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Childhood trauma, attachment style, and a couple's experience of terminal cancer: Case study

LINDA M. MCLEAN, MSC., PH.D., C.PSYCH.,[1,2] AND SARAH HALES, M.D., F.R.C.P.(C)[1,2]

[1]University Health Network, Princess Margaret Hospital, Department of Psychosocial Oncology and Palliative Care, Toronto, Ontario, Canada
[2]Department of Psychiatry, University of Toronto, Toronto, Ontario, Canada

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ABSTRACT

Objective: The primary objective of this article is to elucidate the significance of psychosocial distress and risk in a sub-population of end-stage cancer patients and their spouse caregivers who present with an especially challenging attachment style and histories of childhood trauma. The case study presented highlights the need to both identify and offer an empirically validated couple–based intervention, along with a multi-disciplinary team approach over the trajectory of the illness and at end of life.

Method: A validated marital protocol (emotionally focused couple therapy [EFT]) is modified for this population and conducted by an EFT-trained psychologist as part of a pilot investigation as to the feasibility and effectiveness of EFT for the terminal cancer population. Measures of marital distress, depression, hopelessness, and attachment security are completed at baseline and subsequent intervals, as reported in another publication. Attachment insecurity and the exquisitely intimate relationship with caregiving and care receiving are underscored, given the couple's traumatic childhood history.

Results: The couple described herein, followed from diagnosis of metastatic disease to end of life illuminates the potential effectiveness of a modified EFT protocol, and underscores the need to both identify and intervene with a population potentially at significantly high risk for marital distress, suicidality, depression, and hopelessness.

Significance of Results: The benefits of a multidisciplinary team is evident as the patient's symptoms of physical distress increased toward end of life and she returned to earlier behaviors, namely suicidal ideation and an attempt to alleviate her experience of suffering. The strength of the marital bond, possibly as a result of the intervention, and the efforts of the multidisciplinary team approach, demonstrate potential to mitigate a catastrophic end of life and a complicated spousal bereavement. This case study adds to the current empirical literature in an area that is currently under-studied and under-reported.

KEYWORDS: Terminal cancer, Childhood trauma, Couple intervention, Palliative care, Good dying and death

INTRODUCTION

Cancer and the Marital Dyad

There are few case studies in the literature to elucidate the psychological distress of terminally ill cancer patients and their spouse caregivers, who present with histories of childhood trauma (Johnson, 2002). It is estimated that 33–50% of all cancer patients and their spouse caregivers experience clinically relevant emotional distress or functional impairment over the course of disease (Kissane et al., 1994a, 1994b; 1996a, 1996b; McLean & Jones, 2007; McLean et al., 2008; Weihs & Reiss, 1996; Ybema et al., 2001). Research has demonstrated a high concordance between the patient and their partner in regard to psychological adjustment (Douglas,

Address correspondence and reprint requests to: Linda M. McLean, University Health Network, Princess Margaret Hospital, Psychosocial Oncology and Palliative Care 16-755, 610 University Avenue, Toronto, Ontario, Canada, M5G 2M9. E-mail: lmmclean@rogers.com

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1997; Eton et al., 2005; McLean & Jones, 2007; McLean, et al., 2008; Northouse et al., 1995; Northouse et al., 1998). Distress is often amplified during the terminal phase of cancer when patients experience more disease-related symptoms (Weitzner et al., 1999) and the couple face the most significant changes in well established roles and responsibilities, and ultimately, anticipatory loss and grief (Carlson et al., 2000; Tan et al., 2005). There is an emerging research literature that highlights the need to identify couples most at risk for psychological distress during end-stage cancer to facilitate mutual support throughout the illness experience and alleviate bereavement morbidity in the spouse caregiver (Burman & Margolin, 1992; Kissane et al., 1994a, 1994b, 1996a, 1996b; MacCormack et al., 2001 Weihs & Reiss, 2000).

Attachment and Trauma

Attachment style is a psychological factor that is highly associated with patient and spouse caregiver distress in end-stage cancer (Hunter et al., 2006; Braun et al., 2007). Attachment theory suggests that humans are innately equipped with care-seeking and care-giving systems, selected through evolution, to ensure protection and survival. Early experiences with caregivers form enduring internal working models that are stable and persistent patterns of cognition, emotion, and behavior exhibited in important relationships, such as marital relationships, throughout life (Bowlby, 1969, 1973, 1980). Individuals develop either positive or negative models of self and others. As such, individuals can view themselves as either worthy of support and love, or as unworthy of support and love. Furthermore, individuals can view others as available and trustworthy, or unreliable and rejecting (Bartholomew, 1990). Combinations of these models of self and other yield a four-category model of adult attachment style, including secure, insecure anxious-preoccupied, insecure avoidant-dismissing, and insecure avoidant-fearful (Bartholomew & Horowitz, 1991). Individuals with secure attachment styles view themselves as worthy and believe that significant others will usually be responsive and accessible. These individuals endorse low levels of anxiety and low levels of avoidance, and they are more able to seek and accept care in times of need. Individuals with an insecure anxious-preoccupied attachment style regard themselves as unworthy of care, however have a positive view of others. These individuals appear dependent on others, experiencing high levels of distress, low self-esteem, emotional lability, and a strong need for approval (Bartholomew, 1990). People with an insecure avoidant-dismissing attachment style view themselves as worthy, however regard others as rejecting and untrustworthy (Bartholomew, 1990). In undervaluing the significance of important others, they tend to be compulsively self-reliant and fearful of depending on others (Bowlby, 1979, 1988). Characteristically, these individuals have restricted emotional expression and outwardly appear independent (Bartholomew, 1990; Tan et al., 2005). Individuals with an insecure avoidant-fearful attachment style view themselves as unworthy and tend to expect that others will be rejecting and untrustworthy. This attachment style is the most unpredictable and caregivers may be assigned conflicting and changing roles: the bearer of all attachment security producing dependency, the inadequate attachment figure, stimulating anger, and the predatory threat, producing mistrust and fear (Hunter & Maunder, 2001). The insecure avoidant-fearful attachment style is strongly correlated with a history of trauma and borderline personality disorder (Lyons-Ruth & Block, 1996), and chronic posttraumatic stress (cPTSD) (McLean & Gallop, 2003).

Illness is a threat that heightens attachment needs and insecurities. End-stage cancer is uniquely threatening as it is associated with greater dependency for patients and greater caregiving demands for spouses, mutual anticipatory loss, and grief (Tan et al., 2005). Moreover, while life-threatening illness meets the traumatic stressor exposure criteria of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR, 2000) for posttraumatic stress disorder (PTSD) (Akechi et al., 2004), low prevalence rates demonstrated in cancer patients (e.g., Gurevich et al., 2002; Green et al., 1998) suggest that cancer-related experiences themselves may not commonly result in a clinical diagnosis of PTSD (Akechi et al., 2004).

In the case of couples where one is facing terminal cancer and they present with histories of childhood abuse, especially physical and/or sexual abuse most often perpetrated by close attachment figures, "all close relationships tend to be contaminated by the trauma" (Johnson, 2002, p. 48; Johnson, 2004). Partners may have never known a safe attachment bond and are likely to have relatively rigid insecure attachment styles that challenge the creation of a secure bond. Both partners may be in caught in negative patterns of interaction, absorbing states of insecurity and confirming the world and others as dangerous and themselves as helpless. As such, there is a paradox: the attachment figure becomes at once the source of, and the solution to, alarm. Those who have insecure style of engagement will not only find it more difficult to create a secure bond, but also be more susceptible to the stress that terminal cancer invokes, as such insecurity impacts affect regulation, information processing, as well as the process of

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communication among partners. Emotion in those with avoidant-fearful attachment styles may be expressed in somatization, hostility, and avoidance through instrumental tasks (Mikulincer et al., 1993), often leaving the partner feeling abandoned and rejected. In regard to processing information, attachment insecurity constricts and narrows the ways in which cognitions and affect are processed (Johnson, 2002, p. 53). Finally, attachment insecurity impacts communication behaviors, such as self-disclosure, empathic listening, assertiveness, and collaborative problem solving, all basic to the formation of intimacy and security in relationships (Johnson, 2002, p. 53).

Due to high levels of emotional distress, relational need and distrust, patients with histories of trauma are often perceived as the most challenging and difficult for health care providers (Fonagy, 1998). The following presents the case of a married couple, both with a history of trauma and attachment insecurity facing the end of life experience. The couple provided written informed consent in participating in a pilot study (McLean et al., 2008), that received approval through the Toronto Academic health Sciences Council (TAHSC) for Human Subjects Research. Personal information including names is modified to protect the identity of the couple.

The objective of this case study is to potentially inform treatment of similar patients and families and illustrates the benefit of: 1) a clinical focus on the marital unit informed by an understanding of trauma and attachment needs; 2) provision of end-of-life care with a multidisciplinary health care team approach for ongoing consultation and support in face of high patient and family relational needs and mistrust; and 3) realistic clinical goals with a focus on tolerance of distress rather than an idealized death without distress.

CASE OF HEATHER AND STEVEN

History of Present Illness

Heather was a 60 year-old Caucasian woman, supported by a disability pension, who had been living for two years with metastatic ovarian cancer. Her husband, Steven, was a 30-year-old Caucasian man. Heather had been referred to a palliative care physician for pain management shortly following diagnosis of her metastatic disease. During her initial assessment with the palliative care physician she expressed a desire for hastened death. The couple was referred to psychosocial oncology for assistance coping with advancing disease and end of life.

During the initial assessment with the psychologist, Steven and Heather, as participants in a pilot study (McLean et al., 2008), were administered standardized measures including the Revised Dyadic Adjustment Scale (RDAS) (Busby et al., 1995), the Beck Depression Inventory-II (Beck et al., 1996), the Beck Hopeless Scale (BHS) (Beck et al., 1974), and the Experiences in Close Relationships Scale (ECR) (Brennan et al., 1998) (see McLean et al., 2008 for study protocol/results). Both partners endorsed marital distress, clinically significant depression, were non-hopeless, and presented with insecure avoidant-fearful attachment styles.

During this session, Steven and Heather described experiencing her progressive disease as traumatic and acknowledged this was amplifying longstanding relational distress. Heather explained, "It is difficult for me to depend on anyone…to ask anyone for help or care". Steven explained, "I have a deep fear of rejection and abandonment and I long for close connection". The couple found themselves caught in a distressing, negative cycle of communication and behavior in which Steven would pursue Heather, wanting connection and to fix their problems, while Heather would feel trapped and withdraw. During this cycle, both escalated their defensive responses, saying angry and hurtful words to each other. Heather and Steven endorsed passive suicidal ideation with no active plan or intent and expressed support of the notion of euthanasia as " a way out of pain and suffering", be it emotional or physical. Clinical depression was explored in depth, with an emphasis on the availability of psychiatric assessment however neither Steven nor Heather were accepting of such a referral.

Personal History

Heather, an only child raised by a single mother, described an early history of extensive physical, emotional and sexual abuse. In the context of maternal absence and neglect, Heather was abused by numerous male perpetrators, both intrafamilial and extrafamilial. Steven described an early childhood which involved physical and emotional abuse. The significant perpetrator of abuse was his mother and he characterized his father as uninvolved and highly critical.

Past Psychiatric History

Heather described a long history of depression unresponsive to antidepressant medication. She reported a history of chronic suicidal ideation in the context of depression and three former suicide attempts by overdose in adolescence and young adulthood, and possibly, cPTSD. Despite these chronic difficulties managing affect, in later adulthood she had achieved relative emotional and relational stability. Steven's

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psychiatric history involved episodic individual therapy after marrying Heather.

Course in Treatment

Heather and Steven were interested in a marital intervention to address their relational problems. They were seen every one to two weeks over an 18 month period by the psychologist for marital therapy using a modified EFT approach. EFT, formulated in the early 1980s (Johnson & Greenberg, 1985), arose from the synthesis of experiential (Rogers, 1951) and systemic therapeutic approaches (Minuchin & Fishman, 1981), and a theory of adult love viewed as an attachment process (Bowlby, 1969, 1980, 1988). The focus is on how partners process their emotional experiences (i.e. intrapsychic processes) and how partners organize their interactions into patterns and cycles (i.e. interpersonal processes). EFT has been modified to incorporate the special needs and challenges of this population (McLean & Nissim, 2007). Examples of several issues interwoven for this population are the following: the impact of the terminal diagnosis; awareness of the control of physical symptoms such as pain; assessment of anticipatory grief vs. clinical depression; the impact of physical changes; decline and changing roles; the importance of working with past trauma, attachment insecurity and the need for relationship security; the process of reviewing one's life, and existential issues including meaning and spirituality in some couples (Cohen & Block, 2004; Kuhl, 2003). For Heather and Steven, primary therapeutic goals involved assisting both partners in gaining individual insight into the associations between their traumatic childhood histories and resulting defensive responses. Heather's cancer diagnosis and progression were framed as additional traumas that amplified these responses and complicated provision and experience of mutual support. With increased understanding and the ability to take individual responsibility for their contribution to their distress, the hope was that their marital bond would become stronger. After the initial eight sessions, Steven and Heather reported a breakthrough in their pattern of distress and an internal shift in awareness that allowed them to respond in more effective ways, sharing more primary feelings rather than secondary defensive reactions. They both felt a new sense of control in their ability to de-escalate a distressing cycle. There was clearly more support, empathy and love evident in their interactions.

During the 18 months of marital therapy, Heather continued to be followed by outpatient palliative care as well as community home-based palliative care and was experiencing increasingly debilitating pain. Her primary palliative care physician continued to adjust medications to improve pain control with some benefit but Heather reported anxiety that future worsening of symptoms could not be avoided. In a session with the psychologist, Heather explained, "I am not afraid of death. I am afraid of it being long and drawn out with no control of my pain. But I have had enough suffering. I want an end to this". Steven stated, "I don't want to lay a guilt trip on her but if she dies as peacefully as possible of illness, I will grieve, but if she commits suicide, I will go crazy". In this session suicidal ideation was explored in depth and an active plan and intent were denied. Once again, referral to a psychiatrist and member of our multidisciplinary team was declined. Shortly after this session, however, Heather attempted suicide by ingesting a significant overdose of benzodiazepines while Steven was at work. Heather telephoned Steven 14 hours after the overdose. He asked if she wished an ambulance to be called and she consented. Heather was taken to the emergency room, and then transferred to the inpatient palliative care unit.

Upon admission, a psychiatric consultation was requested due to Heather's increased and now actively planned suicidality. During this assessment Heather endorsed significant depressive symptoms, frustration with the limitations and dependency created by her fatigue and pain, anticipatory anxiety about future deterioration, and distrust and hopelessness that any of her caregivers could help her. While she continued to endorse suicidal ideation, she also admitted ambivalence about her wish to die exhibited by her telephone call to Steven and her willingness to go to hospital for help. Given her psychiatric history of failed treatments with antidepressants, she dismissed consideration of pharmacotherapy for her symptoms.

Upon consultation with Heather, Steven, the psychologist, the psychiatrist and palliative care physician, it was decided that, if possible, Heather should remain a voluntary patient in order to maximize her sense of control and independence. The team agreed better physical symptom control might relieve some of Heather's distress and in turn, decrease her suicidality. Heather and Steven agreed to a short admission for pain and symptom management.

After a week in hospital, with improved pain control, Heather expressed a desire for discharge home and, despite the ongoing suicide risk, Steven supported this. Shortly before discharge was to occur, however, Heather developed an agitated delirium with persecutory delusions that Steven and her nurses were trying to kill her. She disconnected her pain pump and attempted to leave the hospital. The palliative care physician approached Heather with a calm and non-aggressive manner and eventually

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convinced her to return to her room voluntarily and accept sedating medication. Following this incident, Steven understood he could no longer care for Heather at home. As her substitute decision maker, he agreed to ongoing hospitalization and treatment of her agitation with regular antipsychotic medication. Heather spent her final days of life in hospital with Steven at her bedside without further episodes of agitation. Steven was subsequently followed by the psychologist in bereavement.

DISCUSSION

For most patients with advanced cancer, disease burden and loss of independence are distressing and patients may benefit from individual, marital, or family assistance by psycho-oncology professionals in addition to vigilant attention to the patient's physical symptoms, disability, and health care needs. Attachment style and quality of the marital relationship are predictive of a couple's effectiveness in coping together with the trajectory of the illness, and ultimately, death. For individuals with a history of trauma, cancer can be experienced as another trauma that activates attachment insecurities and can complicate cancer treatment and palliative care provision. They may exhibit simultaneously or alternatingly highly distressed need for and highly mistrustful rejection of help from both informal and formal care providers. Heather and Steven, both with histories of trauma and insecure avoidant-fearful attachment styles, experienced increased marital distress and dysfunction in the context of her advancing disease. With a modified EFT treatment approach, this couple was able to examine and restructure patterns of emotional experience and interaction allowing a shift from an insecure to a more secure bond. While the couple-based intervention and multidisciplinary approach potentially contributed to this couple's quality of life, marital satisfaction and cohesion, as Heather's cancer resulted in increased disease-related burden and physical distress, her capacity to regulate her tolerance of uncertainty and affect again became difficult toward end of life. She found herself acting out a way to "end suffering", namely suicidal ideation and attempt, as she did in adolescence and early adulthood. This case study offers support to the notion of the challenging aspects of early childhood trauma, an avoidant-fearful attachment style and its association with borderline personality disorder and chronic posttraumatic stress disorder, within the terminal cancer population.

This case also demonstrates the importance of a holistic, multidisciplinary approach in providing cancer care to dying individuals and families with traumatic histories. Heather and Steven's early relationship experiences created expectations that caregivers would be ineffective and threatening. When Heather's physical and emotional symptoms increased, she had little trust that her psychologist, psychiatrist, or palliative care physician were going to be able to help her which amplified her anxiety and suicidal ideation. In turn, her mistrust and escalating symptoms had the potential to frustrate and demoralize her treating team. Our department is a combined psychosocial oncology and palliative care service allowing regular consultation and collaborative care among professionals. Through regular formal and informal meetings, education, and mutual support, the psychosocial and palliative care providers were able maintain a therapeutic relationship with Heather and Steven. This allowed ongoing physical and psychological symptom management and perhaps prevented a catastrophic and traumatic suicide that might have complicated Steven's bereavement.

Finally, this case illustrates the importance of individualizing psychosocial treatment goals in the context of end-of-life care. Heather and Steven continued to experience crises throughout Heather's dying process, but with the support of a skilled psychotherapist, they also had the opportunity to experience, at times, increased safety, containment, reflective awareness, relational satisfaction, harmony, and sense of control and autonomy. If her palliative care or psychosocial oncology team had promised Heather or Steven that she could have a death free from physical or emotional distress, this might have set up unrealistic expectations that would have destroyed the fragile alliance that had been obtained over the years she had been treated for her metastatic disease. Instead the team held a position of commitment and dedication to respond to their needs with hopeful optimism that there could be relief. For many health care providers, the idealized "good" death is one without distress and with death acceptance and preparation. For many individuals and families this may not be possible, particularly if there is a long history of chronic affect and relational instability. In fact, for many patients, imposition of idealized death expectations by health care providers may lead to struggles for control and autonomy and entrench patients in a pessimistic and hopeless outlook. In these cases, a focus on an individualized "good enough" or acceptable death may be more realistic and less paternalistic (Hales et al., 2008). Therefore, more attainable clinical goals may be increased tolerance of distress and dependency needs and maximizing a sense of control.

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