood sexual abuse (Banford Witting & Busby, 2019; Dalton et al., 2013; Dugal et al., 2020; Nasim & Nadan, 2013). Furthermore, due to the higher prevalence rate of CPTSD compared to PTSD alone, it is very likely that many participants within those prior samples met the criteria for CPTSD.

Relational impact of ongoing CPTSD symptomology. Findings from the current study both supported and elaborated upon prior research with trauma-exposed couples. In terms of support, findings from this study indicated how the impact of individual trauma was systemic (Nelson Goff & Smith, 2005; Oseland et al., 2016; Stadtmann et al., 2017; 2018). In other words, each couple's functioning was largely defined by how they adapted to the expression of trauma

symptomology within the relationship. Similar to what was outlined by Oseland et al. (2016), individual functioning, chronic traumatic stress symptoms, predisposing factors, and external resources all interacted with couple functioning on the levels of safety and security, emotional connection, and conjoint trauma processing.

Findings from the study showed how the impact of symptoms, though distinct, was also like a cascade, in which each symptom had an alienating impact on the relationship in terms of cohesion and interpersonal connection. This was rooted in couples' experiences of each other through the lens of past traumatic experiences, which were often triggered in their efforts to get close (Karatzias et al., 2018a; Perlman et al., 2005).

These findings are supported by traumatic stress research, which identifies trauma-related diagnoses as those that develop out of fear-conditioning models, which "commence when stimuli are paired with an inherently adverse event; subsequent exposure to the conditioned stimuli signals threat and results in anxiety" (Bryant, 2022, p. 212). The current study explicated the inherent nature of CPTSD-related stimuli within the common human experience of simply existing within an intimate relationship. CPTSD symptoms were, in other words, fear-based responses to relational interactions with an intimate partner due to the type of trauma individuals previously experienced with caretakers, former partners, and other attachment figures.

A key finding from this study was how participants experienced their relationship through the lens, filter, or preprogramming of past repeated interpersonal traumas, with each symptom interplaying with their experience of their current relationship (Karatzias et al., 2018a). This overlay of relational trauma impacted how the participants in this sample made meaning, interpreted, and responded to one another based on their specific history of trauma in relationships. However, they also expressed frustration, confusion, and distress related to the

constant burden of discerning between fear-based signals related to past trauma and interpreting signals in the present moment with their partner (Cassidy & Mohr, 2001; Stovall-McClough & Cloitre, 2006). In other words, participants relayed how difficult it was for them to discern between their experience of CPTSD symptoms and their present reality, which affected how they interpreted the meaning of the moment in their relationships (Baldwin, 2013; Banford Witting & Busby, 2019).

The findings from the current study also illustrated how important close relationships are for interpersonal trauma survivors, and how distressing it is when they experience ongoing relational crises and disconnection (Greenman & Johnson, 2012). Findings show that relational discord between partners stemming from past trauma had a degenerative effect and decreased their ability to maintain and benefit from the protective factors of secure and positive intimate relationships (Nasim & Nadan, 2013; Nelson Goff et al., 2006). Just as participants expressed frustration having to manage intrusive symptoms that they did not cause due to past interpersonal trauma, they also expressed how distressing it was for them to be stuck in the negative cycles of their current relationship, which had a strong retraumatizing effect on participants (Alexander, 2012).

Prior research has indicated that while some individuals with CPTSD struggle to maintain their relationships, there is also a high incidence of divorce and separation in this population (Hyland et al., 2017a). This was replicated by the current study, with nine participants experiencing divorce in their past or current relationship. However, as noted from prior research on PTSD samples (Greenman & Johnson, 2012; Karris & Caldwell, 2015), this particular sample for this study also worked extremely hard to maintain their current relationships. Despite high rates of divorce for CPTSD populations, as Herman (1997) described, those with complex

interpersonal trauma histories may try harder than others to preserve or heal their relationship in efforts to experience a different and positive outcome in their relationships. This is also in line with research on adult attachment, which indicates that individuals may enter a relationship hoping to right the wrong that was experienced in previous relationships and stay in a relationship in which they are experiencing severe relational distress (Alexander, 2012; Knefel et al., 2019; Liotti, 2004; Özcan et al., 2016). The way this impacted the current relationship for survivors was an intensity regarding the meaning of interactions within the relationship, interpersonal strain due to "ghosts from the past" impacting the current relationship, and partners responding to current events or experiences through the filter of the past, which resulted in confusion, arguments, disconnection, and emotional distress.

Management of CPTSD symptoms within the couple relationship. Partners in the context of CPTSD in this particular sample were acutely aware of their symptoms, and they had the desire, capacity, and resources to address symptoms on a fairly sustained basis. Even so, the sheer burden of CPTSD symptoms was striking and was described as a core feature of couples' daily lives that they jointly managed, carrying the load of all the trauma symptoms present within the relationship. This finding is supported from prior literature (Hyland et al., 2017a; Karatzias et al., 2019a), which highlights the functionally impairing nature of CPTSD, which interplayed with couples' adaptation to trauma (Oseland et al., 2016).

Ongoing relational distress for this sample was systemic and described as becoming unmanageable for both partners over time. Participants described how important their intimate relationships were, yet they relayed how the circular impact of CPTSD symptoms led to severe relational distress, which in turn further worsened their individual mental health and CPTSD symptoms of feeling fearful in the context of their relationship. Due to the depth of impact of

CPTSD on their individual and relational well-being, these participants sought out many resources to try to alleviate the negative effects of the disorder. It is important to note that this was a unique sample, and in the context of the current study, eligible participants met the criteria for CPTSD and were actively participating in EFT treatment. Therefore, this sample represented a subset of the CPTSD population as a whole, which had both the access to and the means to take advantage of relational mental health care.

What factors helped couples manage CPTSD symptoms. Findings from the current study were supported by prior research, which indicates that CPTSD partners are at risk of experiencing broken attachment systems or negative cycles within their intimate relationships due to past interpersonal traumas and related CPTSD symptoms (Dalton et al., 2013; Dugal et al., 2020). This can incite long-term, unstable cycles of trauma and disconnection within the relationship; however, based on this sample, intimate relationships also have a strong capacity to facilitate a known protective factor for survivors, "the ability to disclose the trauma and to gain social acknowledgement of their victim status" (Maercker et al., 2022, p. 67). Within the environment of the relationship, participants emphasized the necessity of their partners "getting it" in terms of the impact and inner workings of their experience of trauma symptomology. Within the context of prior research on adult attachment, this felt sense of emotional attunement and responsiveness was powerful in its ability to facilitate individual regulation and co-regulation in the midst of trauma related relational distress (Alexander, 2012; Fyvie, et al., 2019; Greenman & Johnson, 2012; Hazan, & Shaver, 1987; Pearlman et al., 2005). However, for each couple, this was an iterative and continuous process that happened within the relationship, and in all cases, it was aided by EFT couple therapy and additional external resources like psychoeducation, individual trauma therapy, community connection, and somatic interventions.

This finding further supports the expansive literature that suggests a multipronged approach to CPTSD intervention (Bryant, 2022; Cloitre et al., 2011; 2020a; 2020b; De Jongh et al., 2016; Gerge, 2020; Karatzias et al., 2019b; Lonergan, 2014; Matheson & Weightman, 2020; Monson et al., 2022; Pearlman et al., 2005; Van der Linde & Edwards, 2013).

Trauma impact awareness and mutual discovery phase. Because the majority of participants in this sample (n=19) met the criteria for CPTSD, and all had exposures to interpersonal trauma, this sample described a discovery phase over the course of their relationship in which they uncovered the impact/presence of trauma symptoms within the relationship. Though this was a key ingredient to managing symptoms, it was also an extremely difficult process due to the lack of inherent safety this population experienced in relationships (Banford Witting & Busby, 2019; Liotti, 2004; Stovall-McClough & Cloitre, 2006). Therefore, interventions and psychoeducation that supported partners' ability to develop a common language and context for their symptoms was key to the development of their emotional awareness related to CPTSD symptomology. A depth of awareness regarding the origins and inner workings of trauma symptoms supported co-mentalization and co-regulation between partners (Greenman & Johnson, 2012; Hazan, & Shaver, 1987; Pearlman et al., 2005). Porges & Furman, 2011; Ruhlmann et al., 2017; Stadtmann et al., 2017; 2018), which in turn enabled them to differentiate between the past trauma and the current moment. The ability to identify and even start to distinguish distinctions and differences between the past and present was extremely valuable and empowering for individuals and couples. This is supported by prior research, which has identified the importance of a mindful attunement and a 'here and now orientation' in trauma intervention to support clients' ability to stabilize and experience safety via intrapersonal and

interpersonal signals of safety (Chouliara et al., 2020; Cloitre et al., 2011; Porges, 2009; Stadtmann et al., 2017; 2018).

Co-regulation, management, and vulnerability. Findings revealed another key ingredient to management, which was an internal shift within the relationship toward vulnerability between partners (Nasim & Nadan, 2013). Emotional transparency and vulnerability were extremely difficult for this population due to individual trauma symptoms that incited emotional avoidance and fear-based responses within their intimate relationships. Adult attachment literature has identified the way in which past negative experiences in primary relationships can create an ongoing insecure (or fear-based) attachment style in adults, which was the case for this sample (Fyvie, et al., 2019; Greenman & Johnson, 2012; Hazan, & Shaver, 1987; Pearlman et al., 2005). However, as couples experienced positive, and emotionally safe, vulnerable interactions over time, this facilitated lower negative arousal toward the relationship and their partner that reflected a more securely attached relationship (Alexander, 2012; Hazan, & Shaver, 1987; Pearlman et al., 2005).). In line with polyvagal theory (Porges, 2009; Porges & Furman, 2011), partners made constant appraisals regarding the safety of connection and vulnerability. Empathy was a key component to the positive management of these symptoms. Across the sample and across symptoms, participants described how empathy from their partners surrounding their difficult symptoms was powerful, and how it stood in juxtaposition to experiences of their partners trying to "fix" or even "change" the symptom (Nasim & Nadan, 2013; Stadtmann et al., 2017; 2018). The participants in this sample indicated that partners' attempts to get involved with their symptoms to either fix or change what was happening for them was not only ineffective, but it further exacerbated symptoms and put strain on the relationship.

Finally, the findings from this study indicated the value of couple relationships for CPTSD survivors. Positive close relationships are a core protective factor mediating against negative outcomes across human experience (Baucom et al., 1998; 2012; 2014; Benjet et al., 2016). As partners gained tools to effectively manage symptoms, namely through co-regulation, they in turn experienced protection from their intimate relationship, allowing them to access an emotional state of calm, reflecting a more secure attachment style (Pearlman et al., 2005). Participants directly attributed this sense of calm to experiencing empathy and being understood, loved, and accepted by their partners despite their struggles (Paivio & Laurent, 2001). Dual trauma couples in this sample were able to offer a depth of empathy and understanding, which was extremely positive for partners in the context of interpersonal trauma (Ruhlmann et al., 2017; 2019). This also included acting as each other's advocate and protector from other unsafe relationships in their lives (i.e., former abusers, many within their families of origin). In this sense, the intensity of their love and bond, despite symptoms, was very strong; however, they all described a way in which the symptoms led to ongoing crises in their relationship that would have furthered their interpersonal distress without intervention (see chapter 5).

Though the participants in this sample reported ongoing CPTSD symptoms, they also described how the growing quality of their intimate relationship served as a protective factor mediating against symptom severity (Vaillancourt-Morel et al., 2019; Volgin & Bates, 2016). In her seminal work, Herman (1997) recognized that healing for interpersonal trauma populations must happen in the context of relationships. Therefore, a depth of understanding surrounding CPTSD symptoms and their inner workings within close relationships was essential for this sample (Chouliara et al., 2020 Pearlman et al., 2005; Stadtmann et al., 2017; 2018; Van der Linde & Edwards, 2013). The findings from the current study offer strong support for a

relational intervention framework for CPTSD conceptualization and intervention (Bryant, 2022; De Jongh et al., 2016; Chouliara et al., 2020; Cloitre et al., 2011; 2020a; 2020b; Coleman et al., 2021; Forbes et al., 2020; Forde & Duvvury, 2021; Gerge, 2020; Karatzias et al., 2019b; Lonergan, 2014; Matheson & Weightman, 2020; Monson et al., 2022).

Clinical implications. Earlier studies have explored couples' adaptations to prior traumatic stress exposure within the context of their current relationship and have provided key clinical guidelines for trauma-exposed couples, including the importance of establishing safety, and emotional attunement (Blow et al., 2020; Nelson Goff, et al., 2005; 2006; Oseland et al., 2016). Empirical research has only begun to explore the multifaceted individual experience of CPTSD (Forde & Duvvury, 2021; Stadtmann et al., 2017; 2018; Van der Linde & Edwards, 2013). Due to the innate relational distinction in trauma type associated with CPTSD, and the severity/relational nature of the diagnosis, the current study sought to examine the experience of couples in the context of CPTSD as a distinct diagnosis. The aim of this research was to uncover the inner workings of CPTSD symptomology within intimate relationships and thus promote a greater understanding of interpersonal trauma survivors' therapeutic needs in the context of their relationships, in turn better informing relational interventions for this intrinsically relational diagnosis.

The traumatology and systemic family therapy fields have each identified the need to further determine the complex relational underpinnings of interpersonal trauma on CPTSD populations to support future intervention research (Bryant, 2022; Chouliara, et al., 2020; Dalton et al., 2013; De Jongh et al., 2016; Pearlman et al., 2005). In light of prior research, the findings from the current study have some important clinical and empirical implications. A key clinical implication of this research is the added support for the importance of the systemic and

attachment-based lens for CPTSD treatment (Coleman et al., 2021; Fyvie, et al., 2019; Greenman & Johnson, 2012; Hazan, & Shaver, 1987; Pearlman et al., 2005). Further, due to the importance of intimate partner attachment bonds to human functioning and well-being, especially for those who are vulnerable and who have been victimized by prior attachment figures, it appears to be of upmost importance to support couples' ability to mutually disclose and acknowledge trauma experiences and ongoing symptoms to promote well-being. Although the extent of disclosure is not clear, couples in this study reported that some disclosure and vulnerability created closeness and cohesion in their relationships. Findings from the current study indicate that couples manage the load of CPTSD together. Therefore, as recognized by prior research (Oseland et al., 2016), systemic interventions can help couples jointly target CPTSD-specific symptomology and aid in the co-management of symptoms to avoid retraumatization through unhelpful relationship dynamics (Alexander, 2012; Dugal et al., 2020; Gerge, 2020).

Due to the retraumatizing nature of chronic relational distress for CPTSD populations, early intervention—and early attachment-based systemic intervention, specifically—is a key consideration to prevent the worsening of symptoms and years of unnecessary distress. CPTSD is high in treatment-seeking populations, and this sample exemplified the degree to which individuals with CPTSD are seeking care. Systemic conceptualization and systemic intervention are essential ingredients for the effective treatment of interpersonal trauma survivors, especially those living in partnered committed relationships. This particular sample reported decades of cumulative therapy, including individual and couple therapy; however, their distress was still high in terms of CPTSD-related symptomology. Furthermore, the couples in this sample reported only experiencing relief in their relational distress after participating in EFT couples' treatment (see chapter 5). Therefore, future research must address the relational nature of CPTSD to further

determine key components and mechanisms of change for CPTSD intervention using relationally based and trauma-informed treatment modalities. Finally, due to the complexity and inherent relational vulnerability of CPTSD, clinicians should seek ongoing training and supervision to develop competencies in working with interpersonal trauma survivors.

Limitations. There were several limitations for this study that impact the generalizability of the results. First, this sample was representative of a subgroup of those who met the diagnostic criteria of CPTSD in that they were all in long-term committed relationships, they all had high levels of education and SES, and they all had access to many resources, including various forms of long-term therapy, to help them manage symptoms individually and as a couple. Despite recruitment efforts, this sample was also fairly homogeneous in terms of race and ethnicity. This sample was highly committed to their current intimate relationship, which is not always the case for those with CPTSD. Therefore, these results reflect the experience of highly committed CPTSD couples. Additionally, CPTSD has a high prevalence in treatment-seeking populations; however, so does drop out for those with interpersonal trauma (Hyland et al., 2017), so this sample is representative of a subgroup of the CPTSD population who successfully utilized treatment.

Future studies should include more diverse samples of CPTSD survivors in terms of race and ethnicity, gender identity, and non-Western cultures. Additionally, this study focused on couples in the context of CPTSD who had received effective relational treatment. Therefore, in order to understand the experiences of other populations, future studies should include couples who chose to end their relationships due to CPTSD symptoms and those couples who dropped out of therapy. Finally, future studies would benefit from exploring how varying trauma types impact couple functioning.

Conclusion

A unique characteristic of this study was that it employed a qualitative approach to privilege survivors' and their partners' perspectives concerning how this diagnosis of CPTSD impacts their relationship and their journey toward finding ways to cope. CPTSD symptoms are an ongoing relational issue that couples co-experience and manage together. CPTSD interventions must factor into the core relational aspects of survivors' experience, both in conceptualization and intervention. The findings from the current study indicate the importance of disentangling past trauma from the current experience of the relationships for interpersonal trauma survivors. Findings indicate the importance of bolstering the protective nature of close relationships and mediating the worsening of interpersonal trauma symptoms by stabilizing couples and strengthening bonds in the couple relationship.

CHAPTER 5: STUDY TWO—COUPLES' EXPERIENCES OF EMOTIONALLY FOCUSED THERAPY IN THE CONTEXT OF CPTSD SYMPTOMOLOGY

Abstract

Complex Post Traumatic Stress Disorder (CPTSD) is the most prevalent form of a traumatic stress diagnosis. It is also the most functionally impairing. Consequently, it is a leading concern among mental health professionals. CPTSD—which can result from physical, sexual, mental, or emotional abuse—includes PTSD symptoms and an additional cluster of symptoms that indicate a Disorganized Sense of Self (DSO), including pervasive disturbances in relationships. The symptoms of CPTSD shave been shown to have a negative impact on intimate relationships. Emotionally Focused Therapy (EFT) with couples has been identified as a promising attachment-based relational intervention for populations diagnosed with CPTSD. In this qualitative study, couples who were involved with EFT treatment, and who had at least one partner who met the criteria for CPTSD, were recruited to participate in a joint, semi-structured interview. Framework analysis was used to analyze the data, examining couples' experiences of EFT in the context of CPTSD symptoms and analyzing their perspectives concerning EFT's acceptability for the treatment of trauma-related distress within their relationships. Findings for this study overarchingly indicated couples' perceptions of the benefits of EFT in treating their relational distress in the context of CPTSD symptomology. Themes from this study relay the value of key components of EFT such as the attachment frame, cycle tracking, emotional attunement, and present process for this population. Findings also revealed important considerations for EFT therapists in treating couples in the context of CPTSD. The conclusion discusses the study's implications for further research and clinical recommendations.

Introduction

Complex Post Traumatic Stress Disorder (CPTSD) has been identified as a primary focus for developing interventions due to the current lack of evidence-based interventions for this long-known (Cloitre et al., 2011; Herman, 1997) yet newly defined disorder (Cloitre et al., 2018; Hyland 2017a). The current standard of care for trauma intervention relies most heavily on addressing the three clusters of PTSD symptomology using exposure-based, memory-processing, or trauma-informed cognitive behavioral interventions (De Jongh et al., 2016; Karatzias et al., 2019). However, due to the complexity of interpersonal trauma exposure involved in CPTSD, it is a more severe disorder, a more complex form of trauma that is both more prevalent and functionally impairing than PTSD alone (Hyland et al., 2017a; 2017b). Empirical evidence indicates that traditional interventions for traumatic stress have proven ineffective for CPTSD, with minimal, if any, long-term outcomes. This has left millions without long-term effective care (Dorsey et al., 2016; Matheson & Weightman, 2020). Empirical studies also suggest that current traumatic stress interventions are ineffective due to their inability to address CPTSD and the specific disorganized sense of self (DSO) symptomology, either in addition to or prior to targeting the PTSD symptoms (Bryant, 2022; Chouliara et al., 2020; Cloitre et al., 2011; 2020a; 2020b; De Jongh et al., 2016). Due to the relational nature of CPTSD-induced trauma (e.g.,, adverse childhood experiences [ACES], sexual abuse, domestic violence) (Herman, 1997; Hyland et al., 2017a; 2017b; 2020), empirical literature supports the central importance of addressing and integrating relational components into CPTSD interventions (Bryant, 2022; Chouliara et al., 2020; Cloitre et al., 2011; 2020a; 2020b; Coleman et al., 2021; De Jongh et al., 2016; Forbes et al., 2020; Forde & Duvvury, 2021; Gerge, 2020; Karatzias et al., 2019b; Lonergan, 2014; Matheson & Weightman, 2020; Monson et al., 2022).

CPTSD interventions. After many years of study, CPTSD was designated in 2018 as a distinct disorder in the International Classification of Diseases, 11th edition (ICD-11; Cloitre et al., 2018). The diagnostic criteria for CPTSD includes a combined presentation of both PTSD and DSO symptomology, along with indications for functional impairment that are related to each subset of symptoms (Cloitre et al., 2018; Hyland et al., 2017b). A critical concern supporting the designation of CPTSD as a distinct disorder from PTSD stemmed from fact that no evidence-based interventions effectively or sustainably address the full spectrum of CPTSD symptoms. Most notably, current trauma interventions struggle to address the complex relational components of CPTSD, including the nature in which interpersonal relationships serve as an ongoing and distressing trauma stimulus, resulting in chronic disturbances in relationships for those with CPTSD.

In terms of evidence-based care for sequela related to CPTSD, Mahoney et al. conducted a meta-analysis and reviewed outcomes and treatment effects for populations with similar symptoms and trauma types linked to CPTSD (2019). The review included studies that address sequela related to CPTSD, which were deemed rigorous in terms of methodology and approach (Mahoney et al., 2019). This review found that, compared to usual care, trauma memory processing was effective in reducing trauma symptoms, which shows promise for similar studies with CPTSD populations. However, it was inconclusive as to whether other aspects of trauma interventions, such as emotion regulation skills training and psychoeducation, were and effective form of treatment (Mahoney et al., 2019). Importantly, this analysis highlighted the preliminary effectiveness of group interventions that actively incorporate social support, and it advocated for the need for further scientific inquiry and the expansion of relational forms of care for CPTSD treatment.

A more recent study by Webb et al. (2022) administered the International Trauma Questionnaire (ITQ) to a female population with a prior diagnosis of emotionally unstable personality disorder (EUPD), a common comorbidity for populations with repeated experiences of interpersonal trauma, and explored the associations of CPTSD symptoms to functional impairment. The results from this study revealed that "a persistent sense of threat and interpersonal difficulties stemming from traumatic experiences may reflect particularly crucial targets in interventions for individuals with EUPD and complex trauma needs" (Webb et al., 2022, p. 1). This suggests that intervening in interpersonal relationships—when it is possible—may be a key intervention approach with this population.

Couple interventions for trauma. Interventions with couples have been shown to help in the treatment of individual mental health disorders, including anxiety, depression, eating disorders, schizophrenia, obsessive compulsive disorders, post-traumatic stress, and substance abuse (Baucom et al., 2014; Doss et al., 2022; McWey, 2022; Fischer et al., 2016, Wittenborn & Holtrop, 2022), for example, demonstrated that interventions with couples, in addition to being as effective as individual therapy, could also help increase relationship functioning. In a randomized control trial conducted by Wittenborn et al. (2018), Emotionally Focused Therapy, a popular attachment-based couples' intervention, was significantly more effective than usual care in helping to treat individual depression and relationship satisfaction. In terms of the treatment of traumatic stress, Suomi et al. found that couple therapy effectively lowered trauma symptoms for individuals with PTSD (2019).

Including intimate partners in treatment acknowledges that clients and their symptoms are not operating in isolation but instead exist in a system (Kozlowska, 2020; McWey, 2022). When couple therapy is used for individual disorders, it allows clinicians to use the intimate

relationship as a mechanism of change by developing a secure foundation and mutual support so that partners can explore the mental health concern and related challenges by creating new interaction patterns, processing previous wounds, and learning new mental and emotional skillsets (McRae et al., 2014). However, the empirical and clinical literature also indicates that "clients' trauma experiences can pose considerable barriers to couple therapy" (Linder et al., 2022b, p. 21). Therefore, further areas of research regarding the use of couple therapy for individual disorders would include its usefulness for specific individual disorders like CPTSD and the determination of the most effective mechanisms of change (Baucom et al., 2014; Costa-Ramalho et al., 2017; Johnson, 2003).

CATS Model. The couple adaptation to traumatic stress (CATS) model was first developed and then expanded in two manuscripts, (Nelson Goff & Smith, 2005; Oseland et al., 2016), which explored the systemic effects and mechanisms of trauma symptomology on interpersonal functioning within couple relationships. The first paper sought to expand prior literature, which identified the negative impact trauma has on couple relationship functioning in addition to exploring the mechanisms of secondary trauma within these relationships (Nelson Goff & Smith, 2005). The authors conclude that the quality of components involving individual factors (i.e., individual stress), predisposing factors such as external resources and support, and couple functioning all interact with and influence how couples adapt to traumatic stress symptomology within the relationship (Nelson Goff & Smith, 2005). Importantly, predisposing factors related to chronic stress, attachment (emotional connection), symptom identification, and empathy within and between partners were core components which influenced couples' adaptation to and coping with traumatic stress either positive or negatively (Nelson Goff & Smith, 2005). For example, couples who had high rates of chronic stress, low symptom

identification, low empathy within the relationship adapted negatively to traumatic stress symptoms. Whereas, couples who experienced protective factors of emotional connection, lower chronic stress, and mutual empathy surrounding symptoms could experience their relationships as a source of healing rather than a source of additional stress (Nelson Goff & Smith, 2005).

The second manuscript by Oseland and colleagues (2016) provided a pragmatic framework for clinicians working with trauma exposed couples. This framework identified key clinical components with this population, which supported an interpersonal or systemic approach to trauma intervention (Cloitre et al., 2011) and highlighted the central importance of establishing, safety and stability, traumatic processing, and emotional connection (Oseland et al., 2016).

Emotionally focused couple therapy. Numerous studies within the field of systemic family therapy field have identified the importance of systemic conceptualization and intervention for traumatic stress response (MacIntosh & Whiffen, 2005; MacIntosh & Johnson, 2008; MacIntosh, 2018; Monson et al., 2022). Additionally, a systemic approach is particularly effective for individuals with accumulated interpersonal trauma histories and ongoing distress in relationships, as captured by CPTSD (MacIntosh, 2018; Roundy, 2017; Suomi et al., 2019; Vaillancourt-Morel et al., 2019). Research in this area has involved EFT, and it has produced early, promising evidence (Dalton et al., 2013; Johnson, 2019; Roundy, 2017).

EFT core components. EFT is an intervention that is attachment-based and experiential. It uses current process and emotional enactments in the creation of new emotional connections and patterns between members of a couple (Johnson, 2003; 2019). Previous research on EFT has demonstrated that mechanisms of change depend on this experiential process and the way it allows partners to develop emotional attunement and safe, secure attachments with one another

(Wiebe & Johnson, 2016). More specifically, the mechanisms of EFT work to restructure couple interactions through three change events, which involve de-escalation/stabilization, withdrawer re-engagement, and pursuer-softening (Johnson, 2019). The de-escalation/stabilization stage explicates partners awareness and experience of their negative relational cycle, which is based on attachment related fears and related primary emotions within the relationship (e.g., fear of abandonment, neglect, or control). Partners' experiences of connecting to their own and each other's core attachment narratives promotes co-regulation through a deepened emotional awareness (between self and other), emotional flexibility, and bonding (Hazan & Shaver, 1987; Porges, 2009). In the second stage of EFT, the withdrawer re-engagement and pursuer softening events promote a secure attachment, which consists of deepening emotional accessibly and responsiveness between partners (Johnson, 2019). Emotional attunement and subsequent co-regulation between partners further promote emotional safety and secure attachment (Hazan & Shaver, 1987) as well as individual emotion regulation skills (McRae, et al., 2014). Each of the stages of EFT are also critically supported by the underlying approach of the model, which is attachment-based and experiential in that the intervention redirects couples to the present moment to process their emotions instead of the content of couple conflict (Johnson, 2019). The goal of EFT is to successfully establish a secure attachment bond between partners and restructure the negative interaction cycle. This shift allows couples to experience each other and the relationship as safe and responsive to their emotional needs, which is especially crucial for populations who have insecure attachment styles and histories of interpersonal trauma (Dalton et al., 2013; MacIntosh & Johnson, 2008; Welch et al., 2019).

Empirical support for EFT and trauma. In terms of EFT as a clinical intervention for trauma populations, the majority of the empirical and clinical support we have for utilizing EFT

as treatment for PTSD/CPTSD involves case studies (Johnson, 2002; MacIntosh & Johnson, 2008), theoretical discussions about EFT's potential efficacy for CPTSD (Johnson, 2002; Roundy, 2017), and Dalton et al.'s randomized clinical trial with adult survivors of childhood sexual abuse (Dalton et al. 2013). All this research has foregrounded the viewpoints of clinicians who work with clients with severe interpersonal trauma, clients who are engaging with "relationship trauma and terminal relational distress" and who have experienced a significant change from EFT (Johnson, 2002, p. 65). The theorizing of EFT's usefulness for interpersonal trauma survivors has been particularly noteworthy; multiple manuscripts offer detailed demonstrations concerning the ways that EFT's attachment-based mechanisms address the insecure attachment and resulting mental health symptomology that commonly result from severe interpersonal trauma (Roundy, 2017; Wiebe & Johnson, 2016; Wiebe et al., 2017). Some of this research has involved populations with a wide range of traumas (Dalton et al., 2013; Macintosh, 2014), but these studies did not involve a CPTSD-specific population. Therefore, in order to understand whether EFT is actually a good fit for the distinct diagnosis of CPTSD, more evidence is necessary.

There are promising studies that demonstrate how it may be useful to use EFT interventions with populations that are affected by CPTSD. This research, however, also makes clear that the symptoms of CPTSD can make a full engagement in the EFT process difficult for survivors (MacIntosh & Johnson, 2008). Consequently, other studies have proposed some other adaptations to EFT for populations suffering for CPTSD. These include a longer duration of treatment, increased assessment, and integration with other trauma therapies such as EMDR (Johnson, 2002; Linder et al., 2022a; 2022b). All of these recommendations, however,

foreground a clinical perspective, and there still have not been any studies concerning how individuals with CPTSD experience EFT interventions.

Present Study

The present study seeks to explore clients' experiences of EFT in the context of CPTSD symptomology as a way to expand our current understanding of CPTSD intervention and the role of key components in treatment. This study was guided by the following research question: How do individuals with CPTSD and their partners experience EFT and perceive the acceptability of EFT in treating their relationship difficulties; in addition, what do they describe as especially beneficial or difficult about participating in EFT?

Method

Procedures.

Recruitment. Before this study was conducted, all procedures were approved by the Michigan State University Internal Review Board. The recruitment of subjects for this study occurred throughout two stages during an open recruitment period between November 2021 and June 2022. The first stage involved a community-engaged approach that used purposive, convenience, and snowball methodology to access advanced EFT therapists as recruitment "liaisons" and "gatekeepers" to clinical participant couples for the study (Archibald & Munce, 2015, p. 35). These liaisons were essential as they provided access to a population of couples in the context of EFT and CPTSD, which would otherwise be extremely difficult to reach. If a therapist's training level and self-reported fidelity to the EFT model with couple clients were unknown, they were asked to complete an EFT therapist eligibility survey using Qualtrics survey software (Appendix E). The next stage of the recruitment process involved purposive sampling. The eligible therapist liaisons were asked to share the study flyer with their couple clients

(APPENDIX A), which included requirements for the study and a link to the couple screening Qualtrics survey (Appendix C). The recruitment process spanned an 8-month period and was completed once the study included 10 couples and once the qualitative data indicated saturation.

Screening and eligibility. This study involved multiple layers of screening. First, therapists had to indicate their level of EFT training and self-report how closely they adhere to the EFT model in their work with couple clients (Appendix E). Participating recruitment therapists had completed advanced EFT training; 24 had completed through core skills 3, and 4 had completed certification in EFT. The aforementioned trainings in EFT require a master's degree in a counseling related field, a four-day training in EFT, which is the EFT externship taught by a certified Eft trainer. Core skills in EFT requires four 12 hour trainings by an EFT trainer from core skills 1 through 4. (Second, the screening of potential couple clients for the study included five key eligibility considerations: (1) the couples had to be in a committed relationship with one another for at least six months, and they both had to be over 18 years of age, (2) to ensure that participating couples could speak sufficiently to their experiences with EFT, they had to actively be engaged in treatment with an EFT therapist for at least eight weeks prior to the commencement of their participation in the study, (3) each participating couple had to individually fill out screening surveys with matching names and email addresses including (their own and their partner's), as well as matching locations, EFT therapists, and duration of treatment, (4) one or both partners had to meet the criteria for a CPTSD diagnosis as defined by the ITQ, and (5) both partners had to consent to participation in a joint interview. Once participating couples successfully passed the initial screening, they completed a second survey (Appendix C) that asked for their demographic background information and a final confirmation, allowing the study's author to send the couple their informed consent form over email (Appendix

B) forms and to schedule a two-hour interview. When couples did not meet all of these criteria, they were withdrawn from consideration for this study. Official enrollment in the study began once participants filled out the informed consent form.

Participants. A final count of 10 couples, or 20 individuals, participated in this study. A majority of participants (90%) identified as White/Caucasian (n=18) and 10% identified as Hispanic or Latino (n=2). In terms of gender identification, 40% identified as male (n=8) and 60% identified as female (n=12). The participants indicated ages within the survey options between 25–34 and 65+ years old, indicating a wide range in age across the sample. A majority of the participants (80%) were married (n=16), while 10% were in a dating relationship (n=2) and another 10% were in a dating relationship after their divorce (n=2). The average relationship length was 17 years, and relationship lengths ranged from 3 to 42 years. A majority of participants (95%) had children within the span of their relationship. Participants' sexual orientation varied, with 75% identifying as heterosexual (n=15), 10% identifying as queer (n=2), 5% as lesbian, (n=1), 5% as bisexual (n=1), and 5% as pansexual (n=1). Overall, this sample experienced a high SES, with the majority of participants (65%) reporting a gross income of $100,000 or higher (n=13), 20% reporting $80,000–$99,000 (n=4), 10% reporting $60,000–$79,000 (n=2), and 5% reporting $40,000–$59,000 (n=1). Participants' education also varied, with 5% having earned a doctorate degree (n=1), 45% having completed a graduate or master's degree (n=9), 40% having earned a bachelor's degree (n=8), 5% having completed some college (n=1), and 5% having completed technical school (n=1).

Within this study, almost the entire sample met the criteria for CPTSD (n=19) based on the scores from the self-report ITQ in their screening, which indicated an average score of 38 (range=22–61). These scores represent a moderate to high level of symptom severity with a

minimum cut of score of 16 and a maximum score of 72 to meet the CPTSD diagnosis. Importantly, most couple scores were somewhat similar differing by an average of 10 points between partners (range 2-22), which indicated that partners within this study overarching partnered with someone who not only also had CPTSD, but experienced symptoms close to the same level of severity.

Measures.

Demographics. Participants were asked to complete a standard demographic screening that asked questions about age, gender, race and ethnicity, SES, relationship status, length of time in their current relationship, number of children, and their length of time in EFT (Appendix, D).

International Trauma Questionnaire. The International Trauma Questionnaire (ITQ) (Appendix F) was developed for the eleventh edition of the *International Classification of Diseases*. Currently, it is the only valid and reliable measure for differentiating between PTSD and CPTSD as distinct disorders (Cloitre et al., 2018). The questionnaire includes 18 questions with Likert scale responses. It assesses both PTSD and CPTSD as distinct diagnoses, and its factor structures have been independently validated to support its accuracy in those diagnoses (McElroy et al., 2018). The ITQ has also been validated worldwide with diverse populations ranging between age groups, geographic locations, and trauma types (Haselgruber et al., 2019; Fernández-Fillol et al., 2020). Administration of the questionnaire occurred as part of participants' initial online Qualtrics screening survey. If either member of the couple did not meet the clinical cutoff for CPTSD, they were withdrawn from consideration for this study. Ultimately, 19 participants met all the criteria for a CPTSD diagnosis.

Intervention.

Therapists involved in this study were either certified in EFT or actively working to gain credentials for certification, which meant they were receiving ongoing EFT supervision with an EFT trainer. To obtain training in EFT, therapists must either be a master's level licensed mental health professional or under the supervision of a licensed mental health professional in marriage and family therapy, social work, or licensed professional counseling. Next, eligible masters level trainees participate in the EFT externship, which is a four-day intensive training offered by a certified EFT trainer. After that, therapist trainees' complete EFT core skills training, which includes four 12-hour (two day) trainings offered in a similar style to the externship and involves implementing EFT skills actively within each training as therapists receive feedback on their fidelity to EFT from EFT trainers. To receive full EFT certification, therapists must complete all of these stages and then complete additional EFT supervision and submit video footage of their ability to use EFT effectively with their own couple clients and gain approval from the EFT certification review board.

Interview procedure. Couples who qualified for the study were then asked to participate in a semi-structured interview (Appendix G). The interviews were held online, and they were recorded using Zoom meeting software that was HIPPA compliant. Before the interview began, the researcher reviewed a number of the study's elements: the informed consent, an overview of the study's purpose and questions, and the study's potential risks and benefits. The researcher also notified participants that they could choose to not answer any questions or end their participation at any point. The interview questions (Appendix G) did not address details concerning past trauma that participants may have reported during the screening process. The interviewer acknowledge that participants had histories of past accumulated trauma and ongoing

CPTSD symptomology as they met the screening cut off. Participating couples asked about their experiences with EFT interventions, giving them an opportunity to talk about their own progress and discuss the aspects of the model that they found to be helpful and difficult.

Data collection. The qualitative interviews with each participant couple lasted for an average of 120 minutes; they ranged between 78 and 134 minutes. In total, this resulted in approximately 20 hours of interview data from participant couples about their experience of EFT in the context of CPTSD symptomology and interpersonal trauma-related difficulties in their relationship. To ensure the responses were comprehensive, and to ensure that both partners in a relationship were given equal amounts of time to respond to the questions, the researcher interviewed participating couples together. All of interviews were conducted using Zoom's video conference software. The audio of the interviews was recorded; these recordings were electronically encoded and protected with a double password. The interviews were transcribed verbatim and transferred to Word documents. These were then stored in files that were electronically encoded and double password protected as well.

Data analysis. In analyzing this qualitative data, I used the framework analysis outlined by Ritchie and Spencer (1994) and expanded by Gale et al. (2013). This methodology's procedure includes seven primary stages: (1) transcription and data organization, (2) familiarizing, (3) coding, (4) the development of an analytical framework, (5) the application of that framework, (6) the incorporation of data into the framework matrix, and (7) data interpretation (Gale et al., 2013).

The first stage of data transcription and management involved standard verbatim transcription, de-identification of participant identifiers (i.e., names, exact locations, therapist names, etc.), and secure encrypted digital data storage. Due to the large size of the data set, it is

considered best practice for framework analysis to a Computer Assisted Qualitative Data Analysis Software (CAQDAS), MaxQDA to help manage, store, and code data (Parkinson et al., 2016; Ward et al., 2013). Within MaxQDA I kept a codebook to organize initial notes, memos, and emergent themes after each interview. Through the familiarization stage, which took place after the first interview until the completion of the tenth and final interview, I reviewed each interview at three to five times prior to coding to develop an in-depth understanding of what each participant couple was communicating along with emergent themes across cases (Creswell & Poth, 2018; Gale et al., 2013). The codebook was used an audit trail in which I relayed my impressions to my advisor who worked with me at that time to develop initial coding categories starting after the first three interviews were completed.

The next stage of framework analysis was coding, which entailed line-by-line coding of each transcript in MaxQDA to uncover structures within the data set that then informed the initial analytical framework (Gale et al. 2013). Development of the analytic framework was an iterative process that developed from building upon emergent themes after the completion of each interview and as I received feedback from participants about the proposed framework as a form of member-checking, and cross-checking with my advisor (Braun & Clarke, 2006; Pelias, 2019). Member-checking from involved participants (n=12) highlighted the importance of the attachment-reframe, therapist directiveness (present process), and balanced alliance within EFT couple therapy.

In applying the analytical framework, I indexed codes from all transcripts into each category of the matrix. This facilitated an organized way in which my advisor and I, as the research team, could compare codes across all cases per category. Once this stage was fully complete after all interviews were completed and data had reached saturation for the scope of

this particular study, the next stage was to chart the data into the framework matrix to summarize participant's subjective experiences across cases under each theme (Gale et al., 2013). The research team, my advisor and I, met routinely to cross-check and compare interpretations. This process revealed seven categories and 16 themes related to couples' experiences of EFT in the context of CPTSD symptomology (Appendix I).

Trustworthiness. Creswell and Poth (2018) detail the importance of trustworthiness and confirmability in qualitative research, and this was a key consideration in the methodology of the current study. As the primary researcher of this study, I worked to ensure there were consistent cross-checks and member-checks ensure the confirmability and trustworthiness of the analysis. As noted, my research advisor served to cross-check my coding, framework, and interpretations of the data. Additionally, within the analytic framework development stage, participants were offered the opportunity to provide feedback about the initial framework categories and themes, which was conducted under the guidelines of Dansby Olufowote and colleagues (2020).

Results

The results of this study indicated the depth to which couples within this sample experienced grave difficulties within their intimate relationships, which led to a need for support via couple therapy. Couples overall relayed extremely positive experiences of EFT interventions and were able to gain tools to support their ability to healthfully develop a sense of connection and safety within their intimate relationships.

Reasons for seeking EFT: A Relational crisis and the need to learn how to be together. Participants in this sample experienced pervasive difficulties in their couple relationships related to past accumulated interpersonal traumas and CPTSD symptoms. Despite these ongoing struggles—that for some, lasted for years or decades—participants described a

tipping point within their relationship and/or a triggering event that served as the catalyst for their participation in couple therapy. The types of crises disclosed within the sample included infidelity (n=6), pervasive sexual problems (n=8), grief and loss (n=4), divorce/separation (n=4), illness-inducing stress on the relationship (n=6), and ubiquitous relational strain related to ongoing interpersonal trauma symptoms (n=20). Some couples had more than one catalyst for therapy participation. These forms of relational crises were described as painful, and participants recognized that reaching out for help was critical to their personal well-being and the sustainability of their relationship:

> We had a really rough year . . . and the EFT thing has really been like, honestly, probably one of the best things for us. . . . I hit a threshold when we were really struggling and [from EFT], I got really grounded with myself and I think [my partner] is doing the same thing (Brent).

Though couples elected to begin therapy amidst a distinctive moment or crisis within their relationship, couples in this sample also described the state of affairs in their relationship prior to seeking EFT as they struggled with CPTSD symptoms. The distress couples experienced was also juxtaposed with the stigma surrounding couple therapy and the role stigma played in couples delaying couple therapy until the relational difficulties became unmanageable:

> There were like several years where we would have big fights, and then we'd be, like, we need to start couples counseling . . . and, like, the stigma around, like, couples counseling being for people going through divorce versus, like, couples counseling being something . . . really healthy and positive; I had to, like, kind of come around to that. And then we were, like, going through, like, a very specific thing that was really hard for us to talk

about and manage, and we kind of triggered both of us simultaneously so that like neither one of us could support the other (Erin).

In this way, couples described a cycle of discord within the relationship and the role of interpersonal trauma (e.g., avoidance, emotion regulation difficulties, negative self-concept), leaving them stuck and confused prior to EFT. As one participant, Janet, noted:

> I think it was, we were stuck. We were stuck. I didn't understand [why]. And all I would know was how to do is try to get my needs met by saying, "What am I doing wrong?" And she was so afraid. You [to partner] can correct me if I'm wrong, but she was afraid to tell me what was really going on [related to her trauma history]. I didn't even know most of it and I don't even think she knew. . . . We were, we were so stuck.

One participant, Matthew, similarly relayed the severity and systemic impact of relational distress symptoms within the marriage before he and his wife divorced prior to reestablishing their relationship and starting EFT:

> We were both in survival mode. I was trying to just keep the peace. I turned into a rug [brushing everything under], and I wanted to shield the kids and stuff too, cause it was a pretty toxic, intense environment (Matthew).

Half of participants did not specifically report having prior experience in couple therapy (n=5); however, the other half described participating in couple therapy on other occasions. For some, this took place over the course of many years and iterations of couple therapists (n=5) while they were still experiencing the frustrating cycle of disconnection and activation within their intimate relationship:

> …[we were] well versed in couple's therapy, you know? I mean, they, it wasn't just that it wasn't that helpful. It just seemed like we were going the same cycle over and over and

> over and over and over again, as we have been for years and nothing was really improving . . . then it seemed like it was getting worse over the years (Gina).

Participant expectations of EFT: A changed perspective from solving to bonding. Despite the stigma around couple therapy and prior negative experiences of couple therapy, participants had a strong desire to work on their relationships. Some participants in the sample intentionally sought out EFT specifically (n=6) due to its standing as an evidence-based couple intervention, whereas others sought couple therapy in general and ended up pairing with an EFT therapist (n=4). Though some participants entered EFT with prior knowledge about the model, all participant couples noted a difference between what they expected from treatment and what they experienced from EFT. More specifically, couples described entering couple therapy with the agenda of "fixing" their relational issues. For example, one participant, Janet, described how she and her partner approached therapy initially: "We have this sexual issue. We just need to handle this, figure it out and to fix it. We're super task-oriented people. We're both educated people . . . just give us the fix." However, participants described how their experience of EFT did not magically solve their relational issues but rather helped them restructure how they related to their individual relational struggles in a way that lowered their relational distress. This new way of relating was facilitated by EFT's attachment focus, which, as opposed to a behaviorally-based intervention, helped identify and then share core emotions between partners. Participant Amy detailed:

> I had thought it would be like, you know, like in the triage sense, that [couple therapy] was fixing a problem we had, but really, the thing that I hope to get out of it every time is, like, to understand [my partner] better and understand how, like, we can be in a relationship together and, like, be respectful and happy and healthy together instead of,

like, trying to fix all our problems. Like, I've kind of accepted that, like, we're human beings, we have issues and problems, but, like, learning about how we both feel about the problems and how we can, like, help each other through them is sort of what I want to get out of our sessions.

Participant Experiences of Core EFT interventions. At the time of the interviews, all participant couples had been in EFT for at least 8 sessions, but some had been in couple therapy for several years. Consequently, participants were able to speak to their experience with most of the core EFT intervention components, including cycle tracking, the attachment reframe, present process, emotional conjecture, and enactments (the identification and sharing of core [primary] emotions between partners). Given the range of participant experiences in EFT (between two months and several years), all participant couples were able to speak to their EFT experience, and those further along were able to address late-stage EFT treatment, with some couples able to speak from a client perspective about the stage 2 components of withdrawer reengagement and blamer softening.

Cycle tracking: A new perspective on couple conflict via the attachment reframe. A core component of EFT is the framing of couple conflict through the lens of adult attachment; that is, conflict between partners is framed as rooted in the unmet attachment needs of emotional safety, security, and accessibility between partners. All participant couples relayed their experience of cycle tracking, a core feature of stage one in the EFT model. The paradigm shift of identifying what EFT calls the "cycle" or "dance" resonated with couples in terms of how they viewed the root causes of their relational conflict. Brittney described this initial process of learning about how her external reactions based in the fear of disconnection from her partner played a role in the negative cycle of her relationship:

> I think that's part of what was brought to our attention in [EFT] therapy was that, like, the dance, you know, like, I couldn't understand [why I was doing] what I was doing to get close . . . that dance . . . it was, like, a very, a big awakening . . . when it was brought to my attention that, like, why, why was I like obsessively texting him? Or like purposely fighting with him, not [consciously]. Cause then he was like, why would you pick a fight? I didn't know what I was doing. I, I just, I didn't know. I just knew that I didn't feel manageable inside and I wanted his . . . I wanted a connection with him.

When asked about cycle tracking, Erin provided a salient description of something others in the sample described, which was how this intervention (cycle tracking/reframing) shifted the relationship between her and her partner in that it helped expose the interpersonal trauma symptomology (in this example, negative self-concept and emotion-regulation difficulties) driving the negative relational cycle.

> [EFT cycle tracking has] kind of, like, completely changed the way I think about conflict that we have. Like, I, I think I never really thought about, like, the reason we're having this elevated conflict is because we're both having this issue regulating or we're both somehow triggered and the idea of I, as a partner, I can help you regulate and you can help me regulate and practicing that in therapy, I think has been huge . . . I think there's so many conflicts we had that I didn't realize that what was going on was, like, I was feeling worthless [related to past trauma]. So, I was, like, flashing [back]. . . . And I think even knowing that that's going on and then being able to name it during a conflict or having you [partner] name it during then, it's, like, oh, it just kind of completely diffuses everything.

CPTSD couples in this sample resonated with the way EFT prioritizes core emotions within cycle tracking, which helped them gain hope for a new way of relating outside of the negative, trauma-based reactions. Participants often described the need to get past the distraction and relational harm caused by the cycle. Early on in their own experience with EFT, a particularly high-scoring CPTSD participant couple who struggled with severe relational distress outlined their process:

> Getting to the core feeling. That's been the best thing actually. It's like, because we can spin for hours, and it'll turn into bullshit about everything and anything. And then [our therapist] will just sort of bring us right back to the pinpoint part and make sure we realize what we're actually talking about. So I guess that's sort of what I mean by reframing, it's like making sure we're communicating on the same planet, which is about how we feel and how we are blowing up because we care so much about this relationship (Brent).

His partner responded in agreement:

> Yeah, I think to reframe [our conflict], get to the core feelings, and break the cycle. Like, that's what I'm most excited about, is when we can use that to stop it on our own (Monica).

Other participants, like Sarah, who were farther along in EFT, described how they were able to make this innate shift by identifying the cycle and seeing past the surface:

> I think it taught us both how to have emotional space for each other, like hands down. Like, it's so easy for me [now] to . . . step aside and say, okay, I understand what I said, why it's upsetting him, like actually getting to the root of it, opposed to just seeing [what's] on the surface (Sarah).

Emotional conjecture helped partners name their emotions and express vulnerability. Emotional conjecture is an ongoing component that informs cycle tracking and subsequent interventions in EFT. One of the goals of this intervention is to uncover partners' primary or core emotions to promote emotional awareness, attunement, and bonding between partners. Often, this occurs by summarizing and repeating emotional language back to partners while also validating their experience of those emotions:

> I think another thing that [our therapist] does that she's good at, like, summarizing or, like, reflecting our, our emotions and our feelings. So, it's easier for us to, like, understand what I'm feeling and what [my partner] is feeling (Ryan).

Another reflected:

> I think [our therapist] does a really good job of, like, turning what we're saying into the emotion, does that make sense? Right. Like, so [our therapist will reflect] I'm hearing fear or I'm hearing . . . I think it's helpful, especially for someone like me who doesn't always, isn't always able to, like, get there myself. Like I need, I need that (Kirsten).

Due to the heightened and chronic experiences of emotional constriction, hypervigilance, reexperiencing, and avoidance within this sample CPTSD population, the utility of emotional conjecture was essential. As outlined in chapter 4, participants in this sample often experienced their partners through the lens of past interpersonal trauma; however, emotional conjecture helped disarm participants' intrusive and protective CPTSD symptoms to identify and experience their own and their partner's genuine emotions. Participant Kristen noted:

> I think like the translation piece, right? Like, helping us to see, like, what's actually happening . . . the core emotion. Like, I think that piece is, is really important for us as two people who . . . really struggle to identify emotions within ourselves and within each

other, right. Like, instead of getting triggered by his anger, like, helping me to see like the fear that's there, you know what I mean? Like, yeah. I think that's been huge . . . in validating him, [our therapist is] also, like, naming the emotion and validating the emotion. So it helps me see through [my] hurt in order to be empathetic. Right. Like I think that piece for me is, like, it, it allows me to, like, step out of my own way. . . . Because she reframes it in a way that is, like, oh yeah, he's just scared (Kirsten).

This process of emotional conjecture was a positive experience for couples in this sample and aided in their ability to access and share vulnerable emotions despite deeply engrained symptoms of emotional constriction and avoidance due to past interpersonal trauma:

> [Our therapist has] helped [my partner] open up. Yeah. You know, to where she wouldn't have been able, she probably wouldn't have gone as much. Right. Or understood that she need, that she needed to do that. Yeah. In order for us to grow and get [closer] . . . I know [this has helped] because [my partner] told me four words that I hadn't heard for 22 years . . . "I need you too" (Matthew).

Process over content: redirection to what is important. An essential component of the EFT intervention is for therapists to redirect clients to the present process. The here-and-now orientation, focusing on process over content, connects couples access their core emotions within the session allowing the therapist to help them model the identification and sharing of core emotions outside of the session, and to have couples experience a new and emotionally attuned way of relating. The present process is, in part, what clients described as different from what they expected from couple therapy. This was important because not only do many clients enter couple therapy with the agenda of resolving arguments, but this sample of couples in the context of CPTSD also managed severe symptoms of reexperiencing and hypervigilance related to their

relational issues (n=10), as noted in chapter 4. Participants in the study had a positive experience with this EFT component, appreciating that their therapists were able to prevent them from getting lost in those symptoms and redirect them back to identifying and sharing their core emotions in the present:

> And even, you know, whereas like with the EFT, it's like [our therapist] doesn't even really wanna hear about the fight. It's like the feelings that are underneath it. So that's what really resonated (Brittney).

Her partner added:

> [Our therapist is] really good at redirecting us because we get so easily caught up in "He said, she said, and this happened." The surface level. Yeah. That's it, and it's so easy for us to bring someone in and wrap them in that tornado. But [our therapist] is really good at, like, hitting the pause button and, like, redirecting us. . . . No one's been able to stop the tornado from spinning [before] (Ryan).

Another participant, Amy, insightfully described how she recognized that the content was a way of avoiding addressing more painful emotions with her partner: "it's almost like you can hide behind the talking about the experience." Participant John further illustrated this experience across the sample, which was how he and his partner valued the therapist's consistent but firm shift away from their content and toward their underlying emotional issues:

> The problems that we present [in couple therapy] aren't really the problems we want solved, even though we don't, you know, don't realize that. Kudos to those who can figure that out. And, but it's not "about the dishes," it's not about the dishes. . . . To help people to where they really want to go rather than where they say they want to go. Yeah. That sounds a little heartless or dismissive, but I, I actually believe that (John).

Successful enactments lead to important relational shifts for trauma survivor couples. A key component of the EFT intervention born out of the cycle tracking, emotional conjecture, and present process is the experiential exercise of enactments. Participants described their experiences of enactments as "uncomfortable, [and] very awkward" (Brittney), even "jarring" at times (Monica), yet they were impactful to their initial and sustained progress in couple therapy due to the new way they learned to relate to their partners through positive experiences of vulnerable emotional expression. Participant Erin illustrated how she and her partner experienced this shift:

> It's like super, super vulnerable . . . at the beginning it was, like, oh, wow, like, we have never been this direct with each other about anything ever. It's just, like, kind of like this, like, pure honesty. And I think that that can be really scary, right? Like, if you're the person saying this is how I feel in this moment, that's a scary thing to say and cause you're also kind of asking not, maybe not directly, but like the implication is, "I need you to help me with this." And then, like, if you're the person hearing it, it can sometimes be really painful because sometimes, like, you've caused that really hard feeling or will be sad about what's happening for our partner. . . . And it can get, like, very raw as you peel back the layers together.

For some, especially those in the sample still in early stages of EFT, enactments remained difficult and surprising. One participant, Mitchell, noted, "I'm supposed to be the emotionally disconnected one and I welcome it. She hates [enactments]" (Mitchell). His partner followed up to share another common thread across participants, which was the aftereffects of enactments and their application outside of therapy:

> It is very challenging; [however], I feel like we're making progress with it. I feel like it's helpful in that if you were looking at our session and watching it, you probably would think it's not helpful, but I think it is helpful because even if I cannot do it in the moment . . . I am able to do it later or I'm able to, like, address whatever that was later. . . . I'll just sit there and stare at him and, like, nothing will come out. . . . But I don't let it go. Like, so it is helpful because I am still processing that and still like coming back to it (Kirsten).

Enactments that went well translated into real-life conversations outside of session, something these trauma surviving participants struggled with. One participant, Ryan, shared that after enactments in session, "it makes it easier then, in real life to turn to her and say what I feel, that's how I learned to kind of turn to her and say what I need, no matter how uncomfortable it was." Indeed, participants described that the more they experienced enactments, the more this modeled a new way of relating to their partners that felt safer, more authentic, and more secure, which stood in stark contrast to their chronic experience of feeling unsafe and/or insecure in their close relationship due to CPTSD. One participant, Ryan, who, like the rest of the sample, had significant struggles of relational distress in his relationship due to CPTSD, expressed how enactments helped him and his relationship:

> That process where they're going to my core emotions, looking at it, evaluating it, talking about it and, like, putting a sense of, like, a safety net around it in a way; then having [my partner] address whatever thing [was] is powerful. And it's not just to me, but also, like, I have the opportunity to see exactly what emotions she's feeling too and the mechanics kind of surrounding that it has nothing to do with the fight . . . but it's all about those raw emotions and feelings underneath for us both, and by just looking at it and examining it has helped me with those [trauma] triggers (Ryan).

Though some participants were still in early stages of change related to enactments, it was clear that overall, enactments had a powerful impact on couples in the context of CPTSD. Their experience of relational distress, negative self-concept, and insecure attachment were being altered due to couples' new way of relating, which Participant Erin described as:

> It's kind of like night and day [from before therapy], honestly. She has us talk to each other. I feel like I imagine therapy just being, like, talking to the therapist, but she actually has us, like, practice talking about our deep emotions to each other and telling each other what's going on, which is just really helpful in our actual relationship day to day. And I think, like, that's why we're much better now about, like, the way we handle conflict and I think that that's really helpful. And I think, like, now we're kind of, like, inching towards at least what I hope, is, like, as we continue to support each other, like, some of those feelings that I have of insecurity, like, hopefully lessen, like I will feel more secure. It's, like, in progress (Amy).

Another participant described how experiencing her partner's vulnerable emotions unlocked something for her that helped her experience her partner outside of her trauma:

> There was a moment where he looked right up close in my face and said how much he loved me and how much my leaving hurt him. I saw it, I saw it in his eyes. . . . I don't know how to even put words to it, but after that, like, everything changed . . . now, I still struggle to feel like it's okay, it's okay to need someone, to need him, nothing is linear, right, but I feel like I can take that risk now, where before I just couldn't. Not after everything I'd gone through (Annette).

As a result of enactments and related EFT interventions, couples in the context of CPTSD in this sample were able to more effortlessly take what they had learned in session to their relationships

outside of sessions, where they could "feel each other's pain" (Sarah), which subsequently enabled them to offer the support described above:

> We are able to turn to each other and speak directly to each other and many times I can see how [my partner] feels based on what I'm saying or how she might be reacting differently based on what I'm saying (Harry).

Participant Experiences of the EFT Pursuer and Withdrawer Framework

Due to the extensiveness of the interviews, and the varied length of treatment and therapeutic needs across the sample, not all participants went into detail regarding interventions from the later stages of EFT but rather focused on the key components of the EFT therapy in general and in stage 1. However, participants were able to speak to the core EFT themes of withdrawer reengagement and pursuer (or, blamer) softening. Withdrawer reengagement occurs in stage 2 when the withdrawing partner is able to express their fears around the relationship to the therapist and their partner. Blamer softening is a key intervention that follows withdrawer reengagement. This intervention involves facilitating a process for partners to explore and express their fear-related views of their partner and to reach out to their partner to experience support, validation, and connection amidst those fears in exchange for self-protection and defensiveness against their partner.

Withdrawer reengagement: shifting out of protection mode. One participant, Cathy, relayed how difficult it was for her to shift into engaging with and exploring her emotions due to past trauma and her symptoms of emotional cutoff, a common traumatic stress experience across the sample:

> So I think emotions in general are really, really hard. Okay. I have to tell you; I think I explained it. I am 54 years old, and I've lived pretty much 53 years without feeling a lot

> of emotions. Or at least not things that weren't, you know, super basic like happy, sad, mad [laugh], right? Pretty basic stuff. So, it's been, it is super hard work. I mean, it's, you know, sometimes it's really hard to even go there, but I know it helps me and helps us (Cathy).

It cannot be overstated how painful and sensitive exploring emotions was for the more relationally withdrawn portion of the sample (n=11), over half the participants, which was also reflected in chapter 4 under emotion-regulation difficulties (constricted emotions). Due to the increased difficulty of emotional engagement for survivors, many in the sample spent some time within treatment or were still in the stage of "just ignor[ing] it, and . . . not lik[ing] it" (Mitchell). However, even early on there was a sense of becoming "more receptive to it" (Mitchell) as emotional safety was established.

The process of withdrawer reengagement was best defined and expressed by Participant Annette and her partner, Matthew. Annette detailed the transformative process of experiencing emotional safety with her EFT therapist and her partner, which enabled her to make the decision to open up and express her need for her partner after many years. This is notable, as participant couple seven, Annette and Matthew, divorced after 22 years of marriage due to the increasing impact of untreated CPTSD symptoms. These symptoms manifested most prominently as emotional disconnection, relational hypervigilance, avoidance, and fear/distrust of close relationships for both partners but particularly for Annette, who expressed a prior negative self-concept related belief of "I don't need [my partner], I don't need anyone." She further noted that EFT, combined with individual trauma treatment, has been helpful for her recovery in this area, and she defined the specific benefit of EFT:

> It's been a cumulative effort, but I think that where [EFT] brings value to the table is to clarify for me, like, you know, [the withdrawing] is not that I'm a cold-hearted bitch, you know what I mean? Like, I am in protection mode. Yeah. Like, and so I think just having that clarification of, you know, this is the behavior, but [the trauma] is why, like, this is the emotion attached to it. Like, I haven't really ever had that. . . . I've never experienced that before. I've never understood the connection (Annette).

Her partner recognized, after also stating his recognition of how difficult this process was for her due to her complex trauma history, "[EFT] helped her to open up and actually allow herself to feel, and then show me those feelings, which has been incredible" (Matthew). Participant Annette followed up to share the importance of not only awareness of her feelings but the decision to choose how she shares her vulnerable emotions:

> Well, [EFT] helps me understand why I'm not, why I won't [allow myself to feel] . . . but now that I understand why I do that, like, and because I understand it, now I get to make that decision. And, and at the same time, [our therapist is] working to develop a safe space for me. To help me make that decision to open up by creating a stronger level of connection between us. It has, it has given me the strength and confidence—and especially with what I've seen in our progress—to go forward and feel again. I was gonna go back in a box again, but I was able to find the trust, I guess, to open back up. And take the risk for, for what I know is ahead.

Participant Matthew again responded to how Annette's emotional reengagement helped him feel more secure in the relationship as well: "[because] I've seen, I've seen the growth in [my partner] and I'm like, you know what, I'm going for it. I'm going to take that risk too."

***Getting past blame:* ‘all I saw was my pain’.** Though the interview did not specifically address the blamer softening event in EFT, there was a great deal of discussion around how EFT helped them restructure their former patterns of blame resulting from feeling “attacked” (Mitchell) or “on the defensive” (Evan) due to past experiences of relational instability. Participant John described how acceptance of core emotions, along with the attachment frame in EFT, instilled a paradigm shift over time in his approach to the relationship, helping him shift out of placing blame on his partner:

> I think it relates back to what [my partner] was saying too about, about what blame is I think, you know, in the, in the past I would be upset and I, and I would, you know, struggle hard to, to vilify [my partner] because, you know, I thought, if something is wrong or if she is upset, somebody’s to blame here. So it’s either her or me, and I’d rather not be that person. Right. Um, so part of it is the, you know, that realization from EFT that, um, I don’t, I don’t have to place the blame somewhere. . . . I think another part is better acceptance of myself since I have felt validated in [EFT] therapy that I have, you know, less—it is probably tied into this blame thing—but less need to, to, to feel perfect or, you know, yeah. Less need to feel that I haven’t screwed up (John).

Again, though partners did not relay details regarding specific blamer softening events, they were able to share the importance of how EFT manages blame within couple conflict and how initial cycle tracking can inform how couples view blame within the context of their relationship. As one participant, Monica, described:

> One big thing that’s honestly been a lot to take in, starting from the cycle to now, like, is how when I was so upset and afraid, and blaming him, I was actually really hurting and attacking him. I was so stuck in my hurt, my trauma, my whatever, I didn’t even know I

could hurt him because all I saw was my pain. So getting past the blame thing was really big for me and for us (Monica).

EFT's handling of blame for CPTSD was powerful and important due to couple participants' often heightened defense reactions based in their symptomology:

I think that's the other thing EFT does, is it doesn't shut one person off. It explains the other person's point of view, but it somehow does that by validating the other person's feelings at the same time. And I think regular couples counseling is, like, it's either one or the other is to blame. And neither of us wanted to find out we were to blame, so we would blame each other. It was always one person is fucked up here or one person's dead right and that's it. But in EFT, blame isn't there (Evan).

General Couple Therapist factors.

To differentiate between participants' experience of the EFT model and therapist factors, participants were also asked about their experience of their therapist in terms of alliance, emotional safety, and attunement. Though these factors are not necessarily unique to EFT, they are a large part of the training and deeply intertwined with the model. It was also clear that these therapist factors were important to this sample, as survivors of interpersonal trauma are more sensitive to interpersonal factors overall.

Balanced Alliance: Helping 'us'. Participants shared across the sample that they not only experienced a strong alliance with their therapists, but they also expressed the importance of how their therapist's positive regard and attunement was felt mutually between partners. In essence, they each expressed feeling personally aligned with their therapist, but overall, they also felt it was important that their therapist was "for" them as a couple, which helped couples feel secure in the difficult process of couple therapy. Participants noted, "I felt like with [our

therapist], I felt like she was helping us. That's why I stayed. Like I got that feeling from her, like she has our back" (Mitchell), and, "[our therapist has] been amazing at accepting both of us . . . rapport is . . . important" (Harry), and, "I feel like [our therapist] is out for the benefit of us" (Matthew). One participant, Ryan, went on to describe how this was not something they experienced in prior couple therapy, which eventually led to dropping out of treatment:

> [Our EFT therapist is] unbiased. And I think that's different for us. I think there were times where it was clear that the counselor [before] was like siding with one. . . . So I'm glad that [our therapist] does not do that because that is the thing that kind of keeps us on track. Cause I know if [my partner's] feelings don't get validated or my feelings don't get validated, it's gonna derail. Right. That was the cause of derailments in the past.

Genuine emotional safety from therapists facilitated the therapeutic environment. The creation of emotional safety was another therapist factor that allowed clients to not only stay committed to therapy but also helped them make therapeutic gains within their relationship. Participant Sarah remarked that with their current therapist, "you feel comfortable, you're not guarded, [you are] safe. Just the things that you want in your relationship, we feel that with her. So it allows us to do the work." Participants noted the additional relational benefit of their therapist modeling emotional safety. One participant, Mitchell, noted, "[my partner is] getting what she needs and I'm learning how to do it [for her]." Another participant, Amy, described how therapist rapport, safety, and attunement was established though the therapists' focus on taking the time to really hear and understand each partner:

> I think I want therapists to know that it does make a difference to take the extra time to build that trust and to have the difficult conversations. The focus should not be that content-oriented stuff. It's more about how each person is feeling and, you know, really

> giving the time and respect to each person's feelings individually, even if it takes like an entire session, [the therapist] shouldn't be afraid to do that and to really understand the emotional experience of each person (Amy).

Participants perception of the fit and acceptability of EFT in the context of CPTSD

EFT was a good fit and a positive experience for CPTSD couples. All participant couples offered salient descriptions of how EFT helped them either initially or significantly over time in how they experienced their partners differently based on their new understanding of their partner's inner experience related to past trauma. All participants described a positive experience of EFT with their current therapists and relayed how EFT fit well with their relational needs as a couple in the context of CPTSD. One such example is indicated by two participants, Harry and Rachel:

> EFT has helped me to [understand what's important] not necessarily solving any problem but understanding how [my partner is] feeling . . . and validat[ing] that I understand how she is feeling. Things that trigger her are not just caused by what I do or don't do but are also caused by the childhood trauma and then combined with trauma that, that I caused in our marriage. . . . Me understanding that and accepting that also helps me because it's, like, yes, I may have done something, but it's not always just about me hurting [my partner's] feelings. It's also about how what I did reminded her of the other trauma, and that causes it to go from a big deal to a massive deal, you know, so EFT has helped me to, to see, to see all that (Harry).

His partner responded:

> Yeah, because of EFT, I think you experienced me in a way that most people don't. Because of EFT we've gone through things, and you've heard things and understand

> things about me that nobody in the world understands. I think that helps a lot with our connection. It's why we are still married and why I can start to even turn to him when I'm struggling (Rachel).

Participant couples described the depth of impact they experienced from EFT amidst interpersonal trauma from their childhoods, prior partners, and each other and how this supported their families as a whole:

> I mean, we started EFT to save the marriage, so I wouldn't lose my wife. It was so we could increase our communication or not even increase, like, actually learn how to properly communicate for the first time ever, even after other couples' therapy. I would say not even make it better, but, like, we had zero clue on how to communicate and it turns out that we actually can do it. And what I hope to get at in the future is, like, a nice calm marriage. That's what I hope to get out of this is to get a more calm, peaceful marriage, because if we're not okay, then the kids aren't. So it has to kind of, like, start with us. And that's what I want more of. I want more of, like, this, what we have now (Ryan).

EFT facilitated a new way of relating: Co-creating safety in the context of trauma symptomology. Partners, especially those further along in the EFT (indicated by length of time in treatment and treatment stage indicators, i.e., those in or past stage 2), detailed a shift in their bond and emotional connection. While barriers to emotional connection related to past trauma were common for couples in the sample prior to EFT, the intervention established a new way of relating where partners experienced sustainable emotional connection, safety, and accessibility within their relationship.

Participant partners remarked how EFT helped them relate differently, even early on in treatment: “I’ve been really impressed with just how much has been addressed in such a short period of time already. So, I have high hopes for EFT” (Monica), or, “Yeah, it’s kind of interesting. It hasn’t specifically addressed our trauma, but it’s definitely addressed how we deal with each other because of it” (Brent). Even when the trauma was still unresolved, EFT couple’s treatment helped participants to live with the trauma. One participant couple, Mitchell and Kristen, relayed a similar experience regarding how EFT helped them become aware of how trauma shows up in their relationship and how it impacts the relationship.

> I think that we’ve learned more about, I don’t wanna call them triggers. But we’ve learned more about our own pasts and we’ve learned more about that, how that impacts [us] (Mitchell).

Partners were able to identify sustainable change by way of a deepened emotional connection and co-regulation, which they attributed to gains made in EFT therapy:

> if we, if we didn’t go to therapy, when all this [relational crisis] happened, we wouldn’t know how to deal with all the triggers and the reactions and yeah. So yeah, it had a direct effect on the relationship, but because we went to EFT and we learned how to manage that and become aware of it, I feel like it doesn’t have as much an effect at all (Ryan).

His partner responded:

> …yeah, like, I don’t even know the last time we had a fight since starting EFT six months ago, like, that’s just not what happens anymore for us like it used to. I would panic and he would panic and it would just blow up, but now we can help each other when we are scared and give each other what we need (Brittney).

As illustrated by all couples to varying degrees depending on their progression in EFT, one participant, Sarah, described how emotional connection between herself and her partner was a "new normal." Her partner described, "I was emotionally unavailable for years. And now I think that I am, at times, still [unavailable], but it's a whole lot more obvious when I do shut down" (Evan). This participant couple further illustrated a theme from the study, which was how ongoing treatment led to a new relational state where emotional disconnect was experienced as a surprising exception rather than the norm due to the sustained shift toward emotional connection in EFT. As Sarah described:

> …definitely a lot of improvement and more so in the last year (while in EFT). . . . So I think he's right, so [when] he now becomes emotionally detached, it's almost, like, you know, you just pumped on the breaks real hard, and you got whiplash because you're almost not expecting it. . . . And we've never left a session angry or upset with each other . . . we've actually gone into a session a few times angry or upset with each other, [but EFT] helps tremendously. Like you feel it's different—I don't know how to articulate it well—but you leave it feeling a different kind of a way with each other. It's pretty incredible . . . it's [also] more rewarding than, I guess, just regular therapy, and I don't want to take away from it, but it's really different. It's a different experience and the big takeaway for us is that . . . we leave not ever upset with each other and if anything, understanding of the other partner better (Sarah).

Her partner relayed the depths of their struggles due to CPTSD and how their EFT therapist helped them reach a milestone of 20 years of marriage while they have also healed many interpersonal wounds both within and outside of their relationship:

> the last two years have been our hardest two years, even though we've made it through, you know, 20 years of military service, four years of me being gone away from the family, you know, in another country, death, issues with raising our son. We've gone through all that, but this is the hardest part that we've gone through. And I think the fact that we had our EFT counselor . . . I think is one of the biggest reasons that we're able to still be here and we make jokes about it. We're like, thanks for keeping us together so we could celebrate 20 years (Evan).

***Trauma therapy competency is key*.** An important experience for this sample was therapist competency in trauma-informed care. This was due to the extent of trauma within each couple's history and how each partner brought their own experience of being additionally impacted by their partner's trauma. As Brittney noted, "I think there was a lot for us to work through . . . there was like a lot of trauma upon trauma. A lot of trauma" (Brittney). One participant, Janet, recognized that in terms of therapist competency, it may be hard for a new therapist to "cut their teeth" with a couples case when a high CPTSD symptomology is present.

Participants further described how important it was that their therapist had been trained and was personally allied with their population and specific needs. One participant, Gina, discussed the importance of therapist competency related to trauma for couples:

> I don't, I don't see how any couple therapy could be effective without taking, taking into account the trauma that comes into it 'cause you bring so much into the relationship. You can't just give people a set of tools and say, here do this, you know, that's, there's no way it will never, ever, ever work (Gina).

This sentiment was also important for participants who were not only part of the CPTSD population but the military population as well:

> [Our therapist] also understands the community. And I think that's probably why we have one of the bigger connections with her . . . the fact that she understands a lot of that stuff too, some things don't need to be said, like she understands the stress [my partner] has to absorb when I was doing my job overseas, she already gets that. So that makes it, like, she's not saying things that are off putting or saying things that are like, oh, I think I understand what you mean when you say this—she, she already gets it (Evan).

Finally, participants in this population described appreciating therapists who took a "non-pathologizing" (Cathy) approach to their trauma and trauma symptoms:

> The key has been having a therapist who does not does not label me . . . but really helps to put my experience in context. Yeah. I think it's huge for me and it's helped me a lot in accepting my own experience (Rachel).

***Participants preferred EFT in comparison to prior relational therapies*.** Participants described a stark difference between EFT with their current therapists and prior experiences of others forms of couple treatment with non-EFT therapists. Unfortunately, participants expressed negative experiences with prior couple therapists and described that overall, their "strategies were not good" (Kirsten). What couples described most about prior experiences in non-EFT couple therapy was that it did not help, and in that sense, their ongoing relational distress, despite seeking help, was harmful. In this sense, participants relayed how EFT's attachment framework was particularly well suited to their needs compared to other approaches in couple therapy:

> My [individual] therapist does do EFT. And then also does like attachment theory and I've, I've noticed that I've responded really well to that . . . in the past we've gone to, I think, maybe like two or three marriage counselors, like, in our, in the past 12 years. And

> really what we find is that we spend the session just replaying the fights, and then that creates, like, more of a fight (Brittney).

One participant, Gina, described another experience of ineffective couple therapy:

> We did do couples therapy, um, through two sets of people, um, prior to EFT . . . we were with one therapist and we were with her for quite a while. A lot of years before we finally saw the light and said, this just, this just is not effective. She was like a band-aid, you know, it's like, okay, you can go there and you can fight in front of her for an hour, but then, uh, you know, and then, and to get some of those feelings out, but then, you know, never really resolve anything (Gina).

One participant couple noted that they found EFT through a referral to the EFT workshop series "Hold Me Tight," which became the catalyst for them switching from general couple therapy to EFT:

> We were actually in couples therapy, for a while, and it just wasn't working. We would come in mad, we'd leave mad, stay mad. So our therapist sent us to an EFT workshop thing, kind of, probably out of desperation, like, "here, you take them," and it made so much sense to us, so we switched to EFT and never looked back (Evan).

EFT with CPTSD couples: Barriers, critiques, and suggestions

When asked if participants experienced any barriers in EFT to achieving their relational goals, participants shared key critiques or recommendations from their perspective for how EFT therapists can best treat couples with CPTSD.

***The importance of a collaborative process*.** A theme that arose was the importance of clients' ability to feel connected and oriented to EFT in two ways; understanding the process, and timeline. Participant Kirsten noted that a "loosely defined process, probably would've been

helpful sooner" (Kirsten). Other participants noted that their therapists did offer a clear map of the EFT process early on and noted that this was helpful for them to understand the goals of EFT and how to "trust the process" (Erin). Therefore, it stands that clarifying the processes and goals of EFT may be an especially important ingredient for establishing a sense of direction and security when doing EFT with a trauma-exposed population.

Similarly, the time frame of doing EFT with trauma-exposed individuals is a debated topic among therapists, and this particular sample offered more insight into this discussion; namely, they felt that time constraints were misleading for their needs. Participant Rachel remarked:

> So there was this idea with EFT that it may only require 6 or 12 sessions. I think putting any number down is wrong. Okay. I would not put, I would not put any number on how many sessions it might take with this couple or that couple (Harry).

Another participant, Gina, went into more detail regarding why the time constraints may not work for a relationally traumatized population due the layers of complex emotions and safety required:

> I mean, maybe I'm speaking through a trauma lens having, you know, having grown up with a lot of trauma, but it seems to me that it would be very, very difficult to just have a short course of, you know, a six-month course of EFT and be all better, you know? I mean, but maybe if you, if you didn't have a hugely traumatic background; neither partner did have a, a lot of trauma. Maybe it can go a lot faster, you know, but I don't. Yeah. I don't know. I dunno if that's the goal. I mean, obviously it'd be great if everybody could get help fast. . . . I don't know if it, I don't know if it's realistic.

Participant, Cathy, described being grateful for the long-term therapy experience with her EFT therapist and the recent breakthroughs she experienced due to a longer form (three years) of EFT-specific treatment.

> [Our therapist] was there and she is stuck with us. . . . My trauma started when I was three years old, probably younger. . . . I'm 54 years old and I'm, I'm not lying when I say just in the last six months to a year, I can start to say that I have hope that it's gonna get better, and that's not against [my partner or therapist]. That's how long it took. Yeah. And all my life I've been dedicated to working on this in one way or another and I'm finally getting some relief. (Cathy)

Visibility and accessibility of EFT for CPTSD populations. Participants described a few indirect barriers to EFT, more specifically related to a lack of awareness about the model and access to therapy and EFT therapists, which supports the expansion of services and the dissemination of EFT for trauma-exposed populations. A theme across couples was their lament that they did not "learn about [EFT] sooner" (Gina). As one participant, Monica, noted:

> I guess I didn't really know that EFT existed, first of all. And secondly, I didn't know that it would've been beneficial, specifically, for people with trauma. So I don't know, like, it would've been nice to have this knowledge previously. So, I guess the only thing I could say, really, is, like, somehow making it more visible.

Another participant couple summarized the importance of accessibility both in terms of financing therapy and physical access, which in this case, was aided by the expansion of telehealth:

> We are privileged to have the time and resources to pay for and have time for this treatment . . . to be honest with you, when COVID hit and we could go to video

> [sessions], that was the best thing. . . . I never found the therapy itself difficult, but the logistics were hard. (Janet).

Cohesive care and the meaningful integration with individual therapy. All participants described meeting with individual therapists throughout their lives, some during their EFT treatment, and they had primarily neutral or positive experiences. In this group, participants relayed they did not feel they needed or significantly benefited from individual therapy over time after experiencing EFT, noting, "I don't know, but I think it's, like, way more useful than just therapy by yourself, because everything I'm dealing with applies to us, and same for [my partner]" (Erin). Another participant said, "it just makes sense to kick everything back into the relationship because we are both dealing with all of this anyway, so we need to work on managing it and healing together" (Janet).

Conversely, in terms of the interaction of EFT with individual care, some participants felt that having additional individual care was both useful and that it offered a different but supportive service to their work in EFT in the context of their traumatic stress symptoms. As participant, Harry, relayed the usefulness of his partner's EMDR and how it helped both him and their relationship: "I do feel like it really helps when she kind of debriefs with me about her EMDR, it really helps me learn a lot about what's happening for her." In this way, couples relayed the importance of awareness of and cohesion with what was happening in individual care and their couple work in EFT in terms of therapeutic goals and being able to support and better understand their partner's experience.

Discussion

Cumulative empirical literature from the traumatology field has called for an expansion of traumatic stress interventions to identify effective treatments for CPTSD (Bryant, 2022;

Chouliara et al., 2020; Cloitre et al., 2011; 2020a; 2020b; Coleman et al., 2021; De Jongh et al., 2016; Forbes et al., 2020; Forde & Duvvury, 2021; Gerge, 2020; Karatzias et al., 2019b; Lonergan, 2014; Matheson & Weightman, 2020; Monson et al., 2022). The literature further has recognized the essential nature of integrating relational features in treatment, which includes the participation of a patient's social system, especially family members (Banford Witting & Busby, 2019; Stadtmann et al., 2017; Van der Linde & Edwards, 2013; Volgin & Bates, 2016).

Similarly, the systemic family therapy field had identified couple interventions (Baucom et al., 2014; Doss et al., 2022; McWey, 2022), and EFT specifically (Blow et al., 2015; Dalton et al., 2013; Greenman & Johnson, 2012; Karris & Caldwell, 2015; MacIntosh & Johnson, 2008; Roundy, 2017), as effective treatments for trauma-related interpersonal distress. The current study was the first of its kind to examine couples' experiences of EFT within the context of CPTSD symptomology to better identify the fit and acceptability of this intervention for CPTSD-specific populations.

Findings from this analysis revealed categories of participants' experience in EFT, which first illustrated how CPTSD symptoms within the relationship became impairing and unmanageable for couples (Webb et al., 2022), which in turn led to or exacerbated relational crises and eventually led to their participation in EFT. Couples in the study experienced EFT as providing relief to their underlying trauma symptoms of relational disturbance within their couple relationship.

The findings from the current study add support to prior clinical PTSD research with couples while also expanding to include a CPTSD-population perspective on EFT treatment (Blow et al., 2015; Oseland et al., 2016). Specifically, findings from this analysis were in line with the clinical application of the CATS model, which highlights the importance of safety and

stability (for the individual and couple), conjoint trauma processing, and emotional connection between partners as core clinical components for couples in the context of trauma (Oseland et al, 2016). Additionally, this analysis also supported the use of EFT for couples in the context of PTSD (Blow et al. 2015; ; Dalton et al. 2013; Greenman & Johnson, 2012; Karris & Caldwell, 2015; MacIntosh & Johnson, 2008; Roundy, 2017). The current study adds specificity to these findings, and it expands to include the context of CPTSD as a distinct traumatic stress disorder, bolstering the case for using EFT for couples in the context of CPTSD.

Reasons for seeking EFT: A relational crisis. In line with the current literature, couples in the context of CPTSD experienced pervasive and extensive difficulties in their relationships (Banford Witting & Busby, 2019; Cloitre et al., 2020b; Herman, 1997; Hyland et al., 2017a), which eventually led to an unmanageable crisis in what participants described as the most important aspect of their lives, their close relationships. These ongoing struggles, in conjunction with developing relational crises, led couples to EFT, which they sought out both intentionally and unintentionally. As noted, almost all couples had extensive prior experiences in couple therapy and eventually dropped out before switching to EFT. Participants described a common theme in their experience of EFT, which was the shift from what they expected to get out of EFT versus what the intervention actually entailed (Wiebe et al., 2017). A common thread for couples related to the shift from their expectations of couple therapy as a fix for their relational problems to their lived experience of EFT as an emotionally focused, experiential, and attachment-based therapy, which altered the core dynamics of their couple relationship (Greenman & Johnson, 2012 ; Wiebe et al., 2016; 2017).

EFT with CPTSD couples: Experiences of EFT interventions. Couples in this sample took part in EFT of either consistent (weekly) or, eventually for some, intermittent (as needed)

treatment, ranging from, at the time of the interview, eight weeks (n=2) to almost ten years (n=2). However, most of the sample reported between six months and three years of active treatment (n=16). Within this sample, all couples reported meaningful therapeutic gains from their experience of EFT. This included couples earlier on in treatment as well as those who were further along in stages two or three of EFT. These findings support and expand upon prior studies and reviews that indicate the probable fit of EFT for CPTSD populations (Blow et al., 2015; Dalton et al., 2013; Johnson 2002; Macintosh & Johnson, 2008; Roundy, 2017).

In terms of couples' experiences of specific EFT interventions, findings revealed this sample benefited from and distinctly recognized the value of EFT core components. Stage one, or the de-escalation stage of EFT, employs several key interventions that aim to restructure, reframe, and deescalate couple conflict by helping partners identify and access core emotions and placing the "blame" for couple conflict on the cycle and unmet attachment needs of connection between the couple (Johnson, 2004; 2019). The attachment reframe, identification of core emotions, and the language of the relational cycle itself resonated deeply with participants. Chapter 4, along with prior studies, have illustrated increased difficulties with escalation between partners within the context of interpersonal trauma and related symptoms, along with increased insecure attachment styles related to CPTSD sequala (Blow et al., 2015; Dalton et al., 2013; Johnson 2002; MacIntosh & Johnson, 2008; Roundy, 2017).

Couples in this study identified strongly with the attachment framework of EFT. The shift from experiencing one's partner through the lens of prior trauma and toward experiencing partners through the lens of attachment, heightening core emotions, and validating their experiences was powerful for couples as a result of EFT. This framework helped alleviate couples' experiences of their partner as the "problem" or "unsafe" person. The sample reported

that the attachment frame was a key component that helped them to manage experiences of fear-based arousal surrounding their partner or the relationship as a trauma stimulus. Lowered arousal surrounding the relationship was facilitated by therapist attunement and emotional conjecture, which led to a subsequent awareness and sharing of core emotions in the present moment between partners (enactments). Enactments, though difficult initially, were impactful and built empathy and mediated against internal signals of defensiveness and trauma-related avoidance between partners (McRae et al., 2014; Wiebe et al., 2017). In other words, by recognizing their partner's vulnerable emotions, and supported by emotional conjecture and enactments, CPTSD couples could start to experience each other beyond the trauma lens of avoidance, fearfulness, and defense. Over time, participants reported that the positive experience of enactments in therapy translated directly to their way of relating in their day-to-day relationship outside of therapy.

Findings further revealed the sample's positive experience of the "here-and-now" orientation of EFT (Johnson, 2019; McRae et al., 2014; Wiebe et al., 2017). EFT therapists' focus and constant redirection toward couples' emotional process, rather than addressing the content of their conflict, was notably beneficial for this sample and resonated deeply with participants. Though this aspect of the EFT intervention is highly directive, participants distinctly recognized this and indicated that it directly restructured the way they understood each other and managed conflict. In this way, participants relayed a paradigm shift in their relationship, moving from deeply rooted, fear-based responses—riddled with hypervigilance, reexperiencing, avoidance, negative self-concept, and emotion regulation difficulties—to more calm, curious, and empathic methods of co-regulating amidst difficulty (McLaughlin et al. 2015).

Findings revealed that the development of attunement via emotional accessibility and responsiveness between partners was a powerful clinical result of EFT for trauma-exposed couples, which is in line with Greenman and Johnson (2012). Shifting cycles of emotional distance and anxious pursuit between partners addressed core CPTSD-related symptomology of emotion regulation difficulties, emotional avoidance (in the form of withdrawal), and hypervigilance in the form of blame and reactivity (chapter 4). It also prevented the spiraling down of couples when one member was triggered (McLaughlin et al., 2015). Participants relayed the relief they experienced being able to co-regulate with their partners amidst distress, despite the prior barriers related to fear-based CPTSD symptoms (Randal et al., 2021; Roundy 2017; Wiebe et al., 2017).

Therapist factors. Importantly, therapist factors, including a balanced alliance with both partners, emotional safety and attunement, and trauma-informed care, were viewed as highly important for participants to experience a positive therapeutic environment (Blow et al., 2007; Chouliara et al., 2012; Davis et al., 2012). Participant couples in this sample experienced their therapists as unbiased, emotionally safe, attuned to their needs, and trauma informed. For this particular sample, participants reported trauma-informed components from their treatment, including therapists validating their experiences, therapists' nonjudgmental stance, and, importantly, therapists "sticking with them" and allowing clients to process and proceed at their own pace.

Participants' perception of the fit and acceptability of EFT in the context of CPTSD. Findings revealed participant experiences regarding the overarching impact, fit, and acceptability of EFT for their specific needs of interpersonal trauma-related relationship distress. Specifically, EFT served to restructure couples' ways of relating in order to support emotional safety and co-

regulation in a way that was trauma-informed, and it was distinctly more beneficial from prior experiences of couple therapy that did not use EFT.

Specifically, analysis revealed that couples experienced relief from getting beyond the surface of their negative interactions, which were reinforcing their trauma symptoms of difficulties in relationships. This understanding of their core emotions and relational cycle further facilitated a pathway for restructuring how couples engaged in their relationship in a way that privileged emotional awareness, transparency, and empathy between partners (Johnson, 2002). This new way of engaging, by attuning to each other's core emotions and co-regulating, was a corrective experience for this sample and allowed them to experience—many of them for the first time—emotional safety, even when they were within otherwise fearful states (reexperiencing, hypervigilance, etc.).

In this way, for this particular sample, EFT seemed to have an impact on couples' experiences of trauma symptoms that were related to both exposure and memory-processing therapies but that were within the unique context of their intimate relationship (Mahoney et al., 2019). In exposure and memory-processing therapies, the goal is to shift the traumatic/negative association of the trauma stimulus from unsafe to safe by guiding survivors through stages of building awareness and corrective emotional experiences where they can establish a way of experiencing safety amidst exposure to the trauma stimulus—in this case, close relationships (Karatzias et al., 2011; Khalfa & Touzet, 2017; Linder et al., 2022a; 2022b). In their work in EFT, rather than being taken over by the intensity of CPTSD symptoms signaling for self-protection, partners were able to reach outside of fearful symptoms and experience emotional attunement and connection. Over time, especially for participants further along in EFT, this

allowed couples to experience safety and co-regulation more readily and override their trauma symptoms together (Randall et al. 2021).

In this way, accumulated positive experiences helped partners shift out of their trauma-related negative beliefs about themselves in relationships and helped them manage symptoms that were linked to past interpersonal trauma. Partners described moving from insecure states of negative self-concept (i.e., worthlessness, fear of abandonment, etc.) to "I can get close" and "it is okay to need my partner."

EFT is an intervention intended to treat relational distress. Therefore, there were several elements of this analysis that confirmed our typical understanding. One important confirmatory element from this study was related to the role of avoidance in couple relationships (Alexander, 1992; Alexander, 2012; Aloni et al., 2021; Oseland et al., 2016) As demonstrated in chapter 4, the CPTSD symptom of avoidance was derived from, and also subsequently impacted, relationships. In terms of traumatic stress, the avoidance of trauma stimulus—if the stimulus exists within the context of relationships—is very much akin to attachment avoidance (i.e., the avoidance of closeness and proximity to attachment figures due to past attachment injuries in close relationships). Therefore, it follows that EFT was helpful for CPTSD couples in that the intervention directly addressed interpersonal avoidance and moved partners toward vulnerability and emotional connection. This experience of connection was viewed as the key ingredient that helped couples experience both relief from CPTSD-related distress and a new way of relating that sustainably impacted their relationship satisfaction.

Trauma-informed care in EFT. Though trauma-informed care is not necessarily a core feature of the EFT model, participants reported experiencing and valuing the trauma-informed care they received from their EFT therapists. Valuable components of care included therapists'

use of the attachment framework to help participants understand their own difficult emotions; and therapists' providing of emotionally attuned care, which involved both validating participants' complex internal experiences and progressing at the client's pace, which was often very slow and gradual. These are key tenants of trauma-informed care (Chouliara et al., 2012), and though the EFT model is designed for a general population of couples, it also accounts for trauma within couple relationships (Dalton et al., 2014; Johnson, 2002; MacIntosh & Johnson, 2008; Roundy, 2017). It is apparent that the EFT therapists from this study understood core components and the importance of trauma-informed care with interpersonal trauma exposed clients.

Compared to other therapies. Participants experienced EFT as unique, valuable, and transformative, especially compared to other prior couple therapies (n=16), though, because it was technically relational, it did not address their needs of safety, validation, and emotional connection. Therefore, in many cases, it perpetuated their relational distress and worsened their CPTSD symptoms.

EFT facilitated emotional connectedness and safety between partners, which was a new way of relating for survivors who expressed a lifetime struggling in close relationships. Participants' experience of EFT was held in stark contrast with their prior participation in couple therapy with therapists who did not practice EFT. Couples indicated that their participation in prior therapy with therapists who did not practice using EFT had a neutral to negative impact on their relationship, in some cases worsening symptoms of relational distress. Conversely, the EFT model fit well with trauma survivor couples because it focused on emotional safety between the therapist and partners, and interpersonal stabilization (de-escalation) (Cloitre et al., 2011; Roundy, 2017). Likewise, EFT's emphasis of validating difficult emotional experiences was key

for participant couples; this is a core feature for interpersonal trauma survivors who often experience invalidation from therapists due to the complex inner workings of trauma (Herman, 1997; Johnson, 2002; Roundy, 2017).

The findings in this study revealed just how vital the attachment-based mechanisms of EFT were for this subgroup of the CPTSD population, which is supported by prior literature with PTSD and couples (Blow et al., 2020; Greenman & Johnson, 2012; Karatzias et al., 2018b). Indeed, what worked for couples in the context of CPTSD may be similarly useful for those with other forms of relational distress. However, it was evident that this population was in desperate need of relational intervention, and once they received effective treatment for their relationship via EFT with trauma-informed therapists, they were able to experience hope for and relief from severe interpersonal trauma symptoms, some for the first time.

EFT with CPTSD couples: Barriers, critiques, and suggestions. Though this sample indicated the strong acceptability of EFT, participants were also able to offer important critiques from their experience. A key element was the desire to understand the EFT process and goals early on in treatment. Some participants felt their progress was not hindered but somewhat delayed because of a lack of clarity in the aims, format, and goals of the EFT treatment model. As an attachment-based experiential model, even couples who knew the EFT process found the emotionally evocative nature of therapy jarring at first; however, those who were fully aware of the process reported a smoother transition and earlier treatment gains. In a similar way, findings revealed CPTSD couples expressed discord and discomfort with the idea of a set number of sessions for EFT. This finding is in line with prior discussions of trauma intervention in general (Karatzias et al., 2019b; Karatzias & Cloitre, 2019), and EFT with trauma populations (Dalton et

al., 2014; Greenman & Johnson, 2012); however, it may be important to further explore how to discuss treatment planning, goals, and termination with trauma-exposed populations in EFT.

Another important perspective from this sample was their insight regarding known barriers to care for mental health care access and the importance of cohesive care between their individual mental health care providers and their EFT therapists. In terms of barriers to care, findings revealed the importance of financial and logistical access to not only general mental health care but to EFT as an evidence-based systemic intervention for couples in the context of traumatic-related interpersonal distress. In terms of logistical barriers, telehealth was one solution that participants indicated helped them access EFT (Hogan, 2022). Another issue raised within the sample was the relief that they found an effective therapy to address their relational needs (Baucom et al., 2014; Stadtmann et al. 2017; 2018), though participants also voiced frustration with the amount of time they spent prior to discovering EFT, suffering with ongoing interpersonal distress and without effective care. Therefore, findings revealed that access to evidence-based systemic care for CPTSD populations is an essential consideration for policy and training. Policy, dissemination, and training efforts should focus on expanding access in the domains of financial, logistical, clinical training, and developing population awareness of attachment-based systemic interventions for CPTSD populations (Collins et al., 2013; Hogan, 2022; Sareen et al., 2007)

Finally, some participants indicated their experience of a known and grave issue in traumatic stress intervention, which was unethical care for traumatic stress populations (Herman 1997). Two participant couples reported that once prior therapists learned about the severity of client's traumatic stress symptomology and diagnosis, they terminated or refused treatment and did not provide referrals. This unethical dismissal from care based on a client's diagnosis and

their presentation of issues was retraumatizing for participants. Early on in CPTSD conceptualization, Herman (1997) outlined the often unethical ways in which some providers address cases with difficult trauma presentations, which was unfortunately experienced by some in this sample. This again highlights the importance of trauma-informed care and the need to expand training and supervision for nonpathologizing, evidence-based interventions.

Clinical implications. What was unique about this analysis was not that EFT seemed to work in a drastically different way for survivors but rather that it was, in fact, acceptable and beneficial to them in the context of their CPTSD symptomology. EFT allowed couples, especially those with dual CPTSD diagnosis, to experience a sense of calm and co-regulation, even amidst their greatest trauma stimulus, the relationship itself (Randall et al., 2021; Ruhlmann, 2017). Therefore, perhaps the most important clinical implication for this study is to heighten even further the value of attachment-based systemic interventions for treating CPTSD-specific symptomology and relational distress rooted in interpersonal trauma (Fyvie et al., 2019). The depth of impact EFT had on this sample in the light of prior research supports the clinical guidelines outlined by Johnson (2002) and Roundy (2017) regarding EFT's fit as a phased, relational intervention for CPTSD-relational distress. The relational conceptualization of CPTSD cases must be a central consideration in treatment. Furthermore, as indicated by this sample and prior research (Dalton et al., 2014; Greenman & Johnson, 2012; MacIntosh & Johnson, 2008; Roundy, 2017), couples seeking treatment in the context of interpersonal trauma can benefit from EFT as an emotionally focused, attachment-based, nonpathologizing, experiential intervention. However, treatment gains can take months or years to materialize, and clinicians must participate in ongoing supervision and training to support their ability to meet the needs of high-trauma populations (Coleman et al., 2021). Additionally, individual trauma treatment may

be useful or necessary for many cases; therefore, the coordination of care between providers is an important consideration to support effective and cohesive treatment for trauma survivors.

Limitations

This sample was unique subset of CPTSD and EFT population, which means there were aspects of this study that limit the generalizability of the results. Almost all participants met the criteria for CPTSD, and all of them had been exposed to interpersonal trauma. Therefore, this was a sample of dual trauma couples, which may not represent all relationships. This sample was a subgroup of the CPTSD population, as they were all married or in long-term committed relationships, which is not considered typical for those with CPTSD (Karatzias et al., 2019a). Therefore, these results reflect the experience of highly committed CPTSD couples who likely experienced protective factors that supported their ability to maintain their relationship, and notably, this sample had access to resources, including individual and couple therapy, which helped them cope with CPTSD symptomology. Relatedly, this sample also reported high levels of SES and education. Despite recruitment efforts, this sample was also fairly homogeneous in terms of race and ethnicity. Future studies should include more diverse samples of CPTSD survivors in terms of race and ethnicity, gender identity, and non-Western cultures. Furthermore, this study focused on couples in the context of CPTSD who had received effective relational treatment; therefore, to understand the broader range of experience of the CPTSD population, future studies should include couples who chose to end their relationships due to CPTSD symptoms, couples who dropped out of therapy, and couples in other forms of treatment.

Conclusion

The findings from this analysis further identify the importance of relational, attachment-based interventions for CPTSD treatment to meet an essential need and expand effective care for

this population. The findings from this analysis confirmed prior empirical assumptions and expanded upon the theoretical understanding of CPTSD-diagnosed populations and their experiences of relationships and EFT as a relational treatment in the context of the diagnosis (Dalton et al., 2014; Greenman & Johnson, 2012; Herman, 1997; Karatzias et al., 2018b; Karris & Caldwell, 2015; MacIntosh & Johnson, 2008; Roundy, 2017). Making recommendations for future studies based on the findings from this study was a core goal of this research, with the aim to inform future feasibility and pilot studies using EFT and other attachment-based systemic therapies for CPTSD populations based on the outcomes of the data.

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APPENDIX A: RECRUITMENT FLYER

Figure 1

Recruitment Flyer

APPENDIX B: INFORMED CONSENT FORM

Study Title: IRB #00006346: The Promise of Attachment-Based Couple Interventions for Individuals Living with CPTSD

Research Participant Information and Consent Form

Study Title: **The Promise of Attachment-Based Couple Interventions for Individuals Living with CPTSD**
Researcher and Title: Jennifer VanBoxel, MMFT; Adrian Blow, Ph.D.
Department and Institution: Human Development and Family Studies, MSU
Contact Information: 615-308-9474; vanboxe1@msu.edu

BRIEF SUMMARY

You are being asked to participate in a research study. Researchers are required to provide a consent form to inform you about the research study, to convey that participation is voluntary, to explain risks and benefits of participation including why you might or might not want to participate, and to empower you to make an informed decision. You should feel free to discuss and ask the researchers any questions you may have.

1. PURPOSE OF THE RESEARCH STUDY

You are being asked to participate in a research study of couples participating in Emotionally Focused Couple therapy(EFT) where one or more partner meets the diagnostic criteria for Complex-PTSD**.** Your participation in this study will take approximately 90 to 120 minutes in total. You will be asked to fill out a screening survey and participate in a joint interview with your spouse/ significant other that will take 90 to 120 minutes. You are required to continue your couples treatment while taking part in this study.

2. WHAT YOU WILL DO

Your participation in this study will involve participating in one 90-to-120-minute joint interview with your spouse / significant other. The interview will be audiotaped. The interview will ask you and your partner together first about your relationship, your experience of trauma symptomology within the relationship based on the ICD-11 C-PTSD diagnosis, and then about your experience of Emotionally Focused Couple therapy in the context of those symptoms. The online screening survey will ask about general categories of past trauma experienced, but the interview will *not* include any detailed questions about past traumatic events. Further, you may at any point skip a question or pause the interview. You will not be expected to discuss any topics that make you uncomfortable or do not wish to discuss. Finally, between one and three months after the interview is completed you will have the optional opportunity to review initial results from the larger study and provide feedback.

3. POTENTIAL BENEFITS

The potential benefits to you for taking part in this study are possible insights from the interview discussion into how a traumatic stress diagnosis impacts couple and relationship functioning; such insights can be used by participants to integrate into their own therapy as they so choose. Following the interview completion participant couples will also receive psychoeducational materials about Complex-PTSD along with evidence-based resources for those with the diagnosis. It is also possible that you may not directly benefit from your participation in this study. However, your participation in this study may contribute to the understanding of how couples in the context of Complex-PTSD experience, manage, and perceive symptoms, which is currently not understood by researchers and can inform future treatments for Complex-PTSD populations. Further, your participation in this study may contribute to the understanding of the fit and acceptability of an attachment-based relational intervention (EFT) in treating Complex-PTSD symptomology within couple therapy.

4. POTENTIAL RISKS

The major risk of this study is loss of confidentiality. Even though we will not ask your name during the interview, there is still a small risk that individuals could identify you because of things you describe in your interview. The researchers will try to minimize this risk by deleting all audio-recordings after they have been transcribed and deleting any information from transcriptions that might allow someone to determine your personal identity. The interviews will be typed and stored electronically on password protected computers for analysis by researchers on the study team. Ten years after the project closes, they will be permanently deleted. Your confidentiality will be protected to the maximum extent allowable by law.

Certain questions asked in this study may make you feel uncomfortable. The interviewer will ask you about current symptoms of C-PTSD and how you may or may not notice them in your relationship in addition to your perspectives on EFT couple treatment. However, the interviewer will not ask any in-depth questions about past trauma experienced and will not ask you or your partner to disclose any past traumatic experiences in detail. Since this is a joint interview between you and your partner you may experience psychological, social, or personal distress from discussing trauma symptomology and or experiences of couple therapy with the interviewer in the presence of your partner. You are encouraged to process any distressing feelings with your current EFT therapists. We will also provide you with a resource packet that will point to additional resources you might find useful.

Participants are reminded that they can share what they are comfortable sharing with the interviewer in the presence of their partner. Further, if a question makes you feel uncomfortable, you are free to skip that question. Individuals conducting the interviews are mandated reporters and are required by Michigan law to report to authorities if someone discloses their intent to harm self or others. If we suspect a child is or may be abused or neglected, we must contact Children's Protective Health Services immediately.

5. PRIVACY AND CONFIDENTIALITY

Your decision to participate is completely at your discretion and you are free to discuss the issue of participation with your partner, your therapist, and with others outside your family unit at your discretion. Involvement in this study may result in a loss of privacy since your partner and research staff may be aware of your participation. Information about you will be kept confidential to the maximum extent allowable by law. All research staff are required to keep your personal information private. Your responses to all questions will be confidential and stored in a secure manner. At no time will identifiable information be stored with your interview. You are free to decline to answer any specific question.

The interview will be audiotaped as a part of participation in the project. The interview will be transcribed, during which all identifying information will be deleted from the transcribed interview and after that, the audio recording will be deleted.

All research data collected as part of this study will be stored according to the privacy and security guidelines established by the Institutional Review Boards of participating organizations. Paper copies will be locked in filing cabinets in locked offices of the study team. Only authorized research staff will have access to study data. Members of the research team will analyze the data collected from this study. The results of this study may be published in scholarly journals or presented at scientific meetings, but participants' names will never be mentioned.

If you indicate interest in future surveys and supply information regarding your telephone and email address, you may be contacted about additional studies by means of the contact information you provide today.

The following individuals will have access to the data:

- Researchers and Research Staff.
- Institutional Review Board (IRB) personnel should they choose to audit the study.
- In all cases, identifying information will not be stored with or connected to study data.

6. YOUR RIGHTS TO PARTICIPATE, SAY NO, OR WITHDRAW

Participation is voluntary. Refusal to participate or discontinue participation will involve no penalty or loss of benefits to which you are otherwise entitled. You have the right to say no. You may change your mind at any time and withdraw. You may choose not to answer specific questions or to stop participating at any time. If you withdraw, your responses from previous participation will remain in the study.

7. COSTS AND COMPENSATION FOR BEING IN THE STUDY

There are no costs to your participation in the study. You and the other adult in your couple relationship, 18 years of age and older will each receive a $50 Amazon.com gift certificate for participation in the 90 minute interview.

8. ALTERNATIVE OPTIONS

You may choose not to participate in the study.

9. CONTACT INFORMATION

If you have concerns or questions about this study, such as scientific issues, how to do any part of it, or to report an issue, please contact either researcher: Jennifer VanBoxel, LMFT, via phone (615)308-9474, or Email jennifervanboxel@gmail.com, or vanboxe1@msu.edu, or Adrian Blow, PhD 7 Human Ecology, Michigan State University, (517) 355-0230 or Email: blowa@msu.edu.

If you have questions or concerns about your role and rights as a research participant, would like to obtain information or offer input, or would like to register a complaint about this study, you may contact, anonymously if you wish, the Michigan State University's Human Research Protection Program at 517-355-2180, Fax 517-432-4503, or e-mail irb@msu.edu or regular mail at 4000 Collins Rd, Suite 136, Lansing, MI 48910.

By proceeding and completing the interview, you are voluntarily consenting to participate in this project and have your responses included in the study.

10. DOCUMENTATION OF INFORMED CONSENT

Your signature below means that you voluntarily agree to participate in this research study.

_____ _____

Signature Date

You will be given a copy of this form to keep.

11. RECORDING CONSENT

- I agree to allow audiotaping/videotaping of the interview.
  ☐ Yes ☐ No Initials_____

APPENDIX C: CLIENT SCREENING SURVEY

MSU - C-PTSD & EFT Study

Participant Eligibility Screening

This is a brief survey for the Emotionally Focused Couple therapy (EFT) and Complex-PTSD research study. Once your response is scored you will receive an email regarding your eligibility for the study.

This survey includes several general questions regarding your current participation in Therapy. You will also be asked to complete and the International Trauma Questionnaire.

Please note that eligibility for the study includes that you are your partner are participating in EFT couple therapy and that one or both partners meet the diagnostic criteria for Complex-PTSD. Please contact the study organizer with any questions at: eftandcomplexptsdstudy@gmail.com

Intro 2 Please write your name and email address:
Note* this address will only be used to inform you about the results of the survey regarding study eligibility

_____

Intro 3 I consent to receiving email contact regarding my eligibility for the study

- ○ Yes (1)
- ○ No (2)

Intro 4 Please list your partner's full name who is participating with you in couple therapy and who will also take this eligibility survey
Note* this information will only be used to determine final eligibility for the study when both partners have completed the survey

_____

EFT 1 Are you and your partner currently in couple therapy with an Emotionally Focused Couples therapist?

- ○ Yes (1)
- ○ No (2)
- ○ Not sure (3)
- ○ Not currently, but we ended/ completed treatment (4)

EFT 2 Please list the name and practice information for your current / most recent EFT Couples Therapist_____
Note: Therapists will not be contacted. This information will be used to determine therapist qualifications for the study

EFT 3 If you are currently participating in couples therapy, or if you have completed treatment please estimate how many sessions you have had with your current or most recent couples therapist

- ○ 1-8 (1)
- ○ 8-16 (2)
- ○ 17-24 (3)
- ○ 25-51 (4)
- ○ 52 or more (5)

ITQ Information: The next six questions are a part of the International Trauma Questionnaire (ITQ) PTSD & Complex-PTSD screening.
ITQ will ask two brief questions about past traumatic experiences and 18 Likert scaled questions about ongoing traumatic stress symptoms.
ITQ - Experience Instructions: Please identify the experience that troubles you most and answer the questions in relation to this experience. Brief description of the experience: _____
ITQ - Time When did the experience occur? (Click one)

- ○ less than 6 months ago (1)
- ○ 6 to 12 months ago (2)
- ○ 1 to 5 years ago (3)
- ○ 5 to 10 years ago (4)
- ○ 10 to 20 years ago (5)
- ○ more than 20 years ago (6)

ITQ - PTSD I Below are a number of problems that people sometimes report in response to traumatic or stressful life events. Please read each item carefully, then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

	Not at all (0)	A little bit (1)	Moderately (2)	Quite a bit (3)	Extremely (4)
P1. Having upsetting dreams that replay part of the experience or are clearly related to the experience? (1)	○	○	○	○	○
P2. Having powerful images or memories that sometimes come into your mind in which you feel the experience is happening again in the here and now? (2)	○	○	○	○	○
P3. Avoiding internal reminders of the experience (for example, thoughts, feelings, or physical sensations)? (3)	○	○	○	○	○
P4. Avoiding external reminders of the experience (for example, people, places, conversations, objects, activities, or situations)? (4)	○	○	○	○	○
P5. Being “super-alert”, watchful, or on guard? (5)	○	○	○	○	○
P6. Feeling jumpy or easily startled? (6)	○	○	○	○	○

ITQ PTSD II In the past month have the above problems:

	Not at all (0)	A little bit (1)	Moderately (2)	Quite a bit (3)	Extremely (4)
P7. Affected your relationships or social life? (1)	○	○	○	○	○
P8. Affected your work or ability to work? (2)	○	○	○	○	○
P9. Affected any other important part of your life such as parenting, or school or college work, or other important activities? (3)	○	○	○	○	○

ITQ C-PTSD: Below are problems that people who have had stressful or traumatic events sometimes experience. The questions refer to ways you typically feel, ways you typically think about yourself and ways you typically relate to others. Answer the following thinking about how true each statement is of you.

How true is this of you?

	Not at all (0)	A little bit (1)	Moderately (2)	Quite a bit (3)	Extremely (4)
C1. When I am upset, it takes me a long time to calm down. (1)	○	○	○	○	○
C2. I feel numb or emotionally shut down. (2)	○	○	○	○	○
C3. I feel like a failure. (3)	○	○	○	○	○
C4. I feel worthless. (4)	○	○	○	○	○
C5. I feel distant or cut off from people. (5)	○	○	○	○	○
C6. I find it hard to stay emotionally close to people. (6)	○	○	○	○	○

ITQ C-PTSD II In the past month, have the above problems in emotions, in beliefs about yourself and in relationships:

	Not at all (0)	A little bit (1)	Moderately (2)	Quite a bit (3)	Extremely (4)
C7. Created concern or distress about your relationships or social life? (1)	○	○	○	○	○
C8. Affected your work or ability to work? (2)	○	○	○	○	○
C9. Affected any other important parts of your life such as parenting, or school or college work, or other important activities? (3)	○	○	○	○	○

End of Block: ITQ - 5 minutes

Start of Block: Post ITQ Info

Post 1 If you experienced these symptoms prior to receiving EFT couple therapy and have reason to believe couple therapy treated these symptoms for you, please indicate below. If not, type N/A

_____

Post 1: Thank you for taking the EFT & C-PTSD couples screening survey!
Once you complete the survey you will receive an email within the next 24 hours to inform you if you might qualify the study. Once you and your partner complete the survey you will each receive notice if you qualify as a couple to participate.

The study organizer will contact you regarding next steps in final consent and interview scheduling. Thank you so much for your participation!

Post 2: Would you feel comfortable participating in a joint interview with your partner to discuss how you experience couple therapy and also to discuss how you experience C-PTSD symptoms (your partner's and/or your own) within your relationship?
Note* the interview will be taken with a trauma informed, couples therapist and will not address past trauma, but focus on learning from you and your partner to help better inform future therapeutic intervention.

Additionally, the interview will seek to be supportive and offer insight and resources for couples who manage C-PTSD within their relationship. You are welcome to contact the study organizer at : vanboxe1@msu.edu to learn more and gauge your comfort level about participating in the join couples interview.

- ○ Yes (1)
- ○ Maybe, but I would like to learn more (2)
- ○ No, I would not feel comfortable (3)

End of Block: Post ITQ Info

APPENDIX D: DEMOGRAPHIC SURVEY

CPTSD & EFT Study Demographic Survey

Start of Block: Demographics & Consent to Schedule

Please enter your name:

_____

Q0 Gender Identification:

_____

Q1 Please list your sexual orientation

_____

Q2 Age

- ○ 18-24
- ○ 25-34
- ○ 35-44
- ○ 45-54
- ○ 55-64
- ○ 65+

Q3 Relationship Status. Please mark all that apply

- ☐ Married
- ☐ Widowed
- ☐ Divorced
- ☐ Separated
- ☐ Not married
- ☐ Engaged

- [ ] In a committed relationship
- [ ] Other

Q4 Length of time in current relationship

_____

Q5 Please list how many children you have, if any

- ○ None
- ○ 1 child
- ○ 2-3 children
- ○ 4-5 children
- ○ 6-7 children
- ○ 8 or more children

Q6 Employment

- ○ Full-time
- ○ Part-time
- ○ Unemployed/ retired

Q7 Highest level of education

- ○ Some high school/ or other
- ○ Technical school
- ○ Some college
- ○ College Degree
- ○ Graduate/ Masters Degree
- ○ Doctorate Degree

Q8 Annual household income

- ○ Less than US $20,000
- ○ US$20,000 - US$39,000
- ○ US$40,000 - US$59,000
- ○ US$60,000 - US$79,000
- ○ US$80,000 - US$99,000
- ○ US$100,000 or higher

Q9 Ethnicity

- [ ] White / Caucasian
- [ ] Black or African American
- [ ] American Indian and Alaska Native
- [ ] Asian
- [ ] Native Hawaiian or Other Pacific Islander
- [ ] Hispanic of Latino
- [ ] Middle Eastern
- [ ] Other

Q10 Please list where are you located (country, state)

_____

Q11 I would like to schedule the joint interview for the study. In doing so I offer permission to the study team to email me and my partner in a joint email to schedule the interview and send the informed consent form for the study.

- ○ Yes, I would like to schedule the joint interview and offer permission to email me and my partner
- ○ Maybe, but I would like to discuss further via email
- ○ Maybe, I would like to discuss further via zoom meeting
- ○ I would not like to participate in the study at this time

Q12 Please list both your email and your partner's email in the field below

_____

End of Block: Demographics & Consent to Schedule

APPENDIX E: THERAPIST SCREENING QUESTIONNAIRE

EFT Therapist Eligibility for C-PTSD Research Study

Start of Block: Default Question Block

EFT 1a
To participate as an eligible EFT therapist for this cutting edge intervention study please answer the following 9 questions:

First, please enter your 1) Full name & license type (e.g., LPC, LMFT, LMSW)

_____

EFT 1b 2) Email address
Note* you will not be contacted or added to any contact list unless you opt in at the end of the survey.

_____

EFT 1c 3) Practice location (full work address, or - city/state in which you practice)

_____

EFT 1d: 4) Professional website URL (if available)

_____

EFT 2: Do you consider yourself an Emotionally Focused Couples Therapist? (i.e., do you conduct therapy with couples using the EFT model?)

- ○ Yes, I have been trained and implement the EFT model with client couples
- ○ Mostly, I have been trained and usually use EFT with client couples
- ○ A little bit, I have been trained to a degree and try to use some EFT principles in my work with couples
- ○ Not really, I know about EFT, but I have not been professionally trained and I am unsure if I am using EFT with client couples
- ○ No, I have not been trained in EFT and I do not use it in therapy

EFT 3: Please indicate the highest level of training have you received for Emotionally Focused Couples Therapy?

- ○ EFT Externship
- ○ EFT Core Skills 1
- ○ EFT Core Skills 2
- ○ EFT Core Skills 3
- ○ EFT Core Skills 4
- ○ EFT - post core skills continuing education / consultation groups
- ○ EFT Certification

○ EFT Trainer

EFT 4: Are you willing to distribute study information to your clients either via email or posted in your office? Please note: if you check yes, or maybe you will receive the study flyer via email along with guidelines about how you can share this opportunity with your clients.

○ Yes, I am prepared to share study information with my clients

○ Maybe, but I would like to learn more about the guidelines

○ No, I would not like to receive additional information about this study

EFT 5: If you have questions about this process, please enter them here, and the study organizer will respond to your questions via email.

_____

EFT 6: If you would like to meet with the study organizer via email, phone, or zoom meeting to learn more please indicate:

○ Yes, I would like more information via email

○ Yes, I would like to discuss more about the study briefly over the phone

○ Yes, I would like to meet via zoom to learn more about the study

○ No, I do not need more information

EFT 7: If eligible to participate as an EFT therapist for this study, would you like to receive an acknowledgment in the published manuscript of this EFT intervention study?

- ○ Yes
- ○ Maybe
- ○ No

EFT 8: If you answered ‘yes’, or ‘maybe,’ please enter your name and contact information again, and you will be contacted prior to publication for a final approval to add your name to the published acknowledgments for this EFT Intervention study.

_____

EFT 9: If you know of other EFT therapists who might be eligible for this study, you can either send them the study website and/or add their contact information below

_____

APPENDIX F: INTERNATIONAL TRAUMA QUESTIONNAIRE

THE INTERNATIONAL TRAUMA QUESTIONNAIRE (ITQ)
OVERVIEW:
The attached instrument is a brief, simply-worded measure, focusing only on the core features of PTSD and CPTSD, and employs straightforward diagnostic rules. The ITQ was developed to be consistent with the organizing principles of the ICD-11, as set forth by the World Health Organization, which are to maximize clinical utility and ensure international applicability through a focus on the core symptoms of a given disorder. The ITQ is freely available in the public domain to all interested parties. Evaluation of the measure continues particularly as it relates to the definition of functional impairment for both PTSD and CPTSD and possibly the content of the items as they might relate to being predictive of differential treatment outcome.
DIAGNOSTIC ALGORITHMS are as follows:
PTSD. A diagnosis of PTSD requires the endorsement of one of two symptoms from the symptom clusters of (1) re- experiencing in the here and now, (2) avoidance, and (3) sense of current threat, plus endorsement of at least one indicator of functional impairment associated with these symptoms. Endorsement of a symptom or functional impairment item is defined as a score > 2.
CPTSD. A diagnosis of CPTSD requires the endorsement of one of two symptoms from each of the three PTSD symptoms clusters (reexperiencing in the here and now, avoidance, and sense of current threat) and one of two symptoms from each of the three Disturbances in Self-Organization (DSO) clusters: (1) affective
dysregulation, (2) negative self-concept, and (3) disturbances in relationships. Functional impairment must be identified where at least one indicator of functional impairment is endorsed related to the PTSD symptoms and one indicator of functional impairment is endorsed related to the DSO symptoms. Endorsement of a symptom or functional impairment item is defined as a score > 2.
An individual can receive either a diagnosis of PTSD or CPTSD, not both. If a person meets the criteria for CPTSD, that person does not also receive a PTSD diagnosis.
Scoring instructions are available at the end of this document.

Figure 2

International Trauma Questionnaire

International Trauma Questionnaire

Instructions: Please identify the experience that troubles you most and answer the questions in relation to this experience.

Brief description of the experience _____

When did the experience occur? (circle one)

a. less than 6 months ago
b. 6 to 12 months ago
c. 1 to 5 years ago
d. 5 to 10 years ago
e. 10 to 20 years ago
f. more than 20 years ago

Below are a number of problems that people sometimes report in response to traumatic or stressful life events. Please read each item carefully, then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

	Not at all	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
P1. Having upsetting dreams that replay part of the experience or are clearly related to the experience?	0	1	2	3	4
P2. Having powerful images or memories that sometimes come into your mind in which you feel the experience is happening again in the here and now?	0	1	2	3	4
P3. Avoiding internal reminders of the experience (for example, thoughts, feelings, or physical sensations)?	0	1	2	3	4
P4. Avoiding external reminders of the experience (for example, people, places, conversations, objects, activities, or situations)?	0	1	2	3	4
P5. Being "super-alert", watchful, or on guard?	0	1	2	3	4
P6. Feeling jumpy or easily startled?	0	1	2	3	4

In the past month have the above problems:

P7. Affected your relationships or social life?	0	1	2	3	4
P8. Affected your work or ability to work?	0	1	2	3	4
P9. Affected any other important part of your life such as parenting, or school or college work, or other important activities?	0	1	2	3	4

Cloitre et al. (2018) *Acta Psychiatrica Scandinavica.* DOI: 10.1111/acps.12956

Figure 2 (cont'd)

Below are problems that people who have had stressful or traumatic events sometimes experience. The questions refer to ways you typically feel, ways you typically think about yourself and ways you typically relate to others. Answer the following thinking about how true each statement is of you.

How true is this of you?	***Not at all***	***A little bit***	***Moderately***	***Quit a bit***	***Extremely***
C1. When I am upset, it takes me a long time to calm down.	0	1	2	3	4
C2. I feel numb or emotionally shut down.	0	1	2	3	4
C3. I feel like a failure.	0	1	2	3	4
C4. I feel worthless.	0	1	2	3	4
C5. I feel distant or cut off from people.	0	1	2	3	4
C6. I find it hard to stay emotionally close to people.	0	1	2	3	4
In the past month, have the above problems in emotions, in beliefs about yourself and in relationships:					
C7. Created concern or distress about your relationships or social life?	0	1	2	3	4
C8. Affected your work or ability to work?	0	1	2	3	4
C9. Affected any other important parts of your life such as parenting, or school or college work, or other important activities?	0	1	2	3	4

Cloitre et al. (2018) *Acta Psychiatrica Scandinavica.* DOI: 10.1111/acps.12956

1. Diagnostic scoring for PTSD and CPTSD

PTSD

If P1 or P2 > 2 criteria for Re-experiencing in the here and now (Re_dx) met If P3 or P4 > 2 criteria for Avoidance (Av_dx) met

If P5 or P6 > 2 criteria for Sense of current threat (Th_dx) met

AND

At least one of P7, P8, or P9 > 2 meets criteria for PTSD functional impairment (PTSDFI)

If criteria for 'Re_dx' AND 'Av_dx' AND 'Th_dx' AND 'PTSDFI' are met, the criteria for PTSD are met.

CPTSD

If C1 or C2 > 2 criteria for Affective dysregulation (AD_dx) met

If C3 or C4 > 2 criteria for Negative self-concept (NSC_dx) met

If C5 or C6 > 2 criteria for Disturbances in relationships (DR_dx) met

AND

At least one of C7, C8, or C9 > 2 meets criteria for DSO functional impairment (DSOFI)

If criteria for 'AD_dx' AND 'NSC_dx' AND 'DR_dx', and 'DSOFI' are met, the criteria for DSO are met.

PTSD is diagnosed if the criteria for PTSD are met but NOT for DSO.

CPTSD is diagnosed if the criteria for PTSD are met AND criteria for DSO are met.

Not meeting the criteria for PTSD or meeting only the criteria for DSO results in no diagnosis.

2. Dimensional scoring for PTSD and CPTSD.

Scores can be calculated for each PTSD and DSO symptom cluster and summed to produce PTSD and DSO scores.

PTSD

Sum of Likert scores for P1 and P2 = Re-experiencing in the here and now score (Re) Sum of Likert scores for P3 and P4 = Avoidance score (Av)

Sum of Likert scores for P5 and P6 = Sense of current threat (Th)

PTSD score = Sum of Re, Av, and Th

DSO

Sum of Likert scores for C1 and C2 = Affective dysregulation (AD)

Sum of Likert scores for C3 and C4 = Negative self-concept (NSC)

Sum of Likert scores for C5 and C6 = Disturbances in relationships (DR) DSO score = Sum of AD, NSC, and DR

APPENDIX G: SEMI-STRUCTURED INTERVIEW GUIDE

Introduction

Today I will be asking questions about your relationship, your experience of trauma symptomology within the relationship, and your experience of Emotionally Focused Couples Therapy. Today's discussion will not include any questions about past traumatic events, however, please let me know at any point if you would like to skip a question or pause the interview.

General/ historical view of current relationship:

To begin I am going to ask a few general questions about your relationship. I will ask each of you the same questions in an alternating fashion to ensure equal time.

- How long have you known each other and/or been together as a couple?
- How would you describe the beginning/ early stages of your relationship?
- How would you characterize your current relationship?
- What are your hopes for your relationship in the future?

PTSD & Relational Experience:

I am going to ask some questions pertaining to your experience of certain traumatic stress symptoms within the relationship.

- *(Avoidance 1)* Some people who have experienced trauma may avoid certain *external* reminders including people, places, conversations, objects, activities or situations:
  - *(Experience)* Within the context of your relationship do you notice that either you or your partner seem to avoid certain external reminders in this way?
    - *(Perceive):* If so: how do you perceive or notice when this is happening?

        - *(Manage)*: If so: what do you notice that you and your partner do when this is happening?
- *(Avoidance 2)* Some people who have experienced trauma may avoid certain *internal* reminders including thoughts, feelings, or physical sensations:
    - *(Experience)* Within the context of your relationship do you notice that either you or your partner seem to avoid certain internal reminders in this way?
        - *(Perceive):* If so: how do you perceive or notice when this is happening?
        - *(Manage)*: If so: what do you notice that you and your partner do when this is happening?
- *(Hypervigilance 1)* Some people who have experienced trauma may notice that they are often 'super-alert,' watchful, or on guard as though something bad might happen and they need to be on the lookout and/or prepare for the worst.
    - *(Experience)* Within the context of your relationship do you notice that you or your partner seem to be super-alert or on guard in this way?
        - *(Perceive):* If so: how do you perceive or notice when this is happening?
        - *(Manage)*: If so: what do you notice that you and your partner do when this is happening?
- *(Hypervigilance 2)* Some people who have experienced trauma may notice that they are often easily startled or jumpy.
    - *(Experience)* Within the context of your relationship do you notice that you or your partner seem to be easily startled or jumpy in this way?
        - *(Perceive):* If so: how do you perceive or notice when this is happening?

        - *(Manage)*: If so: what do you notice that you and your partner do when this is happening?

- *(Reexperiencing 1)* Some people who have experienced trauma may notice powerful images or memories come to mind that are so strong it feels like the experience is happening again in the here and now.
    - *(Experience)* Within the context of your relationship do you notice that you or your partner at times experience powerful images or memories that seem like they are replaying in the present moment?
        - *(Perceive):* If so: how do you perceive or notice when this is happening?
        - *(Manage)*: If so: what do you notice that you and your partner do when this is happening?
- *(Reexperiencing 2)* Some people who have experienced trauma may have upsetting dreams that replay part of a difficult or traumatic experience or are clearly related to the experience.
    - *(Experience)* Within the context of your relationship do you notice that you or your partner have upsetting dreams that are either related to or replay difficult or traumatic experiences?
        - *(Perceive):* If so: how do you perceive or notice when this is happening?
        - *(Manage)*: If so: what do you notice that you and your partner do when this is happening?

<u>DSO & Relational Experience:</u>

- *(Emotion regulation difficulties 1)* Some people who have experienced trauma may experience that it takes a long time to feel calm after getting upset.

- *(Experience)* Within the context of your relationship do you notice that you or your partner struggle to regain a state of calm after getting upset?
    - *(Perceive):* If so: how do you perceive or notice when this is happening?
    - *(Manage)*: If so: what do you notice that you and your partner do when this is happening?

- *(Emotion regulation difficulties 2)* Some people who have experienced trauma may experience feeling numb or emotionally shut down (i.e., cut off from your own emotions).
    - *(Experience)* Within the context of your relationship do you notice that you or your partner struggle by feeling numb or emotionally shut down?
        - *(Perceive):* If so: how do you perceive or notice when this is happening?
        - *(Manage)*: If so: what do you notice that you and your partner do when this is happening?
- *(Negative View of Self 1)* Some people who have experienced trauma may struggle with chronic negative beliefs about themselves: for example, 'I feel like a failure', or 'I feel worthless.'
    - *(Experience)* Within the context of your relationship do you notice that you or your partner struggle with these or other related negative beliefs?
        - *(Perceive):* If so: how do you perceive or notice when this is happening?
        - *(Manage)*: If so: what do you notice that you and your partner do when this is happening?
- *(Negative View of Self 2)* Some people who have experienced trauma may struggle with chronic negative beliefs about themselves: for example, 'I feel distant of cut-off from people', or 'I find it hard to stay emotionally close to people.'

- *(Experience)* Within the context of your relationship do you notice that you or your partner struggle with these or other related negative beliefs?
    - *(Perceive):* If so: how do you perceive or notice when this is happening?
    - *(Manage)*: If so: what do you notice that you and your partner do when this is happening?

- (*Disturbances in relationship 1*) Some people who experience the prior mentioned symptoms (provide a reminder if needed) may also notice that these have either created a concern within the relationship or affect their relationship directly in some way?
    - *(Experience)* Within the context of your relationship do you notice that any of the mentioned symptoms have created concern or have directly affected your relationship?
        - *(Perceive):* If so: how do you perceive or notice how this is the case?
        - *(Manage)*: If so: what do you notice that you and your partner do to address this issue or concern?
- (*Disturbances in relationship 2*) Some people who experience the prior mentioned symptoms (provide a reminder if needed) may also notice that these have affected them in terms of work, parenting, school, or other important activities?
    - *(Experience)* Within the context of your relationship do you notice that you or your partner have been affected regarding work, school or important activities by the prior mentioned symptoms?
        - *(Perceive):* If so: how do you perceive or notice how this is the case?
        - *(Manage)*: If so: what do you notice that you and your partner do to address this issue or concern?

- (*Disturbances in relationship 3 - open-ended)* Is there anything else you would like to share from your perspective regarding how past trauma experiences and current trauma symptoms impact your relationship?

Experience of Emotionally Focused Couple therapy

Now I am going to shift and ask a few questions regarding your experience so far in Emotionally Focused Couple therapy(EFT).

General

- Why did you first seek EFT couples therapy?
- How long have you been in EFT?
- Have you been in couple therapy together before?
- Prior to starting what do you hope to gain from EFT?

Symptomology Specific

- Given the context of our conversation today regarding trauma symptoms (provide a reminder if needed):
    - Do you feel EFT couple therapy has addressed any of the above-mentioned symptoms and issues within the context of your relationship? How so?
    - If anything, what do you find helpful from EFT couple therapy so far?
    - If anything, what does your therapist do that is helpful for you and /or your relationship?
    - If anything, what has been especially difficult about EFT couples therapy?
    - If anything, what does your therapist do that is not helpful for you and/or your relationship?

        - Is there anything that you do not like or do not find helpful about EFT couple therapy so far?
            - Are there parts of EFT that you feel are barriers to reaching the goals you have for your relationship in therapy?
        - Have there been any changes in your relationship since starting EFT couples therapy?
            - What has changed for you individually since starting EFT?
    - Do you feel EFT couple therapy is or will be effective for you as a couple? How or how not?
    - What do you want therapists to know about how they can help couples like you?

Closing & Debriefing

Thank you for your time and participation in this interview. I will now ask a few final questions about what it was like participating in this interview today and also provide some additional resources.

- What was it like to participate in this interview?
    - What was it like to have this discussion together with your partner present?
- Do you feel this conversation will impact your next/subsequent therapy sessions?
- Do you feel like you can talk to your EFT therapist about what came up in the interview today?

Provide resources

Thank you…

APPENDIX H: STUDY ONE—FRAMEWORK MATRIX

Table 3

Framework Matrix

Symptom Category	**Avoidance**					
	Experience			***Relational Impact***	***Management & Coping***	
Theme	*Couples consistently avoided relational trauma stimuli within their relationship*	*Avoidance related withdrawal and disassociation led to distance and disconnection between partners*	*Mutual activation of avoidance symptoms between partner.*	*Avoidance of emotional and sexual intimacy.*	*Lack of resolution with avoidance symptoms*	*Discovering and understanding avoidance within the relationship is a process*
Summary	Conscious and unconscious avoidance of certain ways of connecting or interacting within the context of the couple relationship due to prior trauma stimulus that exists within the context of relationship	Experiencing something that relates to a relational trauma stimulus within the context of the relationship that leads to protective behaviors of disassociation and withdrawal that widen the gap of connection within the relationship	Avoidance from one's partner activating individual's avoidance (emotional detachment)	Partners avoiding past interpersonal trauma triggers via emotional or sexual intimacy	Difficulty and lack of resolution managing avoidance and subsequent disconnection within the relationship	Continual progression toward learning about the symptom of avoidance and its origins for each partner while building mutual empathy when it arises

Table 3 (cont'd)

Symptom Category	**Hypervigilance**			
	Experience		***Relational Impact***	***Management & Coping***
Theme	*A way of being in relationship*	*Pervasive fear and distress within the relationship*	*Defensiveness, fear, and being on guard toward partners and the relationship*	*Mutual awareness and emotional connection*
Summary	Like a constant hum in the background, or a preprogramming of waiting for something bad to happen within the relationship: a constant state of alert &/or also sudden extreme fear responses	Complex and pervasive automated sense of threat related to their intimate relationship and/or partner (being afraid of something bad happening to them within the context of their relationship [i.e., abandonment, neglect, control, loss, or betrayal]).	Negative impact of invasive thoughts: thinking the worst when it comes to the relationship based on past experience. This fearful and relationally hypervigilant state is distressing for couples: sparking negative circular interactions of defensiveness, fear, and blame, and being "on alert" towards and against one's partner guarding against something really severe constantly	Mutual empathy and skills related to mindful acceptance and emotional awareness related to hypervigilance in the relationship were key. Partners' mutual awareness of hypervigilance and its origins from prior trauma directly fed into a couples' ability to redirect and reflect on what is driving fear and conflict within the relationship

Symptom Category	**Reexperiencing**			
	Experience		***Relational Impact***	***Management & Coping***
Theme	*Reexperiencing was intrusive and impaired cohesion in the relationship*	*Relational reexperiencing*	*Relational impact of reexperiencing: The unique impact of the couple relationship as trauma stimulus*	*Reexperiencing: Management and coping—process of identification and discernment between past and the present*

Table 3 (cont'd)

Summary	Partners describing reexperiencing as a pervasive, invasive, and highly distressing symptom individually & within the relationship		Reexperiencing was both tangible (like images or specific memories) and intangible (more like a feeling) or a filter from the past for the present moment within the relationship	The impact of reexperiencing interpersonal trauma within the context of the current relationship meant: partners responding to what was and not what is (and being confused between the two and often disassociated or reactive when this was happening)	Managing reexperiencing required a lot of effort: Partners helped each other identify and discern reexperiencing signals of disassociation and reactivity via recognizing its harmful pattern and impact on the relationship and pausing and being mindful to identify where the intense signals were coming from and redirecting	
Symptom Category			**Negative Self-Concept**			
	Experience		***Relational Impact***		***Management and Coping***	
Theme	*Negative and/or defeating internal experiences of themselves in relationship to their partners*	*Emotional distance and disconnection between partners*	*Negative Relational Concept*	*A mutually activating cycle*	*Extensive intentional effort and resourcing*	*Identification, partner awareness, and safety to be vulnerable*

Table 3 (cont'd)

Summary	Deeply healed beliefs that they will never be safe, enough, or are failing that relate to their intimate relationship creating a harsh, and critical internal and relational environment	The negative self-concept leads to emotional disconnection or shut down between partners because they do not trust they are or can be secure, loved, or accepted on a deep level and emotionally turn away from their partners	Experiencing the relationship from an investable belief of being defeated and unsafe, unwanted, or unaccepted	Negative beliefs creating an unintentionally hostile environment within the relationship (and harm towards partners) that was mutually activating of their negative self-concepts	Individual therapy and external supported reported which aided in individual management of negative self-concept beliefs	Individual and partner awareness, and the emotional safety that allowed them to be vulnerable with each other
Symptom Category			**Emotion Regulation Difficulties**			
		Experience		***Relational Impact***		***Management & Coping***
Theme		Reactive cycles of emotional constriction and hyperactivation.		*Chronic negative emotional experiences between partners*.		Partners discerned and expressed needs for individual and co-regulation.
Summary		Symptoms of fearful reactivity and anger (hyperactivation), or emotional avoidance (hypoactivation) such as emotional cutoffs and disassociation, played a significant role in couple dynamics and communication		Consistent emotion-regulation difficulties within the relationship instilled a negative cycle between partners in which fearful states related to past trauma interrupted the current dynamics of the couple relationship		Coping with strong emotions with resulting reactivity or numbing was difficult for partners to attain; however, they described how combined efforts to emotionally regulate both individually and together were key
Symptom Category			**Difficulties in Relationship**			
		Experience		***Relational Impact***		***Management & Coping***

Table 3 (cont'd)

Theme	Trauma was a filter for how partners experienced close relationships	Interpersonal trauma impact: as a degenerative, invasive, and harmful third entity in the relationship.	Relational impact disturbance in relationships: Polytraumatization and relational layers of complexity.	Coping: building mutual awareness of individual interpersonal trauma symptoms within the relationship	Understanding and identifying trauma while developing mutual support.	The role of hope and importance shifting from individual to relational coping: Developing a healing team.
Summary	Relationships are triggering: Painful, complex, or difficult experiences within their relationship, which were linked to intrusive symptoms derived from past interpersonal trauma	The role of trauma was like an uncontrollable third person in the relationship that caused havoc and broke down relationships leading to extreme distress especially in the context of transition or additional stress	Diverse layers of trauma that, for most, started in childhood, and were later exacerbated by interpersonal trauma in adulthood	The couple relationship itself served as an emotional space that both continually activated partners' relational distress but also conversely facilitated partners' awareness and ability to recognize the presence of ongoing traumatic stress symptoms as they played out within the intimate relationship	Partners' ability to gain a genuine understanding of their own and their partner's trauma history and symptoms was a key ingredient to managing disturbances in their relationship	Despite the complex trauma histories of this sample, couples displayed hope for their relationships and pride for the work they had done in the face of their difficulties and struggles as survivors of CPTSD, at times jointly managing severe ongoing symptomology

APPENDIX I: STUDY TWO—FRAMEWORK MATRIX

Category	Theme	Summary
Reasons for seeking EFT	**A Relational crisis and the need to learn how to be together**	Participants described ongoing relational distress related to past trauma and CPTSD, and a tipping point within their relationship and/or a triggering event that served as the catalyst for their participation in couple therapy
Participant expectations of EFT	***A Changed perspective: from solving to bonding***	Participant couples noted a difference between what they expected from treatment and what they experienced from EFT (so far). More specifically, couples described entering couple therapy with the agenda of "fixing" their relational issues and found it was more about accessing their emotions
Participant Experiences of core EFT interventions.	***Cycle tracking: A new perspective on couple conflict via the attachment reframe***	Reframing couples' conflict through the lens of adult attachment; that is, conflict between partners was framed as rooted in the unmet attachment needs of emotional safety, security, and accessibility between partners was a paradigm shift of how they experienced the relationship

	Emotional conjecture helped partners name their emotions and express vulnerability	Due to the heightened and chronic experiences of emotional constriction, hypervigilance, reexperiencing, and avoidance within this sample CPTSD population, the utility of emotional conjecture was essential and helped partners name their emotions and get out of cycles of fearful reactivity
	Process over content: redirection to what is important	Participants relayed that an essential component of the EFT intervention was when therapists to redirected them to their present process rather than the content of their arguments
	Successful enactments lead to important relational shifts for trauma survivor couples	Participants relayed enactments were difficult, surprising, jarring, and awkward, but led to deeper sustainable shifts outside of therapy in the way they related to each other
Participant Experiences of the EFT Pursuer and Withdrawer Framework.	***Withdrawer reengagement: shifting out of protection mode***	Process of becoming receptive to emotional experiencing despite fear-based CPTSD symptoms surrounding experiencing emotions in the context of relationship
	***Getting past blame: '*all I saw was my pain'.**	Though partners did not specifically discuss the blamer softening event, participants discussed how EFT helped them restructure their former patterns of blame within the relationship

General Couple Therapist factors	***Balanced Alliance: Helping 'us'*.**	Participants expressed the importance of how their therapist's positive regard and attunement was felt mutually between partners
	Genuine emotional safety from therapists facilitated the therapeutic environment.	Emotional safety was a key therapist factor that allowed clients to not only stay committed to therapy but also helped them make therapeutic gains within their relationship
Participants perception of the fit and acceptability of EFT in the context of CPTSD	***EFT was a good fit and a positive experience for C*PTSD *couples***	All participants described a positive experience of EFT with their current therapists and relayed how EFT fit well with their relational needs as a couple in the context of CPTSD.
	***EFT facilitated a new way of relating: Co-creating safety in the context of trauma symptomology*.**	Partners, especially those further along in the EFT detailed a shift in their bond and emotional connection and general way of relating to each other amidst and outside of distress
	***Trauma therapy competency is key*.**	Importance of therapist competency in trauma-informed care: therapists trained and allied with the population
	Participants preferred EFT in comparison to prior relational therapies.	Participants described a stark difference between EFT with their current therapists and prior experiences of others forms of couple treatment with non-EFT therapists

***The importance of a collaborative process*.**	Participants desired an understanding of the goals of EFT while also a lack of constraints in terms of a prescribed timeline
Visibility and accessibility of EFT for CPTSD populations	Indirect barriers to EFT related to a lack of awareness about the model and access to therapy and EFT therapists by location
Cohesive care and the meaningful integration with individual therapy.	Benefits and drawbacks to meeting with individual therapists during the course of treatment