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Introduction

We face an unfortunate reality of increasing numbers of individuals who have endured childhood trauma; who have survived interpersonal and domestic violence; or who, as refugees, have sought asylum from political violence, armed conflict, or torture. As clinical social work practitioners, we need to respond effectively to these individuals who request clinical services to assist in coping with trauma-related issues and symptomatology. In addition to the pathways that lead to posttraumatic stress disorder (PTSD) or complex PTSD syndrome, many Americans have experienced residual effects in the aftermath of the September 11, 2001, terrorist attacks. With certainty, we are aware that many American citizens suffer ongoing, debilitating fears concerning further terrorist activity, including biological and chemical warfare. This climate of heightened anxiety is fueled by ever-increasing rates of violence and child maltreatment and by the ravages of poverty.

The demographic data regarding childhood trauma in the United States are quite alarming. The National Clearinghouse on Child Abuse and Neglect Information (2004) reported that in 2001 approximately 903,000 children were found to be victims of child maltreatment, a figure that represents 12.4 per 1,000 children in the population. In 1996, the third national incidence study of child abuse and neglect, based on reports from Child Protective Services, revealed substantial increases in the incidence of child abuse and neglect as compared with the data gathered from the prior national study completed ten years earlier (Sedlak & Broadhurst, 1996). Rates of physical abuse nearly doubled, those of sexual abuse more than doubled, and incidents of emotional abuse and neglect were two and one half times higher than the earlier levels. Contrary to stereotypical cultural assumptions, the data revealed no significant differences according to race. However, children from

the lowest income families were eighteen times more likely to be sexually abused, almost fifty-six times more likely to be educationally neglected, and twenty-two times more likely to be seriously maltreated or neglected as compared with children from higher income families. Girls are abused sexually three times more often than boys. Although child abuse is sometimes underreported, it appears that low socioeconomic status and female gender are major risk factors in child maltreatment.

As this book goes to press, U.S. military forces are actively engaged in war in Iraq and at the same time facing increasing threats of terrorist activity with chemical, biological, or mass-destruction weapons. The impact on military personnel and their families will undoubtedly be life changing. Some military personnel who return to the United States from Iraq will require interventions from clinical social work practitioners.

Within this sociopolitical context, we propose a couple therapy model grounded in a synthesis of psychological and social theories and attuned to the survivors of traumatic experiences. Although emphasis is placed on the legacies of childhood traumatic events, attention is also paid to the effects of traumatic experiences in adult life. The rationale for writing this text emerges from each of our extensive clinical experiences, respectively, with a diverse range of individuals, couples, and families who have wrestled with the legacies of trauma.

:: THE COUPLE THERAPY PRACTICE MODEL

Without question, legacies of childhood trauma often affect adults in both elusive and fairly direct manners. Although some survivors of childhood trauma approach their adult lives with a unique zestful resilience, others experience difficulties in their capacities for attachment and intimacy (Rutter, 1993). Pain and distress may occur not only on an internal or intrapsychic level, but in interactions with other people as well. As many adults strive to maintain satisfying and productive partnerships, the majority of adult trauma survivors find themselves in relationships that require active work. In addition to issues of intimacy, trust, and control in decision making in these partnerships, parenting also assumes primary importance for many survivors. Although some researchers suggest a low incidence of intergenerational transmission of abusive behaviors from parents who had been abused as children, there is also a population of adults who were abused

as children who actively struggle to use the most effective, nonabusive disciplinary methods with their children (Higgins, 1994; Kaufman & Zigler, 1987).

In spite of what we, as clinicians, see as an increasing prevalence of violence and traumatic events in our society, an accompanying backlash movement reinforced by false memory syndrome proponents is evident (Loftus, 1993; Loftus, Polonsky, & Fullilove, 1994). Major litigation directed against clinicians who have either allegedly or deliberately induced traumatic memories in the course of therapy has further undermined the veracity of some clients' reports. Denial and dissociation remain powerful defenses, not only for clients, but for clinicians as well. As one client who survived the Holocaust as a child stated very directly, "No one can bear to imagine the enormity of the torture and abuses inflicted by one human to another, and so there is a strong pull to minimize and avoid the reality of such abuses."

Although opponents of the mental health system often accuse mental health practitioners of serving only the "worried well," the real world of contemporary practice involves a vast number of adults who have experienced childhood abuse. It is imperative therefore that, in the midst of a political climate that denigrates relationship-based psychotherapy while overvaluing productivity and rapid behaviorally defined progress, we continue to advocate for culturally informed, theoretically grounded, relationship-based clinical social work practice. In our efforts to challenge denials of childhood abuse, it is equally important to avoid the opposite extreme. Here, the risk of problematizing the situation and amplifying aftereffects of trauma could obscure the transformative experiences and positive adaptations for many trauma survivors.

In the field of traumatic stress, treatment has typically focused on individual and group psychotherapy modalities as well as psychopharmacology (Briere, 1996; Courtois, 1999; Figley, 1988; Krystal et al., 1996; Pearlman & Saakvitne, 1995; Shapiro & Appelgate, 2000; van der Kolk, 1996, 2003). Within the past few decades, a number of cognitive–behavioral clinicians have developed psychoeducational couple and family therapy practice models aimed at supporting the family members of a traumatized individual client (Compton & Follette, 1998; Riggs, 2000). In particular, a number of feminist-informed clinicians have developed empowerment therapy models to help the partners and families of trauma survivors (Bass & Davis, 1988; Gil, 1992; Miller, 1994; Walker, 1979). More recently, eye movement de-

sensitization reprocessing (EMDR) and dialectical behavioral therapy (DBT) have been popular and useful models for some clients (Linehan, 1993; Shapiro, 1995; Shapiro & Maxfield, 2003). Yet, once again, the primary therapy goals have involved working through individual aftereffects of traumatic events.

:: EFFECTS OF LEGACIES OF TRAUMA ON COUPLING

Several important questions arise in working with couples where one or both partners may have experienced childhood trauma. First, in what ways do trauma-related aftereffects influence an individual's capacity for a partnership? Second, in what ways do these trauma-related aftereffects influence the relationship itself? Third, in what ways do these couples present issues that are relevant for many adults, in particular, in what ways are their concerns directly related to the sequelae of childhood trauma? Fourth, in what ways are these couples unique?

Aftereffects of trauma are not restricted to the individual. In fact, family members are not only affected by the legacies of childhood trauma, but they also influence, both positively and negatively, the survivor's experience. As a result, it is important to pay attention to the role of couple therapy with adult survivors of childhood trauma that relies on social, psychological, and neurobiological theories as a way of understanding the multiple influences affecting a couple (Basham & Miehls, 1998a, 1998b). The range of influences is organized around institutional, interactional, and intrapersonal factors.

Constructs of Trauma

Before continuing with a discussion related to the legacies of childhood trauma, the constructs of trauma need to be defined. Although social constructionists posit a relativistic view of trauma based on the socio-cultural context at a given moment in time, this fluid approach points to a range of meanings offered by researchers and clinicians in their definitions of trauma.

Figley's (1988, 1995) definition of trauma is useful in a general way. He refers to trauma as an emotional state of discomfort and stress resulting from memories of an extraordinary, catastrophic experience that shatters a survivor's sense of invulnerability to harm, rendering him or her acutely vul-

nerable to stressors. Herman (1992) discusses how traumatic events over-whelm an ordinary system of care that gives people a sense of control, con-nection, and meaning in the world.

This couple therapy practice model focuses primarily on type II trauma, the sequelae of childhood sexual, physical, and/or emotional abuse (Terr, 1999). However, in the context of reenactments of a trauma scenario, some adult trauma survivors also find themselves in domestic violence situations in adulthood that qualify as type II traumatic experiences of a chronic, repet-itive nature. Regrettably, many adults who have experienced childhood trauma have also experienced type I traumatic events throughout their lives. Examples of these type I discrete traumatic events include natural disaster, accident, rape, or terrorist attack.

Different definitions are proposed for type III trauma. Kira (2002) dis-cusses a wraparound treatment approach for survivors of torture. He defines this torture trauma as a modified model of complex PTSD or cumulative trauma disorders that specifically describe the effects of torture. Torture is viewed as "any systematic act by which severe pain or suffering, whether physical, emotional or mental, is intentionally inflicted on a person for any reason, by or at the instigation of or with the consent or acquiescence of a public official or another person acting in an official capacity" (Kira, 2002, p. 23). Clearly massive psychic traumatization also resulted from the horrific genocidal, often tortuous, acts inflicted during the Holocaust and, more re-cently, in Rwanda and Bosnia.

A number of researchers, social scientists, and clinicians propose another definition of type III traumatic experience. They tentatively propose the nosology of type III trauma as related to the chronic repetitive insults in-flicted on individuals who are marginalized based on race, disability, sexual orientation, or religion. Allen (1998), Daniel (1994), Pinderhughes (1998), and Pouissant and Alexander (2000) assert that day-to-day racist assaults in-flicted on people of color perpetuate the legacies of slavery and colonization. In addition, they believe strongly that such racist practices should also be understood as potentially harmful and traumatic. The cultural devastation resulting from the internment of Japanese Americans during World War II and the disenfranchisement of First Nations peoples in the United States are two other examples of culturally sanctioned trauma (Daniel, 1994). The heightened surveillance of Muslim adults and families at this time has led to culturally sanctioned traumatic events as well. (In this text, when we refer to

type III trauma, we are considering the latter definition that relates to the cumulative daily culturally sanctioned abuses inflicted on marginalized populations. When we refer to the effects of torture, we will note this clearly as such.)

Each clinician must be mindful of the effects and legacies of type I, II, and III traumatic events on the lives of his or her clients. Although many children demonstrate extraordinary resilience in withstanding the pernicious effects of catastrophic events and do not suffer PTSD symptomatology, many experience derailments and interference in their identity development and relatedness to others. The severity of aftereffects are generally related to six factors: (1) the degree of violence, (2) the degree of physical violation, (3) the duration and frequency of abuse, (4) the relationship of the victim to the offender, (5) the age of the child when abusive events occur, and (6) the innate constitution of the child (Terr, 1999). When abuse occurs during infancy, the emergence of basic trust, a sense of cohesive identity, and the capacity for secure attachment are undermined. However, if abuse occurs after a child has developed a sense of cohesive self with object constancy, the aftereffects may lead to a DSM-IV-TR diagnosis of PTSD or the diagnosis of complex posttraumatic syndrome or disorders of extreme stress not otherwise specified (DESNOS) (APA, 2001; Friedman & Marsella, 1996; Herman, 1992; Mock, 1998). These latter diagnoses are more useful in understanding the complex processes of identity formation, including distortions in identity and dissociative phenomena that are more prevalent among clients with a history of repetitive maltreatment.

The "victim–victimizer–bystander" scenario is a central construct that warrants review (Herman, 1992; Miller, 1994; Staub, 1989, 2003). Children who have been subjected to physical, sexual, and/or emotional abuse have experienced victimization at the hands of an offender (or victimizer). At the time, a bystander either remained detached and failed to help, or else interrupted the abuse directly or through dramatic rescue efforts. Not only has a survivor of childhood trauma related to other people with these different roles, but she has also internalized a "victim–victimizer–bystander" template that guides her worldview. As individuals are perceived in the "victim," "victimizer," or "bystander" role, the earlier trauma scenario is reenacted in adolescent and adult life. Through the process of projective identification, the unconscious internalized conflict is projected outward through enactments of various roles. For example, a trauma survivor might alternately adopt a victim stance, with an overzealous-rescuing "bystander" role, while dis-

owning her internal aggressive "victimizer" role. This "victim–victimizer–bystander" relationship template is vitally important in understanding intricate interpersonal processes as well as intrapersonal processes. However, we must be mindful to use this knowledge constructively to enhance our understanding about patterns of abuse rather than using the reenactments of the trauma scenario to justify blaming a victim of real maltreatment.

The Cultural Relativity of a PTSD Diagnosis

The exploration of the legacies of childhood trauma raises the controversy surrounding the increasing popularity of the DSM-IV-TR diagnosis of PTSD (APA, 2001; Keane, Weathers, & Foa, 2000). Although the heuristic nosology of a PTSD diagnosis provides a useful way to understand the impact of trauma among diverse cultural groups, the culture-boundedness of the model limits a universal generalizability (Friedman & Marsella, 1996; Mock, 1998).

A discussion of different constructs of trauma is incomplete without acknowledgment of the major role of resilience in mediating the impact of traumatic events. Various research projects have discovered a range of findings related to the absence, or presence, of the development of PTSD syndrome following a traumatic event. Not surprisingly, many studies report that children who live in violent communities are at higher risk for developing PTSD symptomatology (McCloskey & Walker, 2000; Pynoos, Steinberg, & Wraith, 1995). However, rather than presuming that PTSD is an inevitable response to horrific events, Allen (1998) found that a majority of African American individuals demonstrated distinct resilience following a traumatic event without developing PTSD symptoms. It is important to stress that such findings should remind us of the potential resilience of all individuals exposed to maltreatment and violence. However, it is equally important to guard against an assumption that certain people who have been marginalized, whether by racism, ablism, classism, or homophobia, are somewhat inured to trauma. Such an attitude would perpetuate a racial bias.

Cultural anthropologist, Judith Zur (1996) conducted a research study that explored perceptions of the Quiche, a group of indigenous Guatemalans, during their civil war. As this conflict involved genocidal activity, a Western viewpoint might predict PTSD among survivors. Instead, this researcher pointed out the absence of the social context in assessing PTSD, and

concentrated on two elements of social context. First, the Quiche study participants held a belief that fate is responsible for acts of violence. Such a stance relieves the offenders of responsibility for their actions. Second, they valued emotional constraint as the optimal way of coping with their bereavement. Because overt grief is tolerated only for nine days as a cultural prescription, these families experienced the ongoing loss of a loved one as an economic, rather than a personal, loss. Finally, disturbing dreams, typically viewed as PTSD symptomatology, were instead interpreted by the Quiche as valuable portents from the dead and provided a source of relief. For those trauma survivors who suffered from political genocide, research data suggest the importance of evaluating the cultural meanings of trauma-related phenomena before prematurely recommending a treatment regimen for PTSD or complex PTSD. As the number of refugees from war-torn countries seeking sanctuary in the United States and Canada increases, it is imperative for clinicians to react in a culturally responsive manner to these couples and families in crisis.

:: SYNTHESIS OR INTEGRATION?

To design an effective culturally responsive couple therapy practice model, it is essential to attend to institutional, interactional, and intrapersonal factors affecting adult survivors of childhood abuses. Although family issues are often discussed in couple therapy, the unit of focus for this model is the dyad (i.e., the couple), when one or both partners have survived experiences of maltreatment in childhood. We will refer to these couples as either single-trauma or dual-trauma couples. For these couples, the presenting problems range from parenting concerns, relationship ruptures, conflict surrounding roles and responsibilities, sex and intimacy, financial strains, spiritual ennui, and adaptations to a new culture. However, if physical violence exists as one of the presenting problems, couple therapy, as a modality, is contraindicated. Instead, an advocacy approach is recommended to help the victim first access safety. In treating any couple, it is useful to rely on a range of biological, psychological, and social theories to assess a couple from different perspectives. Changes in the couple's capacities and needs may also call for continuing flexibility from the clinician in formulating assessments and treatment plans.

Many integrative couple therapy models aim to incorporate different theoretical models into a whole, through a blending or melding of constructs (Balcolm, 1996; Horowitz, 1998; Riggs, 2000). Instead, we propose a process of synthesis by combining discrete, and, at times contradictory constructs into a unified entity. Such an approach has usually been equated with eclecticism, an often-devalued approach in social work. Negative stereotypes are often hurled needlessly at eclectic practitioners who weather accusations of randomly constructing a potpourri of unassimilated theoretical constructs. A more accurate definition of eclecticism refers to a choice of the best elements of all systems.

Still, this definition differs from synthesis, which aims to build a unified plan with disparate constructs. A serendipitous benefit of such a practice model is the high value placed on the flexible use of different lenses to understand the uniqueness of the couple. Metaphor is helpful in describing this stance. If you visualize staring through a crystal, you may see differences in the texture and color of an object depending on what part of the multi-faceted glass you are observing. Similarly, the fabric of this theoretical synthesis shifts color and shape over time during the course of different phases of couple therapy.

In a similar fashion, a case-specific practice model changes the synthesis of theoretical models depending on the unique features and needs assessed for each couple. Therefore, the assessment and therapy process sustains a continuing dynamic flow of theory models that advance to the foreground while other theoretical models momentarily remain in place in the background. This phase-oriented couple therapy practice model attends differentially to the centrality of the presenting issues. Important decision-tree processes occur at the initial contact with the couple, during the assessment phase, and during the course of the phase-oriented treatment.

Although a range of psychological and social theories are available in the knowledge base of the clinician at any given moment, data forthcoming from the couple's presenting concerns determine which set of theoretical lenses advance to the foreground. Certain theoretical models, however, are used from the onset of treatment. For example, since a relationship base provides the foundation for the practice model, it is essential to understand relationship patterns through the lenses of object relations and attachment theories (Kudler, Blank, & Krupnick, 2000; Lindy, 1996; Scharff & Scharff, 1987). In

addition, social constructionist, racial identity, and feminist theories shed clarity on the family's social context (Manson, 1997; Marsella, Friedman, Gerrity, & Scurfield, 1996; Pouissant & Alexander, 2000). As a couple reveals their shared narrative, the presenting issues further signal which theoretical approaches may be especially relevant.

Stated concerns about interactional patterns in a couple's relationship call for the use of an historical family perspective to explore family patterns, rituals, or paradigms. A narrative family perspective may also illuminate the multiple and unique meanings of the trauma narrative(s) (Sheinberg & Fraenkel, 2001; Trepper & Barrett, 1989; White, 1995; White & Epston, 1990). Symptoms of clinical depression may signal the need to employ a cognitive–behavioral lens to explore affect regulation and cognitive distortions. In general, a review of the cognitive, affective, and behavioral functioning of each partner addresses mastery, coping, and adaptation (Compton & Follette, 1998). Finally, in the individual arena, trauma theory focuses on the short- and long-term neurophysiological effects of trauma on brain function, particularly memory and affect regulation (Krystal et al., 1996; Schore, 2001a, 2001b; Shapiro & Appelgate, 2000; van der Kolk, 1996, 2003). Although an assessment of each partner's trauma history is necessary in all cases, trauma theory may recede in centrality if an assessment reveals the absence of traumatic events. However, in situations in which one or both partners suffered maltreatment in childhood or adult life, trauma theory should remain one of the central theoretical lenses situated in the foreground of couple therapy. In particular case situations, it becomes clear how all of the social and psychological theory lenses are present concurrently from the onset and throughout the course of therapy. However, one or more theoretical lenses may advance to the foreground during the therapy, when that perspective may be relevant to a particular pressing issue at hand.

In summary, this synthesis of neurophysiological, social, and psychological theoretical models informs the biopsychosocial assessment that subsequently guides the direction of practice. A compelling image shared by our dean, Carolyn Jacobs, captures the dynamic process metaphorically (Jacobs, personal communication, 2003). While reflecting on a journey taken several years ago through the Serengeti Plain, she commented on her observations. Struck by a spectacularly beautiful and vast landscape, she was initially aware of the vivid range of primary and muted shades of red, brown, beige, and yellow painting the undulating landscape. After some time, the guide

pointed in a particular direction toward the distant horizon. Very slowly, with a steady gaze, it was possible to see the distant detail of lions, hyenas, wild dogs, and flocks of varied birds revealing themselves. As she stared ahead, the scene changed continually, with different perceptions shifting dynamically back and forth. It was possible, however, to observe and hold the movement of the fauna and flora in the context of the broader background vista. In a similar process, holding the tensions of multiple, often contradictory theoretical perspectives requires flexibility in perception, understanding, and action on the part of the clinician. Knowledgeability about these varied models and perceptiveness is also an essential requirement to sustain this ephemeral yet solid stance.

:: ORGANIZATION OF THE TEXT

The book is organized in four sections: Context, Theoretical Foundations, Couple Therapy Practice, and Specific Clinical Issues. The first section, Context, provides the sociopolitical and historical context for the couple therapy practice model for adult survivors of childhood trauma. Chapter 1 offers an introduction to the text, including a rationale for the couple therapy practice model along with an explication and deconstruction of the range of definitions associated with trauma. In Chapter 2, a thorough and substantive historical review of the traumatology literature highlights the shifts over time in theory and practice within their sociopolitical contexts. Shifts from individual and group treatment models to a focus on practice modalities with couples and families are traced as well.

The second section, Theoretical Foundations, consists of five chapters that provide the theoretical scaffolding for the couple therapy practice model. They include Chapter 3: Social Theory, Chapter 4: Family Theory, Chapter 5: Trauma Theory, Chapter 6: Object Relations Theory, and Chapter 7: Attachment Theory.

The third section, Couple Therapy Practice, contains four chapters devoted to the explication of the phase-oriented couple therapy practice model. In Chapter 8: Biopsychosocial Assessment, the relevant institutional, interactional, and intrapersonal factors are reviewed that contribute to the completion of a thorough biopsychosocial assessment of the couple. In Chapter 9: Phase-Oriented Couple Therapy Model, we describe how the biopsychosocial assessment guides the creation of a treatment plan. Decision-making

processes are included along with a discussion of the ways to build a facilitative therapeutic alliance. The phases of the therapy model are reviewed in detail. They include Phase I: Safety, Stabilization, and Establishment of a Context for Change; Phase II: Reflection on the Trauma Narrative; and Phase III: Consolidation of New Perspectives, Attitudes, and Behavior. Practice themes that are central for all traumatized couples in therapy are addressed. They include (1) composition of a "couple," (2) the role of violence, (3) parenting, (4) sexuality, (5) affairs, (6) dual diagnoses (i.e., substance abuse/addictions and complex PTSD), and (7) dissociation. In Chapter 10: Clinician Responses, we focus on the range of emotional, cognitive, and behavioral responses for the clinician working with traumatized couples in a couple therapy frame. Although we understand the intersubjective nature of the therapeutic alliance, efforts are made to tease out elements of personal, cultural, and objective countertransferential responses. The influences of vicarious traumatization and racial identity development are also explored. In Chapter 11: Clinical Case Illustration, we feature the case example of Rod and Yolanda, which illuminates the use of the couple therapy practice model.

The final section of the book, Specific Clinical Issues, focuses on specific clinical issues with particular client populations. They include Chapter 12: Military Couples and Families, Chapter 13: Gay/Lesbian/Bisexual/Transgendered Couples and Families, and Chapter 14: Immigrant and Refugee Couples and Families.

We now turn our attention to the historical view of couple and family therapy practice models designed for couples who choose to transform the legacies of their traumatic experiences from their childhood and adult lives.