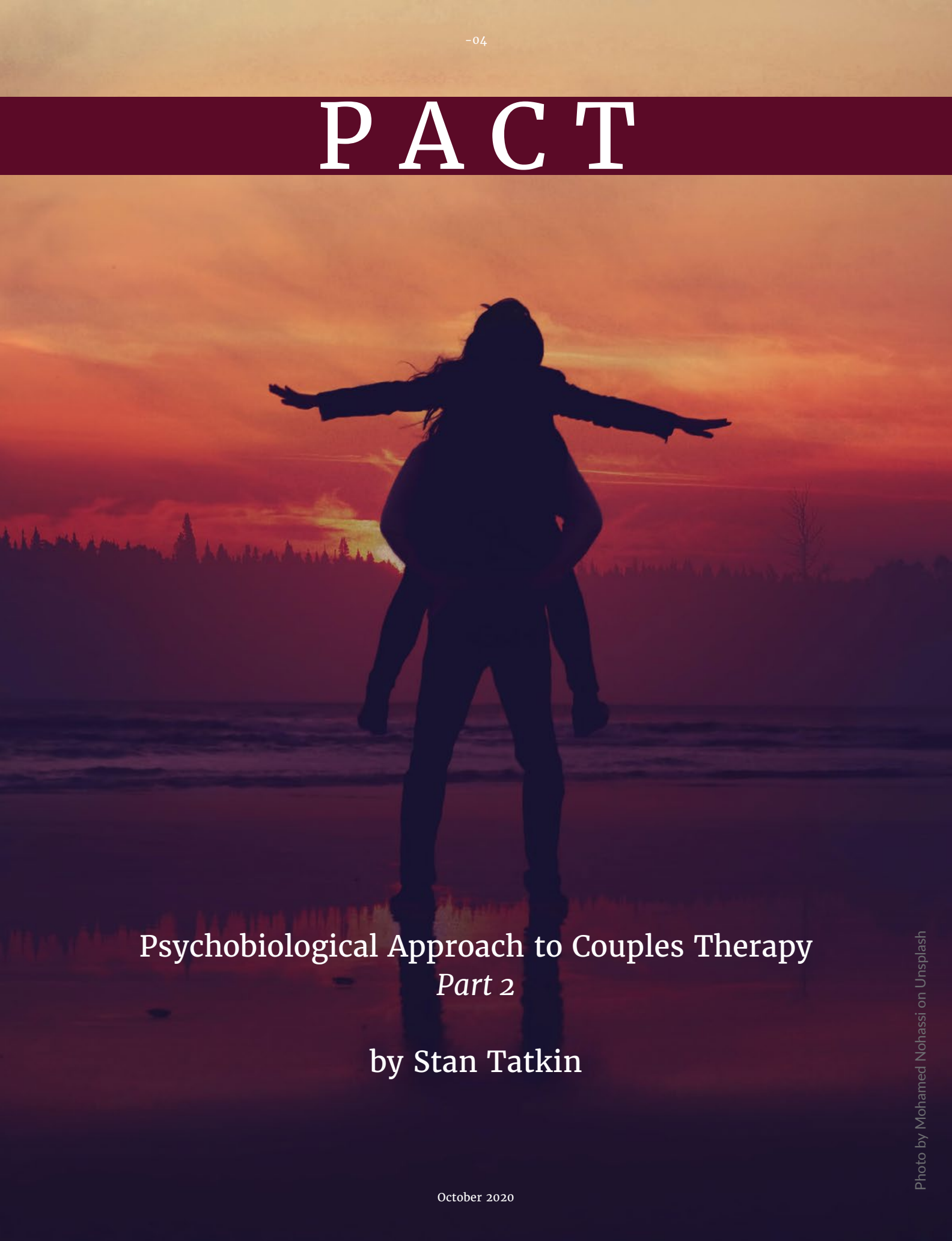
# PACT



## Psychobiological Approach to Couples Therapy
*Part 2*

by Stan Tatkin

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> Secure-functioning individuals might be thought of as adults who fully accept loss, disappointment, and the unreliability of feeling states to adjudicate various challenges and decision-making procedures.

## FEATURE

### USE OF ROLLING CHAIRS

The couple and therapist are seated in office-type chairs that are fully adjustable. The movable chair allows the couple therapist to self-regulate as well as create effective interventions with movement, body, face, and voice. The chairs allow the couple to freely move about and allows the therapist to monitor small movements and adjustments by each partner. The movable chairs also allow the therapist to manipulate partner position to get a somatic reaction.

### CROSS-TRACKING

*Cross-tracking* is the discipline whereby the therapist gaze shifts to the non-talking partner. The non-talking partner is expected to be spending fewer resources thus freeing them up to show more somatically in the face, in the body, in breathing, in movement. As soon as the talking partner finishes, the therapist's eyes go to the talking partner to view physical reactions. Left-brain language function of speech and comprehension take up many resources that inhibit the speaker's move-

*Editor's Note*: As promised in the September, this is the second part of Stan Tatkin's article on PACT. The first part delved into the theoretical framework and foundations of PACT. Now we are shown practical applications and implications. This completes the PACT story.

ments and facial expressions. Once the speaker stops talking, the therapist looks for what washes over that person's face and body and what, if anything, they do reflexively to self-sooth.

Eyes then shift back to the other partner and at the point of their beginning to talk, eyes go back to the nonspeaking partner. Eyes are shifting back and forth in the intermediate. Eyes not only shift back and forth between faces but also up and down to track the body, looking for any part of the body that could be an implicit "tell" that is particular to that person.

In order to collect tells, the PACT therapist must obtain baselines in the very beginning of therapy. To do that, the therapist must be able to shift partners states to get baselines on facial expression, body movement, posture, and vocal expression. Once baselines are obtained, the therapist can start to observe somatic tells that repeat in clusters and match those tells with content areas or other environmental factors. The PACT therapist never assumes to know the target or source of that partner's somatic reaction. They only flag a reaction for further investigation.

The PACT therapist is constantly interviewing and investigating in this manner of cross-questioning, cross tracking and also something called cross-interpreting.

## CROSS-QUESTIONING

The interview process is quite different. *Cross-questioning* focuses on a nontarget partner for getting information on the target. This has several functions. On the regulatory level, the therapist does not look at the target partner but rather at the nontarget partner. The question,

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no matter how provocative, will not disturb the target partner's arousal state in the immediate.

The cross-question is intended also to be a continuous check on the nontarget partners knowledge of the target. The target enjoys being a fly on the wall and hearing what their partner thinks or believes. The therapist then corroborates the information with the target partner and then crosses in the other direction. Similarly, the couple therapist employs cross-commenting or interpretation to direct attention to a partner's facial and vocal reactions in a direct therapeutic expectation of partner co-regulation.

## CROSS-INTERPRETING

Cross-interpretation is particularly effective when dealing with disorders of the self and insecurely attached individuals, those from the distancing group who are developmentally preoccupied with the integrity of the self. Therapists best serve their sensitivity to exposure, shame, criticism, and disapproval with cross-interpretation to the nontarget partner. This technique seems to have little impact on activating the target partner's narcissistic vulnerability or, therefore, defense. It is a strategy to direct eye contact to the nontarget partner, who is less likely to freeze since they are not the subject of the interpretation. The target partner remains relatively undisturbed, especially when the therapist uses the interpretation as a way to "rescue" the target partner from the other.

Under the auspices of explaining one to the other, the therapist can circumvent a partner's defensive reflexes by simply helping the target partner out. The therapist keeps close tabs on the target partner's reactions as they continue to make the interpretation based largely on theory. Because the therapist is unable to gauge any opposition by the target partner to the content, they can easily repair the breach by a) admitting that they were guessing and b) allowing the target partner to make the necessary correction.

*Cross-interpretation* is a strategic bypass of defense, which is useful when dealing with individuals in the distancing group (insecure) and those with type personality disorders (e.g., narcissistic personality disorder, NPD). In individual therapy, the therapist employs other methods, such as mirroring interpretations of narcissistic vulnerability to bypass the narcissist's exquisite vulnerability to exposure and attack. This method, based on a mnemonic of pain – self – defense, can be seen as a Trojan horse, a trick, so to speak, to circumvent the massively walled-off defenses of the NPD.

An example of employing the pain – self – defense mnemonic is as follows: "It seems so painful for you to feel this exposed by me in therapy that the way you soothe and protect yourself is to devalue me in the therapy." Notice the inclusion and worded sequence of pain, self, defense in that sentence. This mnemonic was created by James Masterson in his work with NPDs (Masterson, 1981). He found that this mnemonic worked, even if repeated frequently, to gain a therapeutic alliance with this particular disorder of the self.

We have found that we can make intensely strong interpretations based on theory and observation without activating the targets defensive system. The PACT therapist must shift eyes to the target, check their state, and make

repairs as necessary. The therapist checks their work to see if their interpretation is hitting the mark. The therapist often makes guesses and tells the target that by offering invitations, such as "Please correct me if I'm wrong." They check somatic tells to signal disagreement, discomfort, or negative reaction. If pushback or disagreement occurs, the therapist merely asks the target partner to correct it. No harm no foul.

Particularly important, cross-interpretation is a quick way to gain a therapeutic alliance with a partner from the distancing group, who is hyperaware of manipulation, therapist deception, and direct attempts to gain a therapeutic alliance. The PACT therapist may initially wait for opportunities to "rescue" or protect the distancing target partner from an attacking or complaining non-target partner as a strategic way to make otherwise uninvited cross-interpretations. Here's an example:

THERAPIST: [to the target] Let me help you here and correct me if I'm wrong.

TARGET: Sure.

THERAPIST: [to non-target] I understand what you're trying to say. However, there's something I don't think you understand about your partner here. If you look closely, you'll notice they feel they are being attacked and exposed. I sense your partner is exquisitely sensitive to feeling attacked and exposed and has always felt vulnerable in this way. [To target] And again, please correct me if I'm wrong.

TARGET: No, so far, you're good.

THERAPIST: [to non-target] I'm imaging this is made worse by the fact that your criticism them in front of me which is, perhaps, why they didn't want to come to therapy in the

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first place. It's too exposing. It's experienced as shaming. [Checking the target for signs of disagreement] And so they protect themselves by attacking back [or by withdrawing, being dismissive, devaluing, etc]. Do you know if any one else was shaming, attacking, or highly critical of them early on?

NON-TARGET: Yeah, their father. He was, and still is, brutal.

THERAPIST: [to target] Is that true?

TARGET: He didn't know any better. He did the best he could.

THERAPIST: [to target] Maybe so, but how horrible for you. I'm so sorry. I can understand why this whole process might be threatening.

And now the therapist is further along toward a therapeutic alliance with the distancing partner.

## DOWN THE MIDDLE

*Going down the middle* is a method for directing interventions at the couple system itself. The intervention can be an interpretation of the couple or, more commonly, a confrontation to challenge their maladaptive defensive behaviors in an attempt to gain a therapeutic alliance. By going down the middle, the therapist supports a confrontation at appropriate amplitudes without activating the couple's defenses.

The therapist remains in a neutral stance with eyes focused on a target between the partners. Confrontations, starting with "the two of you," "both of you," signal that the system is being addressed, not either partner. This technique levels the playing field by setting partners on an equal footing. Going down the middle tends to push the couple together, as evidenced by increased physical matching (synchronous movements).

Confrontations down the middle are scaled to the level of acting out and are intended to either stop or start a certain behavior. Therapists confront or interpret maladaptive defensive behaviors, considered self-harming and counter-therapeutic, to gain collaboration and cooperation and to focus the couple on the therapy. The task is to work on the relationship, and not to target each other, the therapist, or the therapy.

## USE OF DIGITAL VIDEO

Therapists record session for selective playback immediately following an event so partners see and hear what they see and hear. As a forensic tool, collecting markers that may have predictive value in future cases, digital video on a high-definition monitor is unmatched. In some instances, employing multiple cameras is valuable in capturing pupil size and angles one camera would miss.

PACT therapists use microanalysis to track somatic responses in the room as well as vocal changes, postural changes, skin color changes, changes in prosody, vocal pitch and speed, and other minute shifts that are captured frame by frame. Clinicians use video to look for what may have gone wrong during therapy or, after discovery that a partner has been lying, to rewatch and scan for markers. Video is also used as a feedback system for couples in therapy.

The therapist chooses an event for playback and focuses each partner's attention as collaborators. The couple corrects mistakes in

perception or interpretation the therapist may be making about an observation. Video offers large amounts of data and can have deleterious results if the therapist does not process it accurately. Also, therapists must show video immediately to make use of each partner's short-term memory. This coaching session is extremely helpful, often making the difference between partners continuing a particular behavior and understanding each other better.

With playback, the therapist can undermine the pro-self partner as to what's wrong in the relationship. The PACT therapist assumes that when partners are in pain, their narratives will turn to focus on their partner as the cause of the problem. Partners in pain generally do not come up with pro-relationship theories about their distress.

As for partners, seeing is better than hearing the therapist talk. The visual impact of watching oneself interact with another and seeing the subtle but significant implicit cues that trigger threat in the other is a game changer in therapy. People never see themselves in action, and real time is too fast to know what we are doing in any given moment.

We are employing lightning-fast recognition systems that are largely implicit in the procedural tasks we do. We give little time to energy-expending thought processes of the neocortex. Those areas are reserved for novelty and tasks that require continuous focus. Because they are energy-expending, the energy-conserving function of the brain and body is to utilize cheap, fast, automatic memory systems to do most tasks. One of the difficulties partners face is the always-present, energy-conserving function of the automatic brain.

While this is a feature in day-to-day life, it becomes a bug in relationships where memory is already drives recognition systems that precede the couple's own history. Without conscious threat reduction, couples trend toward the accumulation of threat, which eventually becomes biological. For example, couples commonly dysregulated in a repetitive way experience threat and a kindled hypothalamic system as their heart rates and blood pressures automatically rise when physically in the same room.

Video playback settles disputes when the therapist comments on problematic micro-behaviors. Understandably, partners will not necessarily believe the therapist. Using slow-mo-

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tion frame-by-frame playback clarifies the verbal feedback. Now the therapist has visual and auditory proof. Of course, video can disapprove things, including therapist misperception. However, the PACT therapist is constantly investigating what is true, so the occurrence of misappraisal is not a problem. It offers better course correction.

A PACT therapist as investigator focuses on "what is it" over "what to do about it." They understand that people are poor self-reporters. People make things up in their minds to fill in blanks they do not know. They protect their interests and avoid losses. As a result, they mislead the therapist by using deceptive tactics and because people are loss-averse, they bend reality.

In the couple therapy world, things are rarely what they seem. The therapist never takes a presenting problem as a truth. Rather, it's a starting place to delve into the granular truth of the matter, which is garnered by putting partners under pressure, utilizing inquiry to maximize the yield of reliable information, and studying each partner's shifts and changes. The PACT therapist uses "outsight" meditation by continually scanning each partner's face and body to catch them in the act of being themselves. The PACT therapist uses strategic methods to gain information, truthful information, by utilizing physical positions, eye contact, and the method of cross-questioning.

## THERAPEUTIC CONTAINERS

This approach orients couple therapists with the concept of containers. A container, as meant here, is a sort of architecture, or frame, that places the therapist and couple in a time-limited, exercise that provides valuable and reliable information about partners to both partners and therapist. These exercises, for lack of a better term, are often playful yet are all to some degree stressful. These containers (be they tasks, games, or exercises) help the therapist assess, elucidate, expose, or establish – through real-time partner interaction – issues concerning social-emotional function, attachment organization (or disorganization), arousal regulation, developmental delay, deceptive behavior or language, and so on. Containers can also provide a structural framework, set of instructions, a task or goal, or a role the therapist plays.

## FACE TO FACE

In every session, the therapist puts partners face-to-face and eye-to-eye at close distance. This is done initially to stress contact maintenance, the couple capacity tolerate sustained eye contact without talk talking. Partners are instructed to attend and not stare. They can laugh or cry but they are not allowed to talk, use sign language or other communicative gestures, or try to make the other react by making a face. The therapist attempts to observe such arousal indicators as heart rate (if visible), breath rate (chest or diaphragm), tension or relaxation in striated muscle areas in face and limbs, pupil size (if visible), skin coloration (blood flow), facial (muscular) controls, movements, and the like. The therapist makes note of anything unexpected or "flag-worthy" for further investigation. Generally speaking, the expected presentation is that of initial mutual excitement (sympathetic spiking) with

relatively quick settling and calming. Some partners will cycle between settled and excited (laughing or talking), while others cry, and other show strong controls in the head and neck region with bird-like micromovements. Still others might fail to mirror a partner's smile or appear overly self-referential and self-conscious.  and whether on the chest were belly, muscle tightness or looseness in the face hands and feet, their positioning and movement, pupil size, skin color, and facial muscular controls also monitored our signs of arousal dysregulation and other arousal signs such as laughing, crying, and urges to talk or talking.

## STAGING SCENES

The PACT therapist works with states. PACT therapists follow the idea that state drives memory, memory drives state, and state altars perception and sometimes radical ways. Because we are dealing with state driven memory, the PACT therapist uses longer than average session lengths to stage stressful events that are problematic for the couple. The states are staged much like a CSI investigation, like going back to the scene of the crime.

There are ways in which we will go step-by-step from the antecedent of the event and then, like an investigator, interview each partner incrementally as if going in real time utilizing body memory for recoil. "Before you get into the room, what are you anticipating, thinking, or feeling?" And then, "What do you think your partner is thinking or feeling or anticipating?" The same questions are asked of the other partner who was perhaps in a different location in the psychodrama. This is taken at each step where questions continue such as, "You see here now and what are you noticing? How is she looking at you, what is she doing? "Each follow-up question goes further, "What is her facial expression mean to you (or tone of voice, or posture, or movement)?" And then, "What do you think or imagine she's thinking or what do you think are her intentions at this moment?"

The staging moments are yet another container the therapist puts the couple in. Remember, the therapist is in this container as well. This container includes a task, a goal, and roles. The role of the therapist in this container is to be an investigator and not a therapist. This keeps the therapist on track and allows the couple to suspend disbelief and to stay in the psychodrama without disruption. It also keeps everybody on task and more likely to achieve the goal which is clarity, insight, and awareness of the multitude of errors that are occurring at every moment. These errors are in communication, perception, memory, and appraisal.

As we play the original scene (or event), the therapist may amplify possible errors with follow-up inquiries such as, "So when you see her turn her head you don't say anything. Is that correct? You don't ask if there's anything wrong? Is that right?" By asking these investigative questions, it becomes clear to couple and therapist, the choices partners make based on unchecked perception, attribution, and appraisal, that lead to behavioral alterations that will be misperceived and handled in the same, non-error-corrected manner by the other partner. Partner threat reactions amplify as mutual dysregulation accelerates in the fog of war due to an automatic, lightning fast, memory-based, implicit survival system.

Both partners are always responsible for both the trajectory and outcome of any one event. In staging, this concept becomes abundantly clear by demonstration. In the staging container, each partner is expected, after the detailed examination of a replayed event, to come up with several course-corrections that would alter event trajectory and outcome.

## THERAPEUTIC STANCE

In all forms of psychotherapy, the therapeutic stance or narrative is the therapist's idea of the therapeutic goal: "Where are we going?" "Where do I expect you to go?"

Arguably, no matter how skillful the therapist or how good the approach, any course of treatment without a firm, coherent, and consistent therapeutic narrative will go nowhere. The therapist must create the setting by which patients will be interested in what the therapist has to say. First, partners must buy into the therapeutic goal. If one or the other does not, that is where the work remains until partners reach a consensus. Without a shared goal, nothing can be accomplished.

The same is true if partners cannot agree on a purpose or shared principles on how they will govern and enforce agreed-upon guardrails. If, and when, partners agree on the therapeutic goal, the therapist must carefully apply and titrate sufficient pressure through explicit and implicit expectation that the goal be met, or therapy will stall. The main ingredient for caring is distress. The therapist must find the pain in each partner, amplify it, and leverage it toward the therapeutic goal. A couple's key interpretations, without some degree of distress and effort, will likely be dismissed. Thus, the couple therapist must strategically stage situations for partners to provide repeated evidence or proof before the therapist can confront or interpret partners or the couple itself.

Here's an important note: The PACT therapist neutralizes and forecloses on any attempts to pathologize or personalize problems discovered during treatment. Most clinical observations, interpretations, and confrontations used during therapy with a therapeutically allied couple – whether concerning error-saturated interactions, mutual dysregulation, insecure pro-self defensive posturing, or matters of real and perceived threat – are blamed on universally shared challenges arising from the base features (and bugs) of the human condition and the obstacles arising of the human brain's error potentials. Attachment insecurity is handled in an equally reassuring manner devoid of right/wrong, good/bad, or healthy/unhealthy. This helps destigmatize each partner and helps level the playing field. We have a saying in couple therapy: "No angels, no devils." And, we have another saying which is equally important to couple therapist and couple, "Where there's one, there's always the other," meaning, each partner participates in a system that can amplify either the best or worst in both self and other; and each possess the bite that fits the other's wound.

## THE ROLE OF PAIN

We might argue that therapists are in the business of pain. If our patients were not in any discomfort or distress, they would have little interest in what we provide. This is especially true with couple therapy. Often, treatment is

driven by one partner only. The other is merely coming along for the ride. The therapist must create a therapeutic alliance with both partners so the less interested partner is convinced that there's a good reason for them to be there. The therapist must find that partner's pain or distress in some way. This should be done in the first session. Without a mutual buy-in from both partners, there can be no therapy.

Without pain, the therapist has no leverage and nothing to offer a patient or couple. Only pain, stress, pressure, allows for interest and motivation as people want out of paying. They want to understand why they can't do something when pressure to do it. They want to understand why they're having a problem self-activating when pressure to self-activate. Without pain, the therapist cannot see what is actually going on.

The therapist should know that people lie, conceal motives, protect self-interests, avoid loss, and hide. The task of the therapist is to constantly find the patient or in early attachment terms, continually find the baby lose

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the baby and find the baby again and again. In order to do that, the therapist must understand that verbal narratives a barely reliable if at all. Because real time is too fast, lightning fast, because humans are memory animals that are constantly using recognition systems to make split moment decisions, it is not possible to know what we are doing at every given moment. Because of this fact, when push to explain, all people will make up to fill in the missing space of knowledge. The mind hits a vacuum and I don't know doesn't cut it not only with the outside world but even with the inside. We want to feel we know even though we don't. And so the brain's capacity to confabulate is employed and we come up

Therapy exists only when there is a therapeutic alliance. Therefore, in the beginning of all couple therapy, the therapist must be alert to the prevalence of lies and acting-out behaviors. Unless partners are secure functioning or both partners are deemed securely attached, they are not likely to come in with a therapeutic alliance. That is, all parties will not be firmly on task, working on the relationship itself, or behaving collaborative or cooperatively. In that case, the therapist must engage other tools to gain a therapeutic alliance and decrease or stop partners from acting out altogether.

Secure-functioning individuals might be thought of as adults who fully accept loss, disappointment, and the unreliability of feeling states to adjudicate various challenges and decision-making procedures. All principles are mutually agreed-upon with each partner being able to defend, in a complex way, how each principle serves both a personal and mutual good.

These partners understand the human brain's error potential and are much more careful in their understanding of threat and how to reduce it on a day-to-day basis. They are very good at co-regulating distress and attenuating in reducing the time it takes to relieve one another. These couples are skillful in getting in and out of conflict quickly, getting things done, and shifting mutual states so that any burst of distress never infects the rest of the day and the other segment of the day. In other words, secure-functioning partners are generally good co-regulatory teams.

It should also be said that, though there is a relationship between self-regulatory function as well as co-regulatory function and attachment, the two are not necessarily on the same track. It is entirely possible for individuals to be secure functioning while having lifelong problems with self-regulation. Having said that, some individuals in clinic with the poor self-regulatory function do quite well in a match with a partner who functions as a master regulator in the dyadic system and thereby can take up the slack. However, when that master regulator is not available physically or ill, the system can easily become dysregulated. The same is not true when the non-master regulator partner is missing physically or ill.

## REFERENCES

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