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PREFACE

Before we proceed with the introduction to this text on couple therapy, we should address a few substantive and structural issues. An obvious question relates to our choice in writing about a couple therapy practice model specifically focused on survivors of childhood trauma. One may ask why each of us gravitated to this topic and how we decided to work together. Since there are many ways of coauthoring a text, the process we chose to follow also deserves attention. Finally we discuss some technical considerations regarding the use of clinical case material.

First we briefly describe how our professional interests in this topic were sparked. Since 1970, after the completion of my master's in clinical social work at the University of California at Berkeley, I (K.B.) have consistently practiced in a variety of mental health settings, with a wide range of culturally diverse clients with varying presenting issues. I first met Dr. Dennis Miehl as a colleague/classmate in 1985, when I returned to complete my Ph.D. in clinical social work at the Smith College School for Social Work. At the time, my academic and practice interests were grounded in psychodynamically oriented individual therapy as well as feminist-informed intergenerational and object relations couple and family therapy. Many years of intensive work with high-conflict divorcing couples drew me to focus on trauma theory as a useful theoretical lens for practice and research on child custody decisions, post-divorce. My fascination with synthesizing often disparate theoretical constructs peaked while I completed my clinical internship at the Department of Psychiatry at the George Washington University Medical Center. The department was the setting for ongoing debates as to the optimal practice models for use with individual clients diagnosed with characterological issues, many of whom had survived childhood trauma. Al-

though psychoanalytic practice, based primarily on the work of Otto Kernberg, ultimately prevailed, ongoing critiques illuminated alternative perspectives for understanding the legacies of childhood trauma. A social constructionist stance allowed me to synthesize my psychodynamic training with trauma theories and immersion in couple and family therapy practice models. As my academic interests deepened, my clinical interests shifted to more couple, family, and individual therapy practice with survivors of childhood trauma. I continued to reflect, write, present locally and nationally, conduct research, and practice in this area.

In 1977, I (D.M.) completed my M.S.W. degree at Wilfrid Laurier University in Waterloo, Ontario. I was immersed in working with a range of couples and families in my first clinical position in London, Ontario. I worked in a United Way–funded agency, and my clients represented the range of sociocultural diversity in this southwestern Ontario urban community. I dealt primarily with what were termed, at that time, “multiproblem families,” and in retrospect I realize that I was working with many dual-trauma couples. In keeping with the prevailing treatment mode of the time, I practiced as a systemic/structural family therapist. My interest in working in mental health peaked when I worked in large in-patient mental health settings in two health care centers. In addition to having serious and chronic mental health issues, many of my individual clients had experienced persistent and ongoing traumatic experiences. I began to look for practice models that would synthesize the biological, social, and psychological. Many clients had multiple diagnoses, and a single theoretical model was insufficient to prepare me to be a competent practitioner. Over time I expanded my training in psychodynamic theories and began to synthesize a range of theories. I had an avid interest in applying dynamic concepts to my couple and family work, and I developed expertise in couple therapy. My dissertation, completed at the Smith College School for Social Work in 1989, examined the impact of adult attachment factors on the beginning stages of intimate partnerships. In that project, I studied factors that promoted growth (resilience) within couples and laid the groundwork for the ongoing application of object relations, attachment, and family theories in my work with couples.

In the mid-1990s, we recognized that we shared similar interests in clinical practice with traumatized couples and started down our path of writing

together. Since that time, we have each presented on aspects of couple therapy with trauma survivors in a range of clinical and academic settings, both nationally and internationally.

As we embarked on this book project, we entertained different approaches to writing. Early on, after consultation with the director of our college's writing center, we altered our shared inclination to co-write each chapter. Instead, we have approached the writing of this text by dividing the tasks involved. After we actively discussed the ideas, controversies, purpose, and structure for each chapter, one of us assumed primary responsibility for writing that chapter. We have regularly commented on and edited each other's writing. Each of us has also contributed clinical case material throughout all of the chapters.

The use of clinical vignettes or case studies warrants some review here. In using any clinical case material, authors must always thoughtfully consider how to balance the inclusion of illustrative material with the requirement to use confidential case material responsibly. We have followed the specific guidelines outlined by the American Psychological Association in its *Publication Manual*. Confidentiality is usually handled by one of two means. "One option is to prepare the descriptive case material, present it to the subject of the case report, and obtain written consent for its publication from the subject. The other option is to disguise some aspects of the case material so that neither the subject nor those who know the subject would be identifiable." Three main strategies have emerged to accomplish an effective disguise. They are "(a) altering specific characteristics, (b) limiting the description of specific characteristics, and (c) obfuscating case detail by adding extraneous material" (*APA Publication Manual*, 2001, p. 9).

We arrived at a mutually supportive yet intellectually challenging collaboration in which we both worked together actively to present this couple therapy practice model and also retained our individual writing voices. We shared responsibility for coauthoring Chapters 1 (Introduction) and 13 (Gay/Lesbian/Bisexual/Transgendered Couples and Families). Dennis Miehls assumed primary responsibility for Chapters 2 (Historical Review), 3 (Social Theory), 6 (Object Relations Theory), 7 (Attachment Theory), 10 (Clinician Responses), and 14 (Immigrant and Refugee Couples and Families). Kathryn Basham assumed primary responsibility for Chapters 4 (Family Theory), 5 (Trauma Theory), 8 (Biopsychosocial Assessment), 9 (Phase-Oriented

Couple Therapy Model), 11 (Clinical Case Illustration), and 12 (Military Couples and Families).

Although this project has demanded perseverance and rigor from each of us throughout the past two years, our collaboration has clearly enriched and strengthened our mutually respectful collegial connection.