Emotionally Focused Therapy with Couples Impacted by Childhood Sexual Abuse

by

Deborah Palmer

A Practicum Report
submitted to the Faculty of Graduate Studies
University of Manitoba
in partial fulfilment for the degree of
Masters of Social Work

THE UNIVERSITY OF MANITOBA

FACULTY OF GRADUATE STUDIES

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CHAPTER ONE

INTRODUCTION

The intent of this practicum was to implement the model of Emotionally Focused Therapy for Couples (Johnson; 1996, Johnson & Greenberg, 1989) as a clinical intervention with couples where the female partner has experienced childhood sexual abuse and to evaluate the effectiveness of the intervention on their intimate relationships. Intimate relationships require that individuals have trust, communication, a willingness to meet each other's needs, negotiate conflict, balance issues of power and control, and maintain physical and emotional contact. These aspects are potentially threatening for women who have experienced childhood sexual abuse and have difficulty in their intimate couple relationships. Herman (1992b) describes the impact of childhood sexual abuse as a violation of human connection. Trauma intensifies our need for safe connection and at the same time undermines our ability to create and maintain such relationships. Therefore, couples therapy has the ability to create safe healing relationships. The capacity to connect and receive comfort from another human being is a more powerful predictor of healing than the trauma history itself (van der Kolk, 1996).

Interventions for the treatment of sexual abuse have usually focused on individual therapy and group therapy. This can complicate the interpersonal dynamics in a couple relationship. Couples therapy strengthens the bond between a couple that can provide comfort, care, and protection. This secure base in an intimate relationship outshines the weekly one hour of safety provided in individual therapy. Emotionally Focused Therapy (EFT) for Couples is based on clear, explicit conceptualizations of marital distress and

adult love. This theory is based on an adult attachment perspective that focuses on creating an emotional connectedness that nurtures contact and comfort. It focuses on the concept of self as lovable and deserving of love with a partner that is loving and trustworthy. In the process of therapy, the couple shapes new bonding cycles that are antidotes to insecurity. Consequently a securely attached individual can assert the self, tolerate differences, and ask for comfort. The goal in EFT is to facilitate the development of a safe and secure bond between partners. Therefore, couples therapy may be an effective treatment to resolve the impact of child sexual abuse trauma.

Background

My interest in couples therapy for women who have experienced childhood sexual abuse and their intimate relationships has been a natural progression as I have developed my skills as a social worker. Most of my clinical experience has been working with women who have experienced sexual violation. Often, the content of the therapy sessions would shift to the client's experience with her intimate partner. It was difficult to capture the dynamics of relationship with only one of the partners in session. As I began providing couples therapy at The Laurel Centre, I was always surprised that observing the couple's interpersonal dynamics gave more context to the impact of sexual abuse trauma. When I started doing work with couples, I was deeply moved by the connection and attachment I witnessed in relationships. I saw the importance of creating connection with the significant other as a way to expand the healing experience. Often the connection in the relationship was not safe, but being alone was too terrifying for the client.

Emotionally Focused Therapy for Couples provided me with a concise framework that fit my theoretical understanding of the impact of trauma and a map that works well with trauma survivors.

Learning goals

1. To increase my knowledge of how the trauma of childhood sexual abuse impacts on a couple's relationship.

2. To increase my knowledge of couple work specifically with women who have experienced childhood sexual abuse and their intimate partners.

3. To develop my assessment and clinical skills in working with couples where one partner has experienced childhood sexual abuse.

4. To increase my understanding of the use of evaluation in clinical practice.

5. To gain skills in the intervention of Emotionally Focused Couples Therapy as a model of intervention with couples where one of the partners has been impacted by sexual abuse.

Importance to Social Work

The values of generalist social work, and its ecological or person-in-environment perspective, is reflected in the use of couples therapy as an intervention for individuals and their partners impacted by childhood sexual abuse. It confronts the interactions between individual, family, and societal influences by integrating the literature addressing the impact of childhood sexual abuse on couple relationships. Emotionally Focused

Therapy for Couples creates safe connections in relationships by incorporating the intrinsic value of people. Healing occurs in a context and the development of social supports from intimate relationships is an important value in social work practice. My passion for working in the area of childhood sexual abuse is congruent with social work values which focus on a commitment to human welfare, social justice, and human dignity.

Organization of the Practicum Report

This practicum report is laid out in chapter format. Chapter one as it has been presented, provides an introduction to the practicum and topic of interest. Chapter two provides a review and discussion of the relevant literature on the impact of childhood sexual abuse and issues for couples therapy, and introduces EFT for couples. Chapter three outlines the practicum procedures, describing the setting, participant selection, discussion of the intervention with the couples, and the evaluation process. Chapter four provides an extensive analysis of the intervention with two couples. Chapter five provides a discussion of the themes and issues raised in the practicum. Chapter six concludes with examination of my learning objectives and further recommendations.

CHAPTER TWO

LITERATURE REVIEW

This chapter is a review of the issues relevant to working with women who have experienced childhood sexual abuse. Particular focus is on the impact of childhood sexual abuse on intimate relationships. Couple therapy as a method of intervention with those who have experienced childhood sexual abuse is also reviewed.

Definition of child sexual abuse

Walker (1998) proposed the following broad working definition, created from a feminist perspective, of child sexual abuse:

> It is essential to recognize as crucial elements the misuse of power and authority, combined with force or coercion, which leads to the exploitation of children in situations where adults or children sufficiently older than the victim have greater strength and power, seek gratification through those who are developmentally immature and where, as a result, consent from the victim is a non-concept. Such gratification can involve explicit sexual acts - anal or vaginal intercourse, fondling, masturbation - or may involve invasive and inappropriate actions not directly involving contact: watching a child undress, bathe, use the toilet, in order to gratify the perpetrator rather than meeting the needs of the child; forcing a child to watch adults having sex or making them watch pornographic videos. What is central is the exploitation

> of the child; the denial of their rights and feelings, and the essential gratification of the abuser through the child, the child being regarded solely as an object for the perpetrator's use and to meet their needs. (p. 11)

This thorough definition places childhood sexual abuse in a social and political context where adults hold power over children and men hold power over women. The denial of rights and feelings with the use of power and coercion may have detrimental effects on the development of children, impacting the capacity to form nurturing and safe relationships.

Long-term effects of childhood sexual abuse

To have an understanding of the impact of child sexual abuse trauma on relationships, it is important to have a clear working knowledge of the effects. Although the impact may be unique to each person, research and clinical practice have identified common themes. The impact of child sexual abuse has been associated with many disruptions in individual and interpersonal functioning. The initial and long-term effects of child sexual abuse have been well researched, and include an increased risk of negative internal experiences such as depression, anxiety, intrusive memories, rage, and shame (Polusny & Follette, 1995; Roth & Newman, 1993). Some survivors report self-harming behaviour patterns for emotional avoidance and tension reducing functions (Briere, 1992; Follette, 1994). Self harming behaviour patterns such as binge eating, substance abuse, suicide attempts, and self-multilation occur at higher rates among survivors (Briere &

Runtz, 1993; Connors & Morse, 1993). The impact of child sexual abuse is similar to the psychological difficulties experienced in post traumatic stress disorder (Anderson, Yaesenik, & Ross, 1993; Dye & Roth, 1991; Herman, 1992).

Briere (1996) divides the long-term effects of child sexual abuse into four categories: (a) post-traumatic stress, (b) cognitive effects, (c) emotional effects, and (d) interpersonal effects. Browne and Finkelhor (1986) developed a framework for understanding the effects of child sexual abuse. They describe four traumagenic (trauma causing) dynamics as the core of the psychological injury inflicted by the abuse: traumatic sexualization, betrayal, powerlessness, and stigmatization. Each dynamic has its own resulting psychological consequences and behavioural dynamic.

Trauma literature categorizes symptoms such as intrusion, avoidance, and hyper arousal under the psychiatric diagnosis of Post Traumatic Stress Disorder (PTSD) (Carlson & Furby, 1997; Herman, 1992a, 1992b; Rodriguez, Ryan, Kemp, & Foy, 1997; Van der Kolk, 1996). According to the DSM-IV (1994) experiencing a situation that involves intense feelings of fear, helplessness and horror are a precursor of PTSD. PTSD is characterized by contradictory and oscillating episodes of re-experiencing of the event (intrusion), paired with episodes of avoidance or numbing. Re-experiencing is the intrusive recollection of the trauma, dreams, feelings that the trauma is actually recurring, or distress in response to psychological or physiological triggers. Avoidance may include avoidance of thoughts, feelings, or talking about the trauma, avoidance of reminders of it, memory loss, reduced participation in activities, feelings of estrangement,

restricted affect, and a diminished sense of future. Herman (1992b) has termed these contradictory reactions between avoidance and re-experiencing as the "dialect of trauma " (p. 47), which manifests in the struggle between the need for truth telling and the need for secrecy.

In the growing body of research over the years, it is clear that PTSD alone does not explain the pervasive impact of sexual abuse. In addition to the symptomology associated with PTSD, Dolan (1991) lists dissociative responses, memory problems, irrational guilt, sexual dysfunction, disturbed eating behaviour, substance abuse, compulsive sexuality, self-destructive behaviour, socially maladaptive behaviour, difficulty with trust. depression, anxiety, and impaired self -esteem. Courtois (1988) identified reactions in the emotional, interpersonal, social, and esteem aspects of those who have experienced trauma. Van der Kolk (1996) recognizes the effects of trauma as impacting on the emotional, cognitive, somatic, characterological, behavioural, and spiritual aspect of people's lives. Long term effects of trauma have been labelled as: (a) generalized hyperarousal and difficulty in modulating arousal - which may manifest as aggression against self and others, inability to modulate sexual impulses, and problems with social attachments such as excessive dependence or isolation; (b) alterations in neurobiological processes involved in stimulus discrimination which manifests in problems with attention and concentration, dissociation, and somatization; (c) conditioned fear responses to trauma related stimuli; (d) shattered meaning propositions which manifest in loss of trust, hope, and sense of agency; (e) social avoidance which manifests in loss of meaningful attachments and lack of participation in preparing for the

future.

The extensive impact of childhood sexual abuse has impelled Herman (1992a, 1992b) and van der Kolk (1996) to further press for a new diagnosis which more accurately reflects the extensive impact of childhood sexual abuse. They argue that although PTSD may fit for a discrete trauma experience such as rape or a natural disaster, an expansion of this concept would better reflect the effects of prolonged and repeated trauma such as childhood sexual abuse on individuals. The distinguishing factors of captivity and coercive control are what differentiates these two types of experiences. Based on this, Herman (1992a) argues that PTSD needs to be expanded to include additional symptomology, distinct characterological changes, and vulnerability to repeated trauma after the trauma. She has termed this Complex-Post Traumatic Stress Disorder (C-PTSD).

The trauma of childhood sexual abuse can influence the self-definition of an individual such as knowledge about likes, dislikes, feelings or values, including the ways in which one is different from or similar to others. In other words, self-definition refers to the characteristics associated with any given individual. Defences associated with trauma, or the fragmentation of memory and self, obviously interfere with the integration of knowledge and experience and thus identity (Briere, & Runtz, 1993; Herman, 1992a).

Russell (1986) describes the extensive damage to identity and self-esteem as an existential crisis for women who have been sexually abused in childhood. The betrayal patterns their connection with others with a generalized mistrust, familiarizing them to the experience of others using them to meet their own needs, or abandoning them.

Relationships are not experienced as safe connections that nurture and protect them.

Attachment is a concept that is often associated with object relations theory - a theory of personality development that connects individuals with their social environment, particularly their early childhood experiences. People in general, and children in particular, seek increased need for protection when they are in danger. When no one else is available, people may turn to their source of fear for comfort (Johnson, 2000). Van der Kolk (1996) indicates that the capacity to connect and receive comfort from the presence of another human being is a more powerful indicator than the trauma history of whether people are able to heal. In an environment of abuse, attachment takes on a different meaning when dependency for survival becomes entrapment or captivity (Courtois, 1988, 1997).

Childhood sexual abuse can seriously interrupt normal developmental tasks regarding social and physical sexual development. Dating patterns and the development of intimate relationships is disrupted (Courtois, 1988). Clinical experience strongly suggests that adults who were sexually abused as children are more likely to report problems in the sexual area (Maltz & Holtman, 1987). A disruption of sexual function may manifest as some form of sexual withdrawal (Maltz, 1988). Other individuals may become hyper sexual with periods where there are numerous sexual partners and sexual contacts (Briere & Runtz, 1993). Courtois (1988) noted that two predominant sexual styles emerge - socially and sexually withdrawn or indiscriminately sexually active. Some sexual problems experienced by individuals who have been sexually abused are desire disorders, arousal disorders, orgasmic disorders, coital pain, and frequency and

satisfaction difficulties. Defences such as denial, numbing, and dissociation may occur during sexual intimacy. Sexual activity may trigger sexual abuse memories or flashbacks that hinder sexual intimacy between partners (Courtois, 1988).

Sexual abuse in childhood may result in confusion regarding sexual reference and sexual orientation. Some survivors who identify as heterosexual may choose to be with a woman because of their fear of males. Their view of men may be skewed because of their experience, thus the belief that all men are unsafe and potential abusers (Courtois, 1988).

Sexual abuse is an ultimate betrayal of trust which results in problems in relating. For the individual who has experienced childhood sexual abuse, everyone may be considered untrustworthy. When this is experienced, the individual feels re-victimized and may project feelings of distrust, fear, disillusionment, mistrust, overvaluation, devaluation, and hostility in the relational patterns. Relationships may be experienced as one way, empty, superficial, guarded, idealized, conflictual, or sexualized. Therefore, individuals who experience childhood sexual abuse may experience special difficulties with intimate committed relationships. The openness and trust necessary in committed relationships may be experienced as a threat. Abuse dynamics may complicate choice of partner and the subsequent interactions. Male partners may be both feared, and over valued and often idealized. Individuals who have experienced childhood sexual abuse may choose an older partner to care for them or continue their caretaking pattern or choose an immature partner. They may choose partners

who were also abused and neglected. Often early family patterns are repeated and the survivor continues to experience negative self-worth and mistrust of others. Early family patterns and unresolved difficulties may also be repeated with in-laws and authority figures (Coutois, 1988).

This discussion of the long term effects of childhood sexual abuse provides an overview of some of the impacts of sexual abuse, however is not an exhaustive description of the traumatic effects of childhood sexual abuse. Furthermore, it is important to note that the effects of childhood sexual abuse can be complex and multifaceted and while some individuals may experience extreme difficulties, other individuals grow up and develop healthy coping strategies and maintain intimate, close relationships. The next section of the paper will explore additional contributions from the literature that speak more directly to the impact of childhood sexual abuse on intimate relationships.

Rationale for Couples Therapy

Safety and a sense of control over life are necessary for people who have experienced childhood sexual abuse. Without genuine safety, the individual cannot give up coping strategies that protect her from further psychological harm. Without reestablishing her own personal power, the woman cannot be expected to regain control of her life. Empowerment not only suggests independence, but also the movement past personal independence to interdependence - the state of being independent and dependent - with other people. Thus the woman's relationships

can be an important part of therapy. The individual therapist helps the woman feel safe within the therapy session, and actively works with her so that she can feel safe and empowered in life outside of session. Child abuse brings with it difficulties in interpersonal relationships and sexual dysfunctions that seriously affect an intimate relationship. Sometimes couples therapy is indicated, either simultaneously with or as an adjunct to, individual treatment. If the women's partner is supportive during the intense periods of treatment, the relationship may survive with greater strength and mutual commitment. However, sometimes it is impossible for the partner to forgo having his or her needs met for the length of the time it takes for the victim to recover. The woman's self-absorption and pain are so great that she may not be able to relate to her partner or her children for long periods of time (Walker, 1995).

Many women who have a history of child sexual abuse, describe their couple relationships as dissatisfying and turbulent (Herman, 1992a). They tend to experience more fear and distrust of others (Briere & Runtz, 1987) and experience difficulty with assertiveness and effective communication (Van Burskirk & Cole, 1983). Many survivors experienced a range of sexual problems, including decreased sexual satisfaction and desire, increased sexual dysfunction, and a tendency to engage in multiple, short-term relationships (Courtois, 1988).

Childhood sexual abuse occurs in an interpersonal context with emotional intimacy mixed with the abuse of power. Therefore, it is common for survivors to have ambivalence about forming close and trusting relationships in adulthood, or

do not have the necessary skills for sustaining intimate and fulfilling relationships (Briere, 1992). The couples may experience decreased emotional expressiveness within their relationships, and report more difficulties with feeling connected to each other (Gottman, 1994).

The first effect of trauma mentioned in the DSM-IV is persistent re-experiencing of trauma. This includes intrusive thoughts, nightmares, flashbacks, and physiological reactions to trauma cues. This impacts on a couple relationship when a partner experiences a sense of helplessness when physically touched that would evoke an immediate fight, flight, or freeze response. These responses alienate partners who may experience this reaction as rejection. Some survivor's sense of shame makes it difficult to openly communicate about such responses. This undermines her ability to form a secure bond with her partner (Briere, 1992, Johnson 1998). Relearning positive interactions that create safety, security, and relatedness in an intimate relationship can help in healing those who have experienced childhood sexual abuse. Couples therapy is able to address key elements in healing such as comfort, the fostering of confidence, and the validation of self in everyday interactions as lovable and worthwhile.

The first step in understanding and diagnosing childhood sexual abuse in couples therapy is to recognize child sexual abuse as a contributing factor in interactional and psychological dysfunction (Mennen & Pearlmutter, 1993). Gelinas (1983) identified that survivors of incest show serious negative effects arising from sexual abuse. According to Gelinas, when they do not disclose

childhood sexual abuse, they usually show a disguised presentation. If this presentation is the focus of treatment, therapy tends to unsuccessful and the client is at risk to repetitively seek treatment. Individuals who were physically or sexually abused (Busby, Steggell, & Adamson, 1993) present with higher levels of psychological symptoms than non-abused clients. A primary clinical implication is that the issues of physical and/or sexual abuse may need to be addressed if intervention is to be helpful. Therapists need be aware of the possibility of childhood sexual abuse as a contributing factor in couple dysfunctions. When a couple presents for couples therapy, it is important to consider that either may have experienced childhood sexual abuse.

Sexual difficulties are commonly experienced by women who have been sexually abused and this is often the presenting problem for couples therapy. Generally, research into sexual difficulty has focused specifically on the sexual desire and the sexual act. Douglas, Matson, and Hudson (1989) identified problems that were experienced in the desire or arousal phase, and suggested that women who experience childhood sexual abuse will avoid general sexual cues. They recommended a modified Masters and Johnson approach as a helpful method to address specific sexual fears and dysfunction. For women who experienced childhood sexual abuse, often problems manifest as sexual difficulties. However, when these problems are explored in the context of childhood sexual abuse, sexual intimacy problems may be resolved more effectively than focusing on the sexual behaviour or level of sexual desire.

In their review of the literature, Pistorella and Follette (1998) suggest that individuals with a history of child sexual abuse experience turmoil and dissatisfaction in

their relationships. Two overall themes emerged in their review: difficulty with emotional communication and intimacy and issues related to either excess or lack of control within the relationship. These findings support treatment modalities that focus on acceptance of self and others and emotional expression. The therapist needs to create a new context for emotional relating that involves acceptance and validation.

Childhood sexual abuse affects the individual and her partner. Traditional treatment modalities focus on individual or group therapy, further alienating the non-abused partner (Reid, Wampler, & Taylor 1995). Maltas and Shay (1995) identified that many partners of sexual abuse survivors experience a phenomena described as trauma contagion. They experience high levels of stress, and doubts about their personal values and assumptions about the world. Unfortunately, partners tend not to seek help, further contributing to their sense of isolation and shame. They fear that they will be identified as the abuser. Partners are reluctant to see themselves as needing help since they are the ones who are helpers in their relationship. Partners (Maltas, 1996) may be drawn into repeating or reenacting aspects of the abusive relationship. Couple interactions that are experienced with an underlying terror of victimization are highly emotionally charged with negative affect. Understanding this dynamic is difficult when the relationship is seen exclusively through one partner in individual therapy. A couples therapist has an opportunity to witness the interaction and assess how the partners unconsciously shape each other's behaviour. Education about the typical impact of trauma on the couple's relationship and acknowledgement of the non-abused partner's suffering may reduce the distress in the relationship. Couples therapy is an essential adjunct to individual therapy,

especially when the individual therapy reaches an impasse. The most critical dynamics are played out in the couple's relationship, instead of the individual therapy session. The greatest leverage for change may be in the couple's relationship where the desire for new ways of relating may resolve the powerful tendency to relive or re-enact what is known, feared, and expected (Maltas, 1996).

Chauncey (1994) researched issues and themes raised by partners of women who experienced childhood sexual abuse. The following relevant themes and issues were identified: conflicting needs, difficulties with closeness, difficulties with spontaneity or unpredictability, feelings of anger, shame and guilt, sexual relationships, survivors' improvement, and relatives. The most relevant theme expressed by partners was how to balance their own needs and autonomy with their desire to be there for their partners. They struggled with directly communicating their needs, fearing it might cause anxiety or cause them to be overwhelmed or to withdraw. Physical and emotional closeness was often a challenge for partners of women who had been sexually abused. Although they were empathic with why there was a need to withdraw or distance, they were still left with feelings of sadness and helplessness at unsuccessful attempts. Partners identified that it was difficult to be spontaneous in their relationships. They often had to be guarded and cautious about touch to avoid frightening their partners. Many partners experienced the unpredictability and inconsistency of their wives'/girlfriends' responses as confusing. It was stressful not knowing what reaction a response would elicit. Partners identified that anger, shame, and guilt were predominant emotions that described their experience. Unmet relationship needs often resulted in frustration and resentment which then resulted

in feelings of guilt. Anger at the perpetrator was a safe expression of emotion that was fuelled by their sense of powerlessness. It felt safer to be angry at the perpetrator than it did to be angry with their wives or girlfriends. Difficulties and fears during sexual activity impacted on all partners. This often resulted in feelings of rejection and hurt. Some described how they had to shut off their need for sex. The unmet need for physical and emotional closeness created feelings of emptiness. Since the recovery process for sexual abuse is individual and uncertain, partners felt a sense of hopelessness. They were able to suppress their own needs for the sake of their wives'/girlfriends' healing but unsure how long this could be sustained that. Partners were often unsure of how to react to relatives on the issue of the abuse. They were concerned around parenting and expressed a desire to stop they cycle of abuse. The secrecy of the abuse made it difficult to share their feelings or deal with family members openly.

The therapeutic implications of the issues and themes identified by partners must be addressed in couples therapy. The therapist must be aware of the issues with which partners are preoccupied. The feelings and internal experiences of the partners must be validated. Partners of women who experienced childhood sexual abuse must be able to express their feelings and concerns in a caring context of the therapeutic relationship. They must be encouraged to share their feelings in order to accept and trust their experiences. Articulating this helps the partners connect with their own needs. The therapeutic relationship can be used to create a safe place for the couple.

Couples in which one or both have experienced childhood abuse report lower marital satisfaction, higher individual stress symptoms, and lower family cohesion than

couples with no abuse history. Not only does trauma affect the individual, it impacts the significant people in their lives. Therefore, when treating couples who experienced childhood abuse it is consider how secondary trauma factors into present relational problems (Nelson & Wampler, 2000).

Dual trauma couples is a term used to describe couples in which both partners have experienced trauma. They present unique challenges for couples therapy. Either one or both may be in crisis. Interpersonal reactivity, transference, emotional withdrawal, and associated responses may potentially complicate an already distressed relationship. There are five patterns that trauma couples exhibit:(a) the typical couple interaction without the overlay of trauma; (b) either one of the partners may exhibit the trauma responses at a time while the other partner may be not; (c) one partner is exhibiting the trauma response while the other partner is exhibiting reactivity or transference; (d) both partners are exhibiting trauma responses, and (e) both partners are exhibiting trauma responses and both partners are exhibiting reactivity and transference. Successful treatment needs to include a wide range of techniques addressing the major themes, characteristics, and patterns distinguishing the past trauma from the current relationship. Treatment can help each partner with her/his own acute stress. It can challenge and change dysfunctional interpersonal dynamics and exchanges. Past trauma must be distinguished from current relationship issues. Treatment can build empathy and compassion for self and partner. If one of the partners is in treatment, this aggravates interpersonal conflict since it does not consider the interpersonal dyad. As that partner improves, the expectation for a better relationship may be unreasonable (Baicom, 1996).

Couples therapy for dual trauma couples may be beneficial in creating a safe place to address the treatment issues.

Byng-Hall (1995) examines the implications of attachment theory for family therapy, recognizing the importance of the therapist providing a temporary secure base for the whole family during therapy. This secure base includes two functions: protection (identifying of dangers and conflicts in the family) and exploration of conflicts. Therapists must understand distance conflicts as insecure attachment instead of assessing behaviours as hostile, distancing, or controlling. Healthy attachment increases security and self-sufficiency. Authors Henderson, Bartholomew, and Dutton (1997) looked at attachment and separation resolution of women in abusive relationships. They found that women often stayed in relationships that were abusive as a result of their fearfulness of being alone. When the fearfulness was resolved they separated from their abusive partners and did not get drawn back in. Preoccupied attachment is characterized as high anxiety and low avoidance. This manifests in a pattern of frequent separations and frequent returns to the abusive relationship. Pistole (1994) explored distance regulation in couples and individual differences in attachment style - preoccupied, fearful avoidance, and dismissive avoidance. During couples therapy it is important to understand the emotional meaning of these interactional patterns. Understanding the pattern of attachment behaviour is helpful in treating distance regulation in couples. For individuals who have experienced childhood sexual abuse attachment styles of fearful avoidance and dismissive avoidance may be necessary to cope with the intrusiveness of abuse.

An important aspect of healing from childhood sexual abuse is giving voice to the

experience. Although that is difficult because of feelings of shame, disclosure is an important step in healing. It breaks down the damaging secrecy of the abuse and sharing that with a partner can increase positive experiences with someone who is safe, supportive, and trusting (Courtois, 1988).

Heller and Wood (1998) identify that intimacy is important for closeness, bondedness, and connectedness. Deriving comfort from another is a more powerful predictor of healing from trauma (Van der kolk, 1996). In order to heal from the trauma that is inflicted by those we love and need, new positive experiences of connection and caring need to happen. This is why couples therapy is an important aspect in healing from the effects of childhood sexual abuse.

Couple Therapy

Research on specific couple interventions that address the impact of trauma and childhood sexual abuse has been limited. The usual interventions for childhood sexual abuse trauma have been individual or group therapy. Couples therapy as an intervention for childhood sexual abuse has been overlooked.

An evaluation of brief couples therapy (Trute, Docking, & Hiebert-Murphy, 2001) at The Laurel Centre, an agency that provides counselling services for women who have been sexually abused in childhood, reported significant improvements in couples' relationships. The authors reported the following set of assertions:

> Brief therapy is of benefit to this population, with the most salient outcomes being a) fundamental skills in affective communication and mutual problem solving;

b) negative emotional atmosphere (i.e., marital burnout), if at high levels at pre-therapy, can be improved in conjunct therapy; c) therapeutic impact of couple therapy may be compromised by high levels of situational stress in the family household; d) long lasting effects may not be evident until some time after therapy has been completed (i.e., 4- 12 months); and e) a decrease in the level of depression reported by partners is not a good indicator of couple improvement (p.108).

Maltz (1988) supports couples therapy for addressing issues of trust, increasing intimacy and dealing with sexual concerns. Part of the work in couples therapy can be to educate the individual who experienced childhood sexual abuse and her partner about the impact of sexual abuse and how it influences the relationship. Safety in the couples session can create a context to negotiate wants and needs.

Follette and Pistorello (1995) assert that "clinical and scientific research suggests that people who experience childhood sexual abuse tend to experience an inordinate amount of distress and dissatisfaction in their couple relationships" (p. 132). They assert that couples therapy plays an important role in the resolution of trauma. Since sexual abuse often occurs in the context of an intimate relationship, the couple's relationship can be "a particularly powerful working context" (p. 133).

Behavioural couples therapy is one treatment approach that can be useful for couples who have experienced trauma. Acceptance and Commitment Therapy (ACT) is an approach that treats emotional avoidance. This technique has been helpful when one partner has experienced sexual abuse and avoids intimacy. Instead of dissociating, the

partner learns to be aware of the behaviour and communicates her acceptance of herself, and her history. The couple outlines their individual goals and works along with the couple goals in therapy (Follette & Pistorello, 1995). This model, while helpful, can be limited because of the focus on behavioural changes.

In conclusion, the body of literature is increasingly beginning to identify the benefits of couples therapy in treating sexual abuse trauma. The literature supports that those who have experienced trauma benefit from re-experiencing connection with others in a safe and nurturing relationship.

The Intervention Model

The intervention model used for this practicum was Emotionally Focused Therapy (EFT) for couples developed by Sue Johnson and Les Greenberg (1996, 1988) and has been used with some success in couples therapy where one or both partners has experienced childhood sexual abuse trauma. Emotionally Focused Therapy (EFT) for Couples is based on clear, explicit conceptualizations of marital distress and adult love. Adult love is viewed as a bond, an emotional tie with an irreplaceable other who provides a safe secure base from which to confront the world. This theory is based on an adult attachment perspective that focuses on creating an emotional connectedness that nurtures contact and comfort. It focuses on the concept of self as lovable and deserving of love with a partner that is loving and trustworthy. In the process of therapy, the couple shapes new bonding cycles that are antidotes to insecurity. Consequently a securely attached individual can assert the self, tolerate differences, and ask for comfort. The process of

change in EFT has been delineated in nine treatment steps. The first four involve assessment and de-escalation of problematic interactional cycles. The middle three steps emphasize the creation of specific change events where interactional positions shift and new bonding experiences occur. The last two steps of therapy address the consolidation of change and the integration of these changes into the everyday life of the couple.

This model addresses pivotal attachment moments, referred to as attachment injuries, that can damage relationship bonds. An attachment injury is a betrayal of trust, or abandonment at a crucial moment of need in the relationship. For example, infidelity would be considered an attachment injury. Attachment injuries are a form of relationship trauma that weakens the relationship. The impact of infidelity may be experienced as a betrayal and abandonment that can create an impasse in the relationship repair (Greenberg & Johnson, 1988; Johnson, 1996).

In EFT there are nine clearly delineated steps that occur in three process shifts or change events. These three shifts or change events are: cycle de-escalation, withdrawer engagement, and blamer softening. With the first shift, the pattern of how a couple interacts negatively de-escalates. For example, the partner who withdraws may begin to take a risk and engage in the relationship while the hostile partner becomes less reactive and angry. In the second shift, the withdrawer may become more active and assert her/his needs in the relationship. As the hostile partner softens in the third shift, s/he may take risks in expressing attachment needs and vulnerabilities (Johnson, 1996).

The nine steps that occur in these three shifts are:

Step 1: Assessment: creating an alliance and delineating conflict issues in the core

struggle.

Step 2: Identifying the negative interactional cycle.

Step 3: Assessing the unacknowledged emotions underlying interactional positions.

Step 4: Reframing the problem in terms of underlying emotions and attachment needs.

Step 5: Promoting identification with disowned needs and aspects of self and integrating these into the relationship interactions.

Step 6: Promoting acceptance of the partner's experience and new interaction patterns.

Step 7: Facilitating the expression of need and wants and creating emotional engagement.

Step 8: Facilitating the emergence of new solutions to old relationship problems.

Step 9: Consolidating new positions and new cycles of attachment behaviours (Johnson, 1996, pp. 11-12).

The first two steps in the EFT treatment process are conceptualized as assessment and are considered part of the treatment process. The conflict issues are outlined and the negative interaction cycle that maintains the couple's distress is identified. The interventions used at this point in therapy are: reflection, validation, evocative reflections and questions, tracking and reflecting interactions, and reframing. It is important that both partners feel understood and acknowledged by the therapist in the first few sessions. Both must feel safe in the session and begin to feel confident that the therapist will respect them and understand the struggles in their relationship (Johnson, 1996).

In Steps 3 and 4, the unacknowledged feelings underlying interactional positions are accessed and the problems are reframed in terms of these underlying feelings and attachment needs. The interventions used at this point are validation, evocative reflections and questions, empathic conjecture, tracking and reflecting patterns and cycles of

interaction, and reframing of the problem in terms of contexts and cycles. In Step 3, each partner's attachment issues emerge and begin to be clarified, and these issues first begin to become an explicit part of the dialogue between the two. With the help of the therapist, the blamer accesses the sense of panic or insecurity that they experience when the withdrawer partner is not accessibility to them. These issues and the interaction patterns that block emotional engagement are framed as the problem (Step 4). The couple is able to adopt this frame and own it because it has come from their immediate emotional experience. This is the time when attachment injuries or traumatic incidents that have damaged the nature of the attachment and actively influence the relationship in the present are defined and further explored and clarified. By the end of this step, the couple has formulated a coherent and meaningful understanding of the patterns of their relationship and how they have created them. De-escalation of the cycle has occurred and is one of the designated points of change in EFT (Johnson, 1996).

The outcome of the first four steps is assessment and de-escalation of the problematic interaction cycle. The therapist and the couple work collaboratively so that the couple can articulate and identify the negative interaction cycle. For example, critical pursuit by one partner may be followed by withdrawal and avoidance of the other. The experience of trauma is included in the description of these cycles. If a partner in the couple is experiencing flashbacks, a natural reaction would be to avoid the other partner. These cycles, often triggered by affect cues associated with trauma are then framed from a bigger perspective as victimizing both partners. This process brings the couple together against the negative cycles and the traumatic experiences that have derailed their

relationship. Partners begin to develop an awareness of how each of them suffers the aftershock of exposure to the original trauma. The couple begins to develop empathy for her/his own and his/her partner's attempts to cope with the residual pain from the trauma. They begin to develop an understanding of how the attempts to cope with the pain can sabotage positive emotional connection between them (Johnson, 1998).

The process of Steps 5 and 6 is characterized by an intensification and heightening of the emotional experience that occurred in Step 3. Step 5 pertains to the clients identifying with the disowned aspects of experience and disclaimed action tendencies in the redefined cycle. As the cycle is enacted in and out of therapy, partners become aware of their automatic reactions and the disowned aspects of experience underlying such reactions. As this experience is differentiated and symbolized as it occurs, the significance of it for the self in relation to the other becomes alive. For example, the withdrawer becomes aware of the feelings of being encroached upon, the fear of being overwhelmed, and the ensuing automatic move to protect himself. Another outcome of these steps is the owning of the experience as belonging to the self, and as the person acknowledges that, they also own the action tendencies arising out of the experience. They see how they have organized their partner's interactional position and are a part of the negative cycle in the relationship. The expanded experiencing and owning of the experience and each partner's position in the cycle involve accessing the core beliefs with the intense emotions involved. For example, a core belief may be that one feels unworthy of love, or like damaged goods because of the sexual abuse. Each partner experiences the pain of how one is defined negatively in the attachment relationship. These outcomes allow for the

processing of primary emotions of the sense of self in relation to the other. Key wishes and longings inherent in this begin to emerge and can be verbalized. From the attachment perspective, attachment behaviours begin to change as the emotions that organized them are reprocessed. Attachment fears and insecurities are reprocessed and become a conscious part of the interaction. The change is critical because it forms the foundation for the withdrawer re-engagement for one partner and softening for the other. Johnson (1996) refers to Steps 5 and 6 as "facing the dragon". These steps promote identification of disowned needs and aspects of self and integrating these into the relationship and promoting acceptance of the partner's experience and new ways of interacting.

The most intra-psychically focused step in the process is Step 5. The first four steps lead up to this and Steps 6 to 9 build on the process necessary in Step 5. The processes that led up this point are used to restructure the partners' interaction. The more intensely partners allow themselves to become in their emotional experience the greater the changes in therapy. This means that the partner who may have been placating now becomes angry and assertive. It is in Step 5 that attachment longings and desires are accessed and articulated. In Step 6, it is the role of the therapist to help the other partner begin to accept and incorporate this new presentation and to be responsive to his/her partner's new behaviour. The therapist must delicately support the new change in one partner while validating the other partner's confusion about the change (Johnson, 1996).

The goal of Step 7 is to facilitate the expression of needs and wants and create emotional engagement. This is the last stage of the process in which new emotional

experience and emotional expression is used to change interactional positions that restructure interactions. At this point in the EFT process, key change events associated with successful outcome in EFT occur. The completion of this step results in the less engaged partner (withdrawer) becoming more engaged. For the more critical partner, the change event is a softening, where this partner is able to ask for connection, and provide comfort from a vulnerable place. As this occurs, this heightens the emotional engagement between the couple, thus constructing a new cycle. The expression of the needs and wants from an empowered, accessible position, constitutes a shift in the interaction position which in turn challenges the other partner to engage in the same process. For example, in Step 5, a partner may say "I live in fear of you leaving me, so I go numb and placate". In Step 7, as the partner speaks from a position of increased efficacy, the statement would be, "I am tired of numbing out. I want to feel special to you, so I want you to quit threatening to leave". There is a different quality when you speak from an accessible position rather than a distant and an inaccessible position (Johnson, 1996).

As each partner goes through Step 7, s/he is able to stay connected to his/her emotional experience and state with clarity what it is s/he needs to feel safe and connected in a relationship. These requests are about key attachment needs that are crucial for each person's sense of safety and positive sense of self and are made in a manner that pulls the partner toward her/him. The interaction stance is now from a more equal position (Johnson, 1996).

The interventions used in this step are evocative responding using reflections and questions, tracking and reflecting the cycle, reframing, and restructuring interactions.

With evocative responding, the therapist focuses on the client's emerging experience to clarify the wishes and longings. At this point, tracking and reflecting the cycle is done to reflect changes to the negative cycle and the beginnings of a new and positive cycle. This is done by reflecting the most minute nuances. It is important to summarize and track the new interactions that occur between the couple. The reframe used in this step is that the difficulty partners experience in stating their needs is from their experience in the negative cycle. It is difficult to be vulnerable in the negative cycle. Restructuring interactions is the most common intervention at this point. The therapist will spend time choreographing a request and the heightening of a positive response. The therapist would make the couple aware of the possibility this holds for a secure bond between them (Johnson, 1996).

Steps 8 and 9 are the termination phase of EFT. In Step 8, the emergence of new solutions to old issues and problems is facilitated. In Step 9, the new positions the partners take with each other is consolidated. "The relationship now becomes a secure base from which to explore the world and deal with the problems it presents and a safe haven that provides shelter and protection" (Johnson, 1996, p. 143).

Interventions used in Step 8 and 9 are reflection and validation of new patterns and responses, evocative responding, reframing, and restructuring interactions. The therapist reflects the interaction between the couple, and validates the new emotions and responses they share and enact. At this point, the couple is able to do with less direction from the therapist, and the therapist only becomes more active when the process is derailed by a response from one of the partners. Evocative responding is used to process

this partner's experience and to diffuse blocks to positive responding. The restructuring of the couple's interaction is made explicit by clearly making aware present positions and cycles. Comments on the process are from the perspective of attachment and the attachment process (Johnson, 1996).

By the end of therapy, the following changes are clearly obvious. Firstly, on an emotional level negative affect has decreased, and the couple can stay emotionally engaged, using the relationship to regulate negative affect such as fears and insecurities. The partners are both more present and engaged for their own emotional experience, and feel more comfortable with emotions. Secondly, on a behavioural level, behaviour is less constricted and more responsive to the other's communications. Partners now ask for what they need that evokes their partner's response and in doing so, meet each other's attachment needs. Thirdly, on a cognitive level, as the partners perceive each other differently, they are able to make more positive attributions about each other's responses. Their definition of their relationship and of the other partner have been modified in attachment terms. Finally, on an interpersonal level, the negative cycles that consumed the couple relationship have been contained and replaced by new positive cycles. They are able to engage in positive connections (Johnson, 1996).

An important concept in EFT is couples' attachment injuries. An attachment injury is a betrayal of trust or abandonment at a crucial moment of need. This is known as a form of relationship trauma in which the partner experiences the relationship as insecure. Unresolved attachment injuries have the potential to create impasses in relationship repair. Generally, it is not the context of the attachment injury that impacts

the partner, but the attachment significant to the event. For example, a new mother may recall the time her partner had to go on a regular business trip leaving her to deal with a baby and especially needed his support. His leaving may touch of feelings of abandonment and never feeling supported. Usually, the injured partner can recall the exact detail, time, place of the event because of the significance of the poignant emotion of abandonment s/he experienced. The way to resolve an attachment injury is by processing the experience. In the resolution of the attachment injury the partner must be able to articulate the injury and the impact. The other partner must acknowledge the hurt partner's pain and respond by elaborating on why they did what they did, adding her/his meaning to it. As the hurt partner integrates the narrative and emotions s/he can access the attachment fear and longing. The other must own responsibility, express regret and stay empathically engaged with the hurt partner through this process. At this point, the hurt partner can ask for comfort and reassurance. When the partner responds this creates an antidotal bonding event. The relationship is redefined as a safe haven. A new narrative is constructed in this resolution of an attachment injury (Johnson, 2000).

The three basic tasks involved in the successful implementation of EFT for couples are: (a) the creation and maintenance of a consistent positive therapeutic alliance with both partners, (b) the accessing and reprocessing of emotional experience, and (c) the restructuring of interactions. The therapist acts as a process consultant in the processing of experience in the task of developing a therapeutic alliance. Emotion in EFT is seen in information processing terms that gathers information by integrating physiological responses, meaning schemas, action tendencies, and self-reflective

awareness of an experience. Emotion is viewed as a rich source of meaning that gives us powerful compelling feedback about how the environment is affecting us. As we process this feedback it regulates our responses and organizes our behaviour. The emotional expression of what we are experiencing as we communicate with others regulates our social interaction (Johnson,1996, Johnson, 2000).

Generally, there are six core emotions: anger, sadness, surprise, excitement, disgust or shame, fear, joy, and love. Emotions motivate people - in anger we assert or defend ourselves; in sadness we seek support or withdraw; in surprise/excitement we attend or explore; in shame or disgust we hide, expel, avoid; in fear we flee, freeze or give up our goal; in joy we contact and engage; and in love we contact and protect. Emotional responses are powerful with attachment relationships, and therefore must be explored and dealt with. Hearing the soothing voice of someone we are connected with can help soothe us in moments of panic and fear. With such a strong connection to emotion the task of accessing emotion is focussed upon, expanded, reprocessed, and restructured throughout the process of EFT. The therapist can focus on the most poignant and vivid aspect of an experience in the therapy process. Often with people who have experienced trauma, it may be safer to focus on a lesser emotion and then build to the stronger and poignant ones. The therapist focuses on and accesses the emotions that are salient in terms of attachment needs and fears. It is important to focus on the emotions that play a role in organizing negative interactions and restrict accessibility and responsiveness (Johnson; 1996, Johnson, 2000).

Application of EFT to Couples Who Have Experienced Trauma

Of particular interest to this practicum is the research of EFT on creating healing relationships for couples dealing with trauma. The EFT intervention has been applied to couples if one or both partners have experienced past physical or sexual abuse. Individual treatment and EFT have been effective in treating the relationship distress and individual symptoms. The steps in EFT intervention parallel the three stages of the constructivist self-development of trauma treatment developed by McCann and Pearlman (1990). These stages are stabilization, the building of self and relationship capacities, and integration. The first four steps of EFT are viewed as stabilization with the initial assessment (step 1), relationship cycles and patterns and underlying feelings are identified (steps 2 and 3), and negative patterns of interaction are framed as the problem (step 4). For couple work with individuals traumatized by childhood sexual abuse, this would involve understanding the nature of the trauma and how it has affected each of the partners and defined the relationship, furthermore, how it pertains to their cycles and patterns of interaction. Steps 5 to 7 can be viewed as building self and relationship capacities. In EFT, Step 5 involves owning the longings and fear that arise in the relationship, Step 6 involves the acceptance of these by the partner, and in Step 7, this is followed by asking for needs to be met in a way that evokes empathic responsiveness from the partner. In this stage, the relationship is created as a safe haven where fears can be confronted and soothed, grief shared, shame transformed, and anger reprocessed. This process builds trust in the relationship. The last two steps parallel the integration phase of trauma treatment as new ways of coping with the problems related to the trauma and the interactional positions are integrated into the

relationship (Johnson and Williams-Keeler, 1998).

In couple therapy with individuals who have experienced trauma, a strong therapeutic alliance is critically important as the therapist validates the couple's struggle with the impact of abuse on their relationship and how it inadvertently creates the cycles that distress them. Each member of the couple begins to develop empathy for his/her own and his/her partner's pain. The individual who has experienced childhood sexual trauma may begin to explore how the emotional experience of her/his relationship can trigger traumatic cues, especially symptoms such as flashbacks and intrusive thoughts and the numbing and avoidance of these cues. The therapist reflects and validates each partner's experience and the strong emotions such as shame and fear that arise. This facilitates compassion and understanding in the partner, rather than rejection or anger. The non-traumatized partner is able to share how s/he has been impacted by the trauma and can begin to understand how it has constrained the relationship. As the couple is able to fully understand each other's experience, the therapist is able to frame the relationship as a safe haven that provides protection, comfort, and a secure base in a dangerous world. Using an attachment perspective, the non-traumatized partner is framed as a safe, irreplaceable other who helps the survivor to cope and become more available for an intimate relationship. This provides relief to the non-traumatized partner who understands the pain and fear of the survivor rather than experiencing it as rejection. The symptoms of marital distress and trauma responses previously experienced in the relationship begin to de-escalate, thus creating a safe place as the partner is experienced as an ally in the healing process. It is important for the therapist to assist the couple in outlining safety rules and

stating of personal boundaries and limits (Johnson, 1998). For example, the therapist may have to support the trauma survivor in her request for no sexual activity as she heals. Reprocessing intense affective responses is important as the sexual abuse survivor is able to risk vulnerability to ask for help with trauma symptoms (flashbacks) or risk disclosing specific fears, hurts and griefs. The partner then may shift from his distant position to offer support, and further risk his experience by expressing his own fear of her reactive rage, requesting that she not mistreat him. As they are both able to hear each other, he can now reassure her he wants to support her in dealing with her trauma history. The next sequence may involve the trauma survivor's struggle to trust her partner. This process might involve facing her fears of abandonment, of being abused again, or of being exposed as shameful. The partner's acceptance of her helps to work through feelings of unworthiness and regulate self-loathing. As the couple is able to work through and support each other through processing the effects of trauma, this strengthens the bond between them (Johnson, 1998).

This process described above involves accessing, formulating, and reprocessing specific fears that arise from attachment insecurity in the relationship. Reducing fear is an important and effective treatment goal in addressing PTSD. One of the mechanisms associated with fear reduction is being able to experience the fear response and have it reprocessed in a safe environment. This creates a new experience that is incompatible with the more dysfunctional elements in the fear experience. The survivor is able to access a sense of mastery in relation to the traumatic experience and fear. In couples therapy, this new information creates a secure attachment base as needs for security and

relatedness are met. The survivor is able to risk trusting her partner. The experience of reassurance and comfort replace the experience of terror and betrayal. This decreases the need for emotional numbing, dissociation, and the avoidance of intimate contact. Continual processing and organization of traumatic experiences are possible as a safe context promotes new cycles of risk taking and empathic responding (Johnson, 1998).

As the couple completes the EFT process, they can successfully work at collaborative solutions to here and now issues in their relationship. They are able to cope with anniversary dates of the trauma effects and other reminders. In the strength and secure attachment of their relationship, they are able to navigate the sensitive issues in their sexual intimacy. Interactions that previously only occurred in the safety of the therapist's office can now occur outside of the session. As the impact of the traumatic experiences are resolved, this is no longer what defines the relationship. The relationship can now have a present and future life of its own (Johnson, 1998).

The interactional patterns that contribute to the interactional sequences commonly referred to in EFT with couples are: pursue - distance; accuse - withdraw; blame - blame; blame - withdraw. These patterns are self-explanatory and can be deeply embedded in fight, flight, and freeze positions. The patterns create a self-reinforcing cycle of reactivity that contribute to marital distress. The cycle becomes an absorbing state to which all conflict leads. For individuals who have experienced trauma, the cycle becomes more compelling than positive affect, triggering responses of fear and shame. For example, it may be more familiar for an individual who has experienced trauma to blame and criticize her partner to keep him away from her. There are gender differences in these responses.

Males who are distressed stay aroused, stay aroused for longer periods of time, but do not show the distress. A female partner may up the anti to get a response to connect emotionally. This is aversive to the partner who then further shuts down, thus further reinforcing an interactional pattern (Johnson, 2000).

As the therapist, it is important to create safety in session. The focus of the EFT therapist is alway the present, the primary affect, the process, and the positions and patterns. If things from the past are important they have a way of coming into the present. For safety, it is important to let the client have the needed defence and use the past to validate. The primary affect is what is expressed when the couple first comes in. Fear, terror, helplessness, and vulnerability are usually underlying the primary affect. The job of the therapist is to process with the couple how they do what they do in an interactional pattern. This involves working to access how each individual in the couple puts together their inner experience in the positions and patterns (Johnson, 2000).

Summary

The nine steps of EFT in the three process shifts provides a map of adult love that can create safe secure connections that contribute to the healing of a those who have experienced trauma. The therapist tasks are to create a collaborative alliance that accesses and processes the emotions embedded in the interactional patterns of the couple. Of particular importance are the resolution of attachment injuries that significantly impact on a relationship. All of these contribute to a safer healing relationship in which an individual who has experienced trauma can heal. Van der Kolk (1996) states that the

capacity of an individual to heal is related to the extent that they reach out to others for comfort.

Research On EFT

Authors began researching (EFT) for Couples in 1985, learning from the behaviorialists that an intervention needs to be empirically proven to test the effectiveness of this approach. The initial study (Johnson & Greenberg, 1985b) compared the relative effectiveness of two interventions in the treatment of marital discord: a cognitive-behavioural intervention teaching problem-solving skills, and an experiential intervention focusing on emotional experiences underlying interactional patterns. The results provided empirical support for the effectiveness of EFT with effects that were superior to the problem solving technique on measures of marital adjustment, intimacy, and target complaint. At follow-up, scores were significantly higher for the EFT group than for the problem solving group (Johnson & Greenberg, 1985a). Comparisons of Integrated System Therapy (IST) and EFT (Goldman & Greenberg, 1992) found both to be effective in alleviating marital distress, facilitating conflict resolution and goal attainment, and reducing target complaints, with EFT sustaining at follow-up. Besides the theoretical differences in the approaches, IST uses a team approach focused exclusively on changing current interactions, reframing patterns of behaviour, and prescribing symptoms. EFT focuses on encouraging the accessing, expression, and acceptance of affective experiences in partners. The couples were positively influenced by the impact of the collective team's provocative messages, expertise, and neutrality. At follow up, the EFT couples continued

to show target complaint improvement and reach pretest goals. IST proved effective for couples in a marginally distressed range. This study raised questions about the specific aspects of treatment that led to change (Goldman & Greenberg, 1992).

Emotionally Focused Therapy and Cognitive Marital Therapy (CMT) (Dandeneau & Johnson, 1994) were compared on marital intimacy, dyadic trust, and dyadic adjustment. EFT scores on intimacy improved at follow-up, whereas the initial improvements in the CMT were lost. This suggests that EFT couples were connecting at a more satisfying and closer level and continued to increase their intimacy when the therapist was no longer present. Disclosure of vulnerability is minimized in CMT, and in EFT it is an essential element of intervention. These results suggest that understanding enhances closeness, but unless affect is also addressed, the closeness is short lived (Dandeneau & Johnson, 1994). James (1991) is the only study that assessed communication when added to EFT. The EFT plus communication level was equally effective as the EFT only treatment, and it appears to have higher consumer satisfaction.

Predictors of success following eight sessions of EFT and at follow-up are a positive alliance with the therapist and client perception of the task of promoting emotional engagement as relevant. The females' trust in their partners appears to be an important predictor, as couples satisfied at follow up tended to be those in which the females reported a higher level of trust of their partner at intake (Johnson & Talitman, 1997).

Emotionally Focused Therapy (EFT) has been applied to several kinds of problems and populations. Couples with chronically ill children are at an increased risk

for experiencing marital stress. EFT was observed to be effective in decreasing marital stress in these couples and these effects were maintained at a five-month follow-up. Longer follow-up was not an option (Gordon-Walker, Johnson, Manion, & Cloutier, 1996). Viewing bulimia from the theoretical perspective of attachment described by John Bowlby, EFT was applied to create more secure attachment in families of adolescents with bulimia (Johnson, Maddeaux, & Blouin, 1998). This perspective allowed for a greater focus on disengagement and insecurity as a source of distress and development of symptoms rather than on the concept of enmeshment. Although the n size of this study was small, treatment results were encouraging.

Johnson and Taltiman (1997) examined the client variables of relationship attachment quality, level of emotional self-disclosure, level of interpersonal trust, and traditionality to the therapy outcome variables of marital adjustment and intimacy. Results of this study indicate that couples successful after 12 sessions of EFT and at follow-up were the ones who made a positive alliance with the therapist. Authors of this study explained this result as the therapist understanding the tasks of EFT which promotes emotional engagement. Therapeutic alliance predicted successful outcome, including in particular, the couple's satisfaction.

In a randomized trial with forty couples using EFT (Denton, Burleson, Clark, Rodriquez, & Hobbs, 2000) using novice therapists and with only eight sessions, EFT remained effective in improving marital satisfaction. It proved effective in both between groups experimental study and within subjects replication study. Accepted pre-test T-scores for participant couples were those in the slightly below average range.

Conclusion

Emotionally Focused Couple Therapy appears to be a model that can fit for the individual who has experienced sexual abuse and her partner. It can create a healing environment that regulates negative affect and re-experiencing symptoms. The traumatized partner in the couple may then be able to turn to her partner for comfort and support. For example, instead of self hurting she may be able to ask her partner for security and connection. Connecting to a secure base further protects the survivor from retraumatization. EFT can foster new learning of connection and security that is incompatible with the effects of trauma. As the trauma survivor is able to process flashbacks and the impact of trauma with her partner, this further promotes the integration of trauma. Experiences of numbing may be less as she develops confidence in people she trusts and trusts herself to deal in more adaptive ways. EFT fosters a "hereness" vs. "thereness" engagement as the survivor connects and feels safe with her partner. As validation is experienced and received from the supporting partner, a new sense of self as worthy and competent is promoted. There is a significant difference in receiving validation from an individual therapist for one hour a week versus receiving validation from her partner at all times (Johnson, 2000).

CHAPTER THREE

THE PRACTICUM

This chapter provides a description of the agency setting for the couples therapy intervention, information about the practicum committee and the participant selection, an overview of the couple work, and ends with the evaluation process.

The Setting

The setting for this practicum was the Laurel Centre located on 62 Sherbrook Street, Winnipeg, Manitoba, which is the clinician/practicum student's place of employment. The Laurel Centre, formerly known as the Women's Post Treatment Centre was established in 1985 as an agency that provided counselling to women who had experienced childhood or adolescent sexual abuse and who use compulsive coping behaviours. The idea for such an agency grew out of the experiences of eight women working in the addictions field who were concerned about the number of their female clients who were struggling with the dual issues of addiction and childhood sexual abuse. The mission statement of the Laurel Centre is:

1. To enable the provision of counselling services for women who have experienced childhood or adolescent sexual victimization and want to resolve long term effects of the abuse. The agency recognizes compulsive coping behaviours as one of the long-term consequences related to unresolved trauma.

2. To address the issue of societal denial - of the seriousness and prevalence of the

problem of childhood sexual abuse - and the detrimental long term effects (one of which is compulsive coping behaviours) (The Laurel Centre, Annual Report, 2000).

The philosophy of The Laurel Centre is:

- that women have a right to social, political, and economic equality and power
- that childhood sexual abuse has a long-term damaging effect over one's well-being (physical, emotional, social, spiritual, intellectual), and one of these effects is the adoption of compulsive coping behaviours
- that problematic adaptation is a consequence of inadequate resources and supports, rather than a reflection of deficiencies within the woman
- that women have the right to choose the course of their own healing process

Given these beliefs, The Laurel Centre provides counselling which allows women to understand the context of their lives and to make the link between their compulsive coping behaviors and the trauma experienced in their childhood. This understanding empowers them to make life affirming choices and to resolve the impact of trauma by integrating physical, emotional, social, spiritual, and intellectual aspects of self in context (The Laurel Centre, 2000).

Clients of The Laurel Centre are either self-referred or are referred through various other community or social services agencies. The first point of contact for clients is a brief intake interview on the telephone to determine if the woman meets the mandated criteria of experiencing childhood or adolescent sexual abuse and impacted by compulsive coping behaviors. Compulsive coping may cover a wide range of behaviours such as alcohol abuse, drug abuse, gambling, shopping, and overworking. Following the intake, women

are then placed on a wait list. Currently, the wait list is eighteen months long. Upon nearing the top of the wait list, women have the option of participating in a three session pre-counselling orientation or a parenting group within the agency. Women who do not wish to be involved in a pre-counselling orientation or a parenting group may begin individual therapy. The Laurel Centre staff have found that many clients have a long history of help seeking from addiction and mental health services. The agency works with approximately 300 women per year, with the average length of service being twelve months (The Laurel Centre, 2000).

The Laurel Centre offers a variety of services to women: individual counselling, group experience, and couple counselling. Treatment and therapeutic plans are developed collaborately by the therapist and the individual client. Several therapy and educational groups are offered each year at The Laurel Centre. The groups presently offered within the agency are: pre-counselling orientation; journey into healing group; parenting program; sexuality group; positive coping group, aspect of self group, and anger group (The Laurel Centre, 2000).

The Laurel Centre is involved with three other projects that specifically target the youth population. There is a youth counselling program aimed at the specific needs of younger women between the ages of sixteen to twenty-four. The second is a Girls Outreach program, run in co-operation with The Andrews Street Family Centre. The Girls Outreach program is intended to provide supportive education to young girls ages seven to sixteen in developing self-esteem and confidence, and to gain information about issues of violence and abuse. Most recently, the Girls Outreach program has won the Governor

Generals Award for Crime Prevention. A third program has been recently developed which trains young women from the ages of fifteen to nineteen to provide mentoring for the young girls in the Outreach Program (The Laurel Centre, 2000).

The Laurel Centre provides workshops and training to other agencies funded by the Family Violence Prevention Branch (Department of Family Services, Manitoba) regarding childhood sexual abuse and its long term impact on survivors. The Laurel Centre is also involved in the Winnipeg Development Agreement and provides supervision to five satellite programs aimed at providing services to women who have experienced domestic violence and are impacted by compulsive coping behaviours.

Of particular importance to this practicum is the couple's therapy program. This program was developed in 1996 - 1997 from a pilot project funded by The United Way and has now become part of the regular therapy services offered at The Laurel Centre. Difficulty with relationship skills such as trust, intimacy, sexuality, and communication are often pivotal issues facing our clients, particularly as change occurs during their therapy. The Laurel Centre believes that it is necessary for the continued growth of our clients to also experience growth in their relationships.

Participant Selection and Intake

The clients seen at The Laurel Centre are women who experienced childhood or adolescent sexual abuse. Referrals of couples meeting these criteria were provided by the therapists at the Laurel Centre. Criteria for inclusion for the practicum study were: (a) the female partner must have experienced childhood sexual abuse trauma; (b) the female

partner must be seen for individual therapy at the Laurel Centre; and (c) the couple must be experiencing difficulties in their relationship. This process was open to both heterosexual and homosexual couples. Criteria for exclusion for the practicum study were: (a) on-going physical violence occurring in the relationship; and (b) excessive use of alcohol or drugs that would impede functioning in a relationship and in therapy sessions.

During the intake session, couples were informed of the practicum and if appropriate, were offered counselling regardless of their choice to participate or not. Participants signed a consent form that allowed the information from their therapy process and their evaluation to be included in the practicum report and which gave consent to the video taping of sessions (Appendix A). As part of the intake, participating couples also completed the Dyadic Adjustment Scale (Spanier, 1976). During the intake process, participants were informed about the therapeutic intervention. Although Johnson (1996) describes EFT as a short-term process of 8 - 20 sessions, she recognizes that this process takes longer with trauma survivors. The number of sessions was specific to each couple's needs.

Summary of the Intervention

During this practicum experience I worked with eight couples for a varying numbers of sessions (Table 1). Couple one and couple two will be described in fuller detail in the analysis chapter.

Table 1

Demographic Information of Couples

C #	Name	Age Category	Ethnicity	Income Category	Relationship Status	
					Pre	Post
1	Kim Alex	40 - 44 40 - 44	Caucasian Caucasian	10,000 - 15,000 40,000 - 45,000	Married	Separated
2	Jennifer Brad	25 - 29 25 - 29	Caucasian Caucasian	N/A 30,000 - 35,000	Married	Married
3 *	Lori Max	40 - 44 45 - 47	Caucasian Caucasian	N/A 40,000 - 45,000	Married	Married
4 *	Wendy Peter	30 - 34 40 - 44	Caucasian Caucasian	25,000 - 30,000 35,000 - 40,000	Common Law	Common Law
5	Julia Ben	25 - 29 25 - 29	Caucasian Caucasian	15,000 - 20,000 35,000 - 40,000	Married	Married
6	Nadine Don	40 - 44 40 - 44	Caucasian Caucasian	0 - 10,000 0 - 10,000	Significant Other	Significant Other
7	Linda Shane	35 - 39 35 - 39	Aboriginal Metis	15,000 - 20,000 15,000 - 20,000	Common - Law	Common Law
8	Rene John	35 - 39 35 - 39	Mixed Caucasian	20,000 - 25,000 20,000 - 25,000	Significant Other	Separated

Note C = Couples

* = Dropped out

Of the eight couples, couple one and couple eight ended their partner relationships. A significant segment of the couple therapy work for couple one was the process of unattaching after a period of twenty plus years. With couple eight, Rene was clear about wanting to end the abuse cycle in her life. Her fear of being alone kept her trapped in a compromising relationship. She was able to provide John with respectful feedback about his behaviour which he chose to use as an opportunity to take action. The goal of couple therapy work is to provide a safe nurturing connection. If that is not possible, a successful resolution may necessitate ending the relationship.

In this practicum, two couples withdrew from the couple therapy work. Couple three withdrew abruptly after two sessions. Although there was a significant attachment injury to resolve, the fear of being close may have also contributed to this. Couple four participated in twelve sessions and ended by not returning after a requested break. These couples appeared to be affected most by the childhood sexual abuse in terms of their ability to form safe and connecting relationships. Often, the marital distress is less threatening than the unknown fear of re-creating a new experience bonding experience.To experience emotional and sexual intimacy may be too terrifying.

Couple Three

Lori and Max attended two couple counselling sessions and each participated an individual intake session. I had been Lori's individual therapist for a three year period and a reoccurring focus in her individual work was the marital distress in their relationship. When it began to consume the individual work, I recommended couple therapy. At the

Laurel Centre, I am the only therapist doing couple therapy. Lori refused to access couple therapy elsewhere. Three months prior to beginning couple work Lori had transferred to another therapist at The Laurel Centre and agreed to participate in the practicum process. In the initial couple session rapport was established quickly. Both identified that they had problems with communication and sexual intimacy. They did not feel connected to each other at all and slept in separate bedrooms. Max's experience of the relationship was that he could not ever do anything right. Lori had come to a place in individual therapy that she realized she needed to deal with the "unsaid things" in her relationship.

Lori and Max were a dual trauma couple; both had experienced difficult childhoods. Lori experienced long term childhood sexual abuse by several perpetrators and had never felt safe in childhood. Her parents never protected her, being too consumed with the violence in their relationship. When she met Max, she felt safe and accepted. Max described his childhood experience as difficult. He never expected to get married until he met Lori, and fell in love with her.

Their cycle consisted of Max withdrawing and Lori pursuing by blaming and being critical. Max stated he felt like he could never say anything right and often would not respond. He used sarcasm to say what he needed to say. When he got angry at Lori he would deliberately ignore her by turning up the volume on the T.V. Lori admitted to venting her anger on Max. She described feeling desperate when he would not respond to her and would become enraged.

In the second session, Lori stated that she wanted to know that Max supported her. Upon exploration of what she wanted to do, Lori stated that she wanted to share a painful

experience that occurred in their relationship several years ago. I validated for Lori that this seemed to be a significant issue for her and asked if she felt ready to do so at this early stage of the couple work. Lori insisted that this issue be cleared up before couple therapy went any further. Max stated he wanted to do anything to make this relationship work. When I explored what Lori needed from Max to know that he supported her, she related that she wanted him to side with her, not his family. Lori recounted the incident when she had been sexually assaulted by Max's brother and wanted to press charges against him. She wanted to get a restraining order against him too. At that time, Max did not want her to do so. Unfortunately, in session Max denied that he did not want to press charges or get a restraining order. Lori was visibly upset by Max's response in session. I attempted to maintain neutrality in session by validating her experience, and validating how difficult it was for Max to see her in so much emotional pain. When Lori regained composure, I attempted to explore what she needed from Max at that moment. She was unable to answer.

Before the next session, Lori cancelled the appointment. Lori stated that "I do not want to be with someone who does not want to admit to what his brother did". She further explained "that I've had to deal with people like that all my life". Attempts to have them come in to work through this were unsuccessful. This was obviously a painful attachment injury for Lori and unfortunately not being supported by Max in session re-opened old wounds for her.

The pre-treatment T-scores on the the Dyadic Adjustment Scale indicated a distressed relationship, with a total T-score for Lori < 20 and for Max of 34. This places

their scores in the "very much below average range" and "much below average" categories respectively. The DAS indicated high level of martial distress which fit what I observed in session.

In reflection of this difficult incident, I learned that I needed to clarify what exactly Lori expected from Max. I learned that I needed to ensure that Max was prepared to and able to do so. A part of me feels that I let Lori down, just like many other people in her life. I learned the importance of slowing things down in couple work with people who have experienced trauma. From my individual work with Lori, I would guess that primary emotions embedded in their cycle would be fear of abandonment for Max and terror of being close for Lori.

Couple Four

Wendy and Peter participated in twelve sessions. After twelve sessions, they requested a break and did not return. In the twelve sessions, the change in the first shift, cycle de-escalation, was beginning to occur. Their interaction cycle illustrated a blame-withdraw pattern. The pre-treatment T-scores on the the Dyadic Adjustment Scale indicated a distressed relationship, with a total T-score for Wendy of 32 and for Max of 33. The DAS indicated high level of martial distress which fit what I observed in session. Trute et al. (2001) suggest that addressing behavioural self- management skills such as listening skills, and impulse control are a prelude to assisting highly chaotic couples. This would have benefited this couple and perhaps would have been a more effective starting point.

Couple Five

Julia and Ben participated in twelve couple therapy sessions. Julia had completed individual counselling and wanted to be pro-active about her relationship with Ben. Ben enthusiastically shared in her concern and was vested in avoiding relationships like his parents or Julia's parents. The pre-treatment DAS T- scores reflected some marital distress, with a total T-score of 44 for Julia and for Max of 48. This places their scores in the range of "slightly below average" and in the range of "average" respectively. After the intervention both their T-scores were in the "slightly above average range". Issues relevant for Julia and Ben were communication, finances, disagreement on when to have children, and in-laws.

Julia desired more closeness with Ben, and had wanted to start a family. More time together as a couple was difficult to do when Ben worked sixty plus hours a week. Julia reached out to her family to do things because Ben was unavailable. Although Ben agreed about having a family, he felt they were still newlyweds and did not want that to change. They were committed to each other and to the concept of marriage.

The issue of closeness raised different concerns for them. Ben felt that being close or wanting closeness made you vulnerable. Julia was close to her family and relied on them for emotional support. In their interactional cycle for intimacy she pursued Ben, and he distanced by keeping busy at work. Julia would respond by spending more time with her family which Ben resented. He judged Julia as being "daddy's girl". Julia assured him that she wanted closeness and if he was not around, she turned to her family. This was resolved when Ben prioritized his relationship with Julia. They learned to spend couple

time together doing projects around the house and having fun. Ben felt more comfortable having connection with Julia when he realized the he had to "work" at having a meaningful relationship.

Julia and Ben lacked effective communication skills. Their interactional style around conflict consisted of him pursuing her, and being direct with what he had to say. Julia would withdraw, and not know what she was feeling. Ben would have to give her feedback about what he noticed about her body language. As we worked on communication skills, Ben admitted to needing to be defensive to protect himself. He realized the significance of having a safe bond with each other. A shift for them in their communication came when they realized they were name calling during a disagreement and were able to step back and laugh at themselves. In session they role played scenarios that they struggled with at home. For example, Julia would actively negotiate spending more time with Ben by directly asking and setting a plan. They would set aside time to connect and touch base daily, which made it easier to deal with conflictual issues. Ben and Julia were still learning how to balance spending time alone and spending time together as a couple.

As a young couple, they had to develop some comfort about setting boundaries with their parents. Ben resented Julia's ongoing conceding to her parents. I asked Ben if there was one person in his life he had difficulty saying no to. He quickly responded his deceased grandmother because of the trust he had in her and her strength. I asked him how he would respond to her if she were still alive and wanted to spend time with her. He understood how Julia felt pulled by giving into her parents because she cared for them.

Julia agreed to work at making decisions for herself instead of constantly checking in her with her family. Ben and Julia worked at responding from a responsible adult place with her parents. For Julia this meant being assertive. Ben worked at engaging in conversation and participating when he was at their home. In the past, he would pout because he felt left out of things.

A number of sessions were spent exploring expectations and myths about relationships. Together they explored the impact of gender roles and how that scripted their expectations of each other. For Julia, being a woman meant that she had to take things as they came, acquiesce to a male role, and cook meals. For Ben this meant working hard, being financially responsible, and planning for the future. As a couple they worked at defining what marriage meant to them. They discussed what they did not want to repeat from what they observed in their parents relationship and other married relationships in their lives. Together they created what they wanted as partnership.

The impact of the childhood sexual abuse on Julia was her difficulty in connecting with herself. She struggled with identifying the emotions she was experiencing. Julia was unsure of her identity, desperately wanting a child to give meaning in her life. Her work in couple sessions was to articulate what her needs were in this relationship.

This couple's enthusiasm and commitment was refreshing. They were pro-active about their relationship, and aware of the patterns they did not want to repeat. Neither of them had experienced any attachment injuries in their relationship. At this early stage of their marital relationship they were cognizant of the social responsibilities of a partnership. My last contact with them was when they called to inform me that they were expecting a

baby in the summer months.

Couple Six

Nadine and Don participated in twelve couple therapy sessions. The pre-treatment DAS T-scores reflected a distressed relationship, with a total T-score of 34 for Nadine and 30 for Don. These scores placed them both in the much "below average range". The post - treatment DAS T- scores of 37 for Nadine and 20 for Don placed them in the "below average" and "very much below average" category. The couple work ceased when Nadine was hospitalized. Although he wanted to support her through this, Don decided to end the relationship. He was dealing with a serious physical aliment himself and was overwhelmed by Nadine's illness. When he completed the post treatment data this was the status of their relationship. Nadine completed her post treatment data four months later and informed me that they were back together.

This couple were both ambivalent about being in relationship. I was surprised to hear that they reunited a few weeks after their break-up. The energy that was required to deal with their ailments depleted them. Nadine identified her fear of abandonment as predominant. Don had difficulty saying no to people, consequently he was taken advantage of. She resented the time Don spent helping other people. In session, Don learned to prioritize his own needs and prioritize his relationships. Both worked on communication skills and resolving conflict.

Couple Seven

Linda and Shane participated in ten couple therapy sessions. Their attendance was sporadic due to Linda's impossibly busy schedule and babysitter problems. The pre-treatment scores on the DAS reflected a high level of martial distress, with a T-score total of 36 for Linda and 32 for Shane. This places their scores in the range of "below average" and "much below average" respectively. After the intervention, their T-score totals of 33 for Linda and 37 for Shane placed them in the "much below average" and "below average" range respectively. At the collection of data for the post scores, Linda's life was extremely stressful and unmanageable with exams, hectic work schedule, financial pressures and increased flashbacks from childhood sexual abuse. Shane's scores accurately reflect his continued fear of abandonment as Linda distanced herself because of the sexual abuse flashbacks. The client satisfaction survey reflected that they found the couple work helpful, particularly benefiting from the increased communication skills. They acknowledged that they needed continuing work but were unable to continue due to increased situational demands.

Linda and Shane were a dual trauma couple. Shane was abandoned as a child by his mother. He poignantly recalls waiting in an empty house for days waiting for her to return. This significant event impacted on his ability to trust in relationships. Linda was experiencing flashbacks during sexual intimacy and requested no sex contact while she was healing. Sexual intimacy was the only way Shane felt safe connecting, and he experienced the no sexual contact as a rejection of him. As Linda's work and school pressures increased, her flashbacks also increased. She would further distance from Shane

who responded by increasing his controlling behaviours. Shane used negative coping behaviours which further increased their financial stressors. Linda was responsible for the financial obligations and this further increased her stress. The impact of increased situational stresses and intraphysic pressures for both partners escalated their withdraw - distancing and attack-blame interactional patterns. There had been previous issues of physical violence in this relationship. During intake, Linda stated that Shane no longer physically hurt her. Shane stated he learned his lesson and this was no longer an issue for them. With permission from Linda, her individual therapist expressed safety concerns for Linda. When I met with Linda individually, she stated she was not concerned and wanted to continue couple work. The couple work ceased because of Linda's schedule but I continued with a few individual sessions with Shane to assess this situation.

Despite these issues, this couple were loyal and connected to each other. They conveyed how it was them against the world and they wanted to improve the lives of their children. Although chaotic, the strength in this couple was a testimony to the resiliency of the human spirit. Shane would have benefited from individual work to deal with his issues of abandonment and childhood sexual abuse.

Couple Eight

Rene and John participated in eight couple therapy sessions. They had been dating each other for about a year and were experiencing high levels of relationship distress. They both viewed couples therapy as a "make it or break it" for their relationship, consequently Rene ended the relationship after eight sessions. In couple sessions she

realized she was settling for a relationship out of her fear of being alone.

The pre-treatment T-scores on the DAS indicated a distressed relationship, with a total T-score for Rene of 36 and for John of 44 . This places their scores in the "below average range" and "slightly below average" categories respectively. The post-treatment post T scores on the were 24 for Rene and 43 for John, which placed their scores in the "very much below average" and "slightly below average respectively". These divergent experiences of the relationship were reflected in their therapy work.

Rene was overburdened with the special needs of her children and experienced his need to be with her constantly as engulfing. Since her past relationships were extremely volatile and physically violent, initially she experienced John as calm and supportive. As she processed the frustration she was experiencing she recognized that he was psychologically and emotionally abusive. John described his relationship experience as positive. He viewed their "fighting" as normal. Their interaction cycle consisted of John pursuing to connect sexually but withdrawing emotionally. When there was conflict, they usually began discussing things rationally but digressed to shouting and name calling. When Rene wanted to connect emotionally, John would withdraw and then become critical and blaming if she kept pursuing. When John was unhappy with his day, he would be critical and judgmental of her. Rene compared their interaction cycle to an abuse cycle. There would eventually be an explosion and they would withdraw for several days. Experiencing violence in the home as a child, she was adamantly clear about not wanting to expose her children to this.

It was important to frame John's experience from a gender perspective. He grew up

being bullied at home by his dad and by the kids at school, very quickly learning to stuff his emotions. His experience with depression and an workplace injury contributed to his feelings of being a failure. Although he had been in a number of unhappy relationships, he believed that a woman was just supposed to be there for you. Relationships just happened.

In the last session, Rene decided to end the relationship, although it took several weeks for the final break-up. John went back into a men's treatment program to further address some of his behaviour. After several months, Rene met an individual and was for the first time in her relationship experience, actually going through the progression of acquaintance to dating. She stated she was consciously aware of breaking a pattern of getting involved too quickly to avoid being alone.

My work with this couple reinforced that sometimes people stay in relationships because they are afraid of being alone. Rene would end their relationship, and request he not call. John would call and Rene would let him back into her life when she felt lonely. John did not hear Rene's experience in the relationship which was further reinforced by her setting boundaries and not following through. She would tell him the impact of his hurtful comments and name calling. When he continued to escalate she would ask him to leave, but let him back into her home when she felt lonely. This emphasized the importance exploring the mixed messages in the push/pull dynamics. Although it was important to honour John's experience through a gender lens, he had to take ownership of his abusive behaviour. However, he felt victimized by Rene's response to his behaviour.

The Practicum Committee

The practicum committee consisted of Dr. Diane Hiebert-Murphy, academic advisor from the Faculty of Social Work at the University of Manitoba; Marlene Richert, M.S.W., Clinical Supervisor, New Directions and adjunct professor of the University of Manitoba, and Ellen Tabisz, M.S.W., former Executive Director of The Laurel Centre.

Clinical supervision was provided by Marlene Richert for two hours on a biweekly basis. Supervision consisted of viewing video tapes of sessions with discussion on client sessions for the week. Sessions were documented after each session. Files were maintained for each couple with updated weekly session reports, couple evaluation reports, and a closing summary at end of therapy. The therapist adhered to the guidelines for The Laurel Centre on client file security. For the purpose of the practicum writeup the therapist devised her own process notes.

The Evaluation

The evaluation is based on a one group pretest - post-test. The Dyadic Adjustment Scale was administered by the therapist before and after treatment. The client satisfaction scale devised by the therapist was enclosed in a stamped return envelope addressed to the clinical supervisor of the practicum. That process hopefully allowed for honest feedback by the participants. The client satisfaction scale was helpful in obtaining a picture of the couple's subjective experience of therapy, of as myself a therapist, and of The Laurel Centre as a facility.

To evaluate the effectiveness of the intervention, EFT for Couples, the Dyadic

Adjustment Scale (DAS, Spanier, 1976) was administered. This scale is a widely used global assessment of relationship satisfaction. The DAS total provides an overall index of the severity of the distress and reflects the couples' level of satisfaction.

The Dyadic Adjustment Scale (DAS) is well researched and accepted for its ease in administration. This scale was developed by Graham B. Spanier (1976) to serve as a rapid measure of the adjustment of partners in any committed couple relationship. It is a 32-item self-report inventory intended to measure adjustment in close relationships. Scores range from 0 to 151, with higher scores reflecting a better relationship and any score at 97 or below indicating poor relationship adjustment. The following are the interpretive guidelines for the T-scores: above 70 is very much above average, 66 to 70 is much above average, 61 to 65 is above average, 56 to 60 is slightly above average, 45 to 55 is average, 40 to 44 is slightly below average, 35 to 39 is below average, 30 to 34 is much below average, and below 30 is very much below average. The DAS total score is the sum of four intercorrelated but distinct subscales (dyadic satisfaction, dyadic cohesion, dyadic consensus, and affectional expression). This scale can be completed in just a few minutes, and is easily incorporated into a self-administered questionnaire (Spanier, 1976).

Reliability means the consistency of measurements. As a total score, the DAS has impressive internal consistency, with an alpha of .96. The subscales have fair to excellent internal consistency: Dyadic Satisfaction (DS) .94, Dyadic Cohesion (Dcoh) .81, Dyadic Concensus (Dcon) . 90, and Affectional Expression (AE) .73 (Corcoran & Fisher, 1987). Reliability was determined for each of the component scales as well as the total scale to ensure a comprehensive dyadic adjustment scale with identifiable and empirically verified

components (Spanier, 1976).

The validity of an instrument is the extent it is measuring what it is supposed to measure. The instrument was first checked with logical content validity procedures. The DAS has also shown known-group validity by discriminating between married and divorced couples on each item. The instrument also has evidence of concurrent validity, correlating with the Loche-Wallace Marital Scale (Corcoran & Fisher, 1987). To ensure content validity items were evaluated by three judges. Criteria for including the items were: (a) relevant measures of dyadic adjustment for contemporary relationships; (b) consistent with the nominal definitions suggested by the author for adjustment and its components (satisfaction, cohesion, consensus and affectional expression); and (c) carefully worded with appropriate fixed responses. Criterion-related validity was tested by administering the scale to a sample of divorced persons and a sample of married persons and each of the 32 items in the scale correlated significantly with the external criterion of the marital status. Construct validity was tested and established by comparing the DAS with other previously used marital adjustment scales. It was further established through factor analysis of the final 32-item scale and the four interrelated components (dyadic satisfaction, dyadic cohesion, dyadic consensus, and affectional expression) were found to exist.

Since its inception in 1976, the DAS had been widely used in research applications. Eddy, Heyman, and Weiss (1991) addressed two fundamental issues with the DAS:(a) is it a measure of measure of unidimensional "satisfaction" or is it a measure of multidimensional adjustment; and (b) how well does the DAS classify couples as

"distressed" or nondistressed". The results supported the DAS as a multidimensional measure of a couple relationship. Evidence supports the DAS in being able to discriminate between distressed and nondistressed couples. Eddy, et al. (1991) concluded that it does what it is intended to do. Kurdek (1992) assessed the reliability and validity of the four subscores derived from the DAS with samples from both partners of 538 married heterosexual couples and 197 cohabiting homosexual couples. This study found the reliability data for each subscore acceptable. DAS scores compared to four other measures of relationship quality supporting convergent validity. Evidence supported the multidimensional nature of the DAS, concluding this it is better to use the subscores separately. Kurdrek (1992) concluded that the subscale of Satisfaction is reliable and valid enough to stand on its own. Carey, Spector, Lantinga, and Krause (1993) further supported that the DAS and its four subscales are internally consistent and stable. The DAS has shown the ability to discriminate between couples who remain together and those who divorce, thus measuring marital stability (Vaughn & Matyasik, 1999).

The client satisfaction survey (Appendix B) is a qualitative measure that allows for participant response about their therapy experience. It provided feedback on what was helpful about the therapy process, the changes they were aware of, what has stayed the same in the relationship, and if the couple therapy program at The Laurel Centre was helpful.

Although DAS scores and the client feedback may reflect little change in the couple relationship, therapy provides clients with a language to talk about their problems and creates an awareness for the need for change that may not have been there in the

beginning of the sessions. Often clients need time to integrate the changes in their relationships, thus a longer period of time may be necessary to reflect this.

Appendix A

CONSENT FOR PARTICIPATION AND RECORDING OF COUPLE SESSIONS

- I understand that the Couple Therapy sessions are being offered as part of Deborah Palmer's Masters of Social Work degree.
- I understand that I will not be identified by name in the practicum report and that any identifying information will be modified to protect my confidentiality.
- I give permission for the therapy sessions to be videotaped with the understanding that the therapy session tapes may be viewed by a clinical supervisor.
- I understand that the video tapes will be evaluated only for the therapists effectiveness and to assist in treatment planning.
- I understand that the video tapes will be stored in a secure location at The Laurel Centre and will be erased at the end of the couple therapy work.

Signed: _____

Therapist: _____

Date: _____

Appendix B

CLIENT SATISFACTION SCALE

In order to help improve the services we provide at the Laurel Centre, please answer the following questions. We are interested in your honest opinions, whether they are positive or negative.

PLEASE ANSWER ALL THE QUESTIONS. Thank-you very much for the time you have taken in completing this survey.

1. What was the main reason for coming for therapy?

_____

_____

_____

2. How often did you feel you got the kind of help you needed in therapy sessions?

Circle one: a) always b) usually c) sometimes d) rarely

3. Was the therapy helpful in providing ways for you to understand your problems better?

Circle one: a) always b) usually c) sometimes d) rarely

4. What has changed since you came for help?

_____

_____

_____

_____

5. What has stayed the same?

_____

_____

_____

6. What was most helpful?

7. Overall how helpful was the therapy experience?

Circle one: a) helpful all the time b) helpful most of the time c) helpful a little of the time d) not helpful at all

8. If you need help in the future would you come back to Te Laurel Centre?

_____ Yes _____ No

Please explain? _____

9. If you could change one thing about your therapy experience, what would it be?

CHAPTER FOUR

ANALYSIS

Introduction

In this chapter I will present an extensive analysis of the intervention process of two couples. The analysis will be organized around the three process shifts or change events identified in EFT: cycle de-escalation, withdrawer engagement, and blamer softening. I will also discuss my learning in each of the cases. The first couple, Kim and Alex, were seen for approximately thirty-six sessions over a period of ten months. In addition to the couple sessions, each was seen for approximately four individual sessions, once during intake and at times of impasse in the couple work. During the process of couples therapy, Kim decided that they needed to "unattach" from each other and go their separate ways. The second couple Jennifer and Brad were seen weekly for approximately twenty sessions over a period of six months, and each once individually during intake. These two couples were committed to the therapy process and both had significant attachment issues.

Couple One

Background information

Kim and Alex were referred for couple therapy work by Kim's therapist at The Laurel Centre. Kim had been diligently involved in individual therapy for three years and during that time frame had participated in the following three groups at the agency: impact of sexual abuse, sexuality, and positive coping. She participated in the sexuality

group during the couple therapy. Kim continued to see her individual therapist regularly during the couple work.

Kim and Alex, both in their forties, have been married for twenty years and have two children, an adult daughter and an adolescent son. They first met when Kim was an adolescent and Alex was a young adult, and married a few years later. Kim and Alex agreed that their relationship assumed traditional roles with Kim at home with the children and Alex working to provide for their financial needs. A pivotal factor in their relationship has been Alex's abuse of alcohol for twenty years and his recent journey into sobriety for the last three years. Kim said that she had stopped enabling Alex's drinking and stopped waiting for him to connect with her. Prior to that, she pursued him for closeness and intimacy. Kim's role in the relationship changed when Alex quit drinking. Previously, she was the one who reached out and pursued him. Alex's sobriety shifted this dynamic in their relationship. When he began pursuing Kim for intimacy and connection she described her world as falling apart. Kim experienced severe depression and was hospitalized. At this point, she began her healing process from the impact of sexual abuse. Kim had separated from Alex for a six month period a few years ago. She moved into her own apartment but they continued to have daily contact. When Kim moved back in with Alex, they sold their previous home and purchased another one. They continued their relationship without resolving anything. Although they have been married for twenty plus years, Alex stated that he felt that their relationship began when he quit drinking about three years ago.

A number of issues have impacted on Kim from her family of origin. Kim was

sexually abused by her father and by her much older brother. Her mother was emotional and physical unavailable due to depression for which she was often hospitalized. Kim was affected by the suicide of a sibling. Kim was put in the middle of her parents' marital problems that resulted in her feeling responsible for their emotional needs. Kim has a history of diagnosed depression for which she was hospitalized. She was taking anti-depressant medication at the onset of couple therapy but over the course of the intervention stopped.

Alex was also impacted by a number of family of origin experiences. His father left home to work and Alex assumed the role of "man of the house". He was sexually abused by his mother and sister. Alex's mother and siblings experienced learning difficulties throughout their life, and Alex realized he was the "smart one" in the family. Alex acknowledges that he had too much power for a child and no guidance growing up. Alex's shame about the sexual abuse limited exploring the impact on him and their relationship. Alex recognized that drug and alcohol use beginning at age twelve was a way for him to cope. He was aware that he used alcohol through most of his life to numb. Alex left home at age sixteen and "made it on my own".

Analysis of the Couples Intervention

Upon entering therapy, Alex and Kim wanted to resolve issues in their relationship. They both recognized that they had a history of " hurts" to work through. According to the pre-treatment scores on the DAS, Kim and Alex experienced a distressed relationship. Kim's overall T-score for dyadic adjustment was 30, which is in

the much below average category. Alex's T-score of 21 suggests that his assessment of overall dyadic adjustment was very much below average.

Kim and Alex were aware that their history together had left them feeling distant and disconnected. They identified their struggles as the following: the impact of Kim's childhood sexual abuse, the impact of Alex's abuse of alcohol on their relationship, and Alex's infidelity and dishonesty about his affairs. Alex was confident that they could resolve their issues. Kim was ambivalent, struggling with her need to pull away and her awareness that they had a history of hurts to work through. Kim recognized that her leftover anger was affecting her ability to trust.

A core presenting problem for Alex and Kim was their struggle for sexual intimacy. In individual therapy Kim was processing her sexual abuse and experienced intrusive flashbacks while they were sexually intimate.This was normalized as the impact of sexual abuse and Kim requested no sexual contact, unless she initiated it. Alex reluctantly agreed, but experienced the no sex contract as a rejection of him. Alex was angry about Kim sleeping in a separate bedroom. Unable to hear that Kim was working through issues in therapy about sexual abuse he felt that it was an excuse to distance from him. While they were able to negotiate safe physical and emotional connection, this did not always meet Alex's need for connection.

Cycle De-escalation

The therapeutic tasks of the first shift of cycle de-escalation are building a therapeutic alliance, identifying the core issues, identifying the cycle of interaction, and accessing the underlying emotions of the interactional positions.

Initially, building an alliance with both Kim and Alex was a challenge. Alex was somewhat uncomfortable being at "Kim's agency" for couples therapy. Given her history of individual and group work, focussing on the relationship was a different experience for Kim. I had to ensure that she did not become invisible in the process. It was helpful to understand these dynamics in terms of attachment theory -

> that seeking and maintaining contact with others is a primary motivating principle in human beings. Dependency is an innate part of being human rather than a childhood trait we grow out of as we mature. The building blocks of secure bonds are emotional accessibility and responsiveness. When the security of a bond is threatened, attachment behaviours are activated. If these behaviours fail to evoke responsiveness from the attachment figure, a prototypical process of angry protest, clinging, despair, and finally detachment occurs (Johnson, 1996, p. 19).

Understanding their responses from this perspective ensured my position of neutrality in this process. This was an honouring way to frame a couples' experience. I was aware of my reaction to Alex when he demanded to have his sexual needs met. Alex experienced rejection when he was not able to connect with Kim.

The negative interaction cycle for this couple consisted of Alex pursuing and Kim withdrawing. At the point when they were distant from each other, Alex would blame and withdraw; Kim would eventually respond to this by disconnecting from her needs and placating Alex. In session, when they were at a difficult impasse, Kim would take responsibility for everything, and acquiesce. When Alex felt disconnected from Kim, he would be defensive and had difficulty accepting Kim's experience, often replying, "that is

not entirely factual". Using empathic conjecture, Alex's confusion and distrust of Kim's differing experience were identified as the underlying emotions to his defensive response.

The following is an account of the underlying inner emotions and the interactional positions for Alex in this cycle. When Alex experienced distance from Kim, he felt distrust and suspicion. He reacted by asking questions and investigating. Then Alex experienced greater distance with the underlying feelings of anger, frustration, and abandonment which increased his defensiveness. To protect himself, Alex withdrew and would not talk to Kim, experiencing anxiety and anger. Alex identified that he was retaliating, knowing that would get her attention. He would continue this "hard line" by not talking and not listening to her, and experienced underlying feelings of abandonment and anger. Being alone increased these feelings. When he could not tolerate feeling lonely and afraid, he would then start to talk to Kim. This would initiate them connecting but he would feel leery about this connection.

The following is Kim's experience in this negative interaction cycle and her underlying emotions: Kim was feeling at a strong point and was spending time on "herself and her process", and was not as available to Alex. At this point she felt comfortable with their connection. Kim was aware that Alex became frustrated, and how he reacted by withdrawing and not being emotionally available. Kim began to feel wrong for spending time alone, and reacted by being defensive. Alex intensified his actions to get connection and to resolve the tension. At this point she had to "deaden" what she was feeling inside to meet his needs in the relationship. Her feelings of insecurity intensified. She considered splitting up with him, often bringing this up and then over the next few days she convinced

herself that she could change to meet his needs. She named this part in the cycle as "being submissive".

This cycle of interaction, interactional positions and underlying emotions was framed in the context of the intimacy problem experienced by Alex and Kim. The cycle was further expanded to include Kim's experience of flashbacks and dissociation as part of her withdrawing position. Using empathic conjecture, Kim identified with her feelings of worthlessness and how that further silenced her. When she felt silenced, she would withdraw further from Alex. Alex's underlying feelings of being alone and abandoned were presented as his need for connection and safety. He resisted in acknowledging how his response silenced Kim. In the past, since Kim was not aware that she dissociated, Alex would name Kim's experience for her. In the therapy process he would often respond, "that is not entirely factual" when he did not agree with Kim's experience. Kim had difficulty connecting to herself and knowing her wants and needs. When Alex responded this way she would doubt and question herself. Using empathic conjecture, Kim connected with feelings of distrust and was able to tell Alex what she needed from him. Although Kim and Alex initially said they felt closer after the first shift, cycle de-escalation, it was soon evident that they were in a cease fire and that reconciliation had not occurred.

Withdrawer Engagement

The next shift involved changing the interactional positions. The steps in this shift are promoting identification of disowned needs and aspects of self and integrating these into the relationship interactions, promoting acceptance of the partner's new construction

of experience in the relationship and new responses, and facilitating the expression of wants and needs and creating emotional engagements. The goal in this shift is for the partner who withdraws to become more available for the other partner. For Kim and Alex this meant that Kim would be available for Alex and Alex would honour Kim's need for space and not blame her. This is a delicate balance for trauma survivors, especially for this couple with lack of sexual intimacy being the core issue. The work then was to have Kim stay connected in ways that felt safe for her. She was able to set appropriate guidelines around touch, asking first, and not sexualizing touch. A way of shaping new interactional patterns was creating safety for Kim so that she could be present for Alex.

This is where I realized we hit an impasse in the therapy process. Kim was not present but rather, was just giving in. As we worked in session, attempting to create new experiences of Kim connecting, she would visibly become invisible. She would become silent in session, often responding in a small quiet voice. She would take responsibility for everything wrong in relationship. Alex would not allow Kim her experience, by challenging her experience. Recalling that Kim had talked about Alex's infidelity in the first session, I explored the potential of an attachment injury.

An attachment injury is a betrayal of trust or abandonment at a crucial moment of need. This is known as a form of relationship trauma in which the partner experiences the relationship as insecure. Unresolved attachment injuries have the potential to create impasses in relationship repair. A specific session was planned for the resolution of the attachment injury. Kim was able to articulate the injury and the impact on her. She felt betrayed that Alex would have an affair with her best friend. When he initially told her

about the affair he was not entirely truthful. Alex later gave more details. Kim felt that she could not trust him and always wondered if he had more to tell her. When it was Alex's turn to validate Kim's feelings and take ownership of his behaviour, she let Alex off the hook, and shifted the content of the session. I clarified how important it was to resolve unfinished business and acknowledge Kim's feelings around Alex's infidelity. Kim responded by saying that she wanted to deal with other issues in session time. In reflection, I would have asked Kim more directly if she was wanting to avoid this issue.

At this time of impasse, I collaborated with Kim's individual therapist. She said Kim was doing well in individual work. As Kim pulled away, Alex became more defensive and shifted to other things that he thought were wrong about Kim. The model's focus on underlying emotions was helpful in keeping this about the process and not content. In retrospect, I might have spent more time with Alex exploring very gently his interactional stance of blaming and feelings of abandonment. I might have explored the role of his family history in his relationship with Kim. After meeting with Kim's therapist, I was told that Kim was afraid to be honest about her plan to leave Alex. In session I created more space for Kim to name what was honestly happening for her. As the couple therapist, it was difficult for me to sit with this information. In an individual session with Kim, she stated that her intent was to separate from Alex but she was not emotionally ready. She also mentioned she was terrified of the financial aspect of this decision.

Kim's fear of being financially responsible for herself speaks to a reality of traditional roles in marital relationship where the woman must rely on her partner for financial support while at home raising the children. In session Alex openly stated that he

brought more value to the relationship because he worked outside the home. He would devalue Kim's domestic contribution of raising the children and looking after the home. Knudson-Martin (1997) asserts the importance of problems being placed in the context of the relational system but also in the context of gender. Couple therapy cannot be fair and effective if it does not embody the understanding of the role of gender and how that contributes to concerns.

After a frustrating and prolonged impasse, Kim decided to end her relationship. She acknowledged feeling both exhilarated about being on her own and terrified. Kim said that her experience in the sexuality group, and her progress in individual therapy had facilitated a new sense of self. In the process of couple therapy she realized that her relationship contributed to feelings of low self-worth, worthlessness, and being powerless. That did not fit with her new concept of who she was. Alex, not accepting of this, felt she was being adolescent. That validated her decision to end the relationship. Kim added that when Alex needed her, she experienced it as him being a needy little boy and not an adult.

Although Alex waited for Kim to say that she no longer wanted to be in relationship with him, they said that the decision to end the relationship was mutual. That was not evident in session, conversely Kim was the one decided to end the relationship.

Since Kim was receiving individual work, I felt it was part of my obligation to work with Alex to process the break-up. I talked about this in the last couple session and checked how my working with Alex would impact on Kim. Kim was relieved that Alex had the opportunity to work through the ending of their relationship. Initially he was angry and blaming of Kim and just wanted to vent. I was uncomfortable about Alex's

judgements of Kim and would refocus the session to having him connect to what he was experiencing inside. When he connected with that, I would have him attend to that scared part of himself from his strong adult self that made wise choices for him. Finally he was able to accept how terrified he was about the ending of the relationship. After a short period of time, Alex started a new relationship with someone he had know for several years. It was only when he felt safe and connected that Alex was able to acknowledge his role in the relationship ending. Alex connected with his disowned guilt about his infidelity, and the dishonest way he had disclosed the affair. He recognized the impact of his drinking on the relationship. The guilt he experienced about his role in the relationship break-up stopped him from being the one to end relationship; instead he made Kim be the one to do it. Only after he was in a new relationship did he admit how he was terrified about being abandoned. When he was not able to connect though sexual intimacy with Kim, he felt abandoned and alone. It was only when he felt safe and connected in his new relationship did the shift of blamer softening occur. The EFT model clearly identifies this as an important step in the process, it was ironic and unfortunate that Alex experienced this in his new relationship.

Evaluation

The Dyadic Adjustment Scale was administered before and after treatment (Table 2). As noted earlier, the pre-treatment T-scores on the the Dyadic Adjustment Scale indicate a distressed relationship, with a total T-score for Alex of 21 and for Kim of 30.

Table Two

Pre and Post-Test Dyadic Adjustment Scores (Raw Scores and T Scores) - Couple One

	Dyadic Consensus		Dyadic Satisfaction		Affectional Expression		Dyadic Cohesion		Dyadic Adjustment	
	K	A	K	A	K	A	K	A	K	A
Pre-Test - Raw	38	26	27	23	5	4	10	10	80	63
T-score	(34)	(20)	(31)	(20)	(33)	(28)	(42)	(42)	(30)	(21)
Post-Test Raw	35	36	23	16	3	2	11	10	71	64
T-score	(30)	(20)	(26)	(20)	(24)	(20)	(44)	(42)	(25)	(21)

This places their scores in the "very much below average range" and "much below average" categories respectively. The post-treatment T-scores were 25 for Kim and 21 for Alex which places them both in the "very much below average range".

In comparison of the pre-test and post-test scores, both scored either the same or bit lower for each subscale, confirming no improvement in their relationship, with exception to Alex's scoring on the dyadic consensus scale. The pre-treatment score for dyadic consensus was 26 and post treatment was 36, indicating that they were agreeing on things that were important to them. That did not fit what I observed as Kim became more assertive at stating her needs and Alex disagreed. Perhaps the mutual decision to end the relationship was reflected in the score. The sub-scale dyadic satisfaction measures the amount of tension in the relationship and the extent to which each has thought about ending the relationship. Both of their scores were categorized as very much below average which accurately fit what I observed in session. The focus of their couple work was on deciding if their needs were met and if the relationship was still viable. The sub-scale of affectional expression measures expression of affection and sex in the relationship. Again, both scored in the very much below category. The core presenting issue in this relationship was sexual and emotional intimacy. Kim wanted to feel emotionally close to Alex without their physical affection being sexualized. Alex wanted to increase their sexual intimacy. The sub-scale dyadic cohesion score measures the common interests and activities shared by the couple. In this category both scored slightly below average. Interestingly enough, I would have thought they would have scored in the very much below average category.

Although Kim and Alex had diverse interests and often disagreed on how to spend

their time together, they worked well together when they had a house project or yard work to do. This accurately reflected that they did well when their was a crisis or home project but had difficulty agreeing how to have fun together. In conclusion, the DAS accurately fit what I had observed in the therapy process.

Alex and Kim responded to the client satisfaction survey. Kim stated that she usually got the help she need in therapy. Kim said that what she found helpful was being pushed to be honest about her feelings and needs. Overall she found the couples therapy helpful most of the time. Alex responded that he usually got the help he needed in therapy. Alex stated that the therapist's continual understanding and clarity was most helpful. He stated that having to focus on his needs made him realize how disconnected he was to himself. Overall he found the couples therapy experience helpful all of the time.

My Learning

In summary, through my work with Kim and Alex I learned an immense amount about the intervention of EFT. The concept of how attachment behaviours are activated when security is threatened with angry protest, clinging, despair, and finally detachment really stands out in my work with this couple. When the couple reached an impasse it was important for me to re-evaluate my work with them and retrace the steps by reassessing the unacknowledged feelings underlying their negative interactional cycle, and their disowned needs. The process of uncoupling was a great learning experience about how the model works based on attachment theory.

This couple demonstrated how their cycles of interaction (pursue-withdraw, critical demand - withdraw) maintained an acceptable level of emotional and sexual intimacy in their relationship for years. Kim and Alex were aware of their feelings at each stage of the cycle. It became evident as they progressed through a number of those cycles in session that Kim would disconnect from herself to meet Alex's needs. Kim's disconnection from herself, a common experience for individuals who experienced childhood sexual abuse, made it possible for her to connect with Alex in this way. Through her work in individual therapy she learned to stay connected to herself. It would have been helpful to have done a trauma checklist on both Alex and Kim. I learned the importance of doing so. This would have given me more information on the trauma dance that occurred within their cycle which may have shifted Alex from his blame stance by linking the similarity of their childhood experiences, thus decreasing the focus on Kim.

In retrospect, I realized I did not have clear understanding of the trauma dance that occurred in their relationship. Kim was clear about feeling overwhelmed when she had to meet Alex's needs. She experienced him as coming from his little boy place by being clingy, indirect, and expecting her to know what he wanted.. When Kim requested that they not have sexual relations, she would often acquiesce when Alex pressured her. Although she would state in session that at the time it was something she agreed to, I wondered if this was a familiar pattern to not voice her needs. I questioned what her trauma dance was and how she would re-enact this in the relationship.

From this couple, I learned the most about how sexual abuse impacts on a

relationship. Herman (1992) refers to constriction as the numbing response to surrender. Kim displayed this in her relationship and in session. In session when she did this, she would agree to anything Alex requested. They both had difficulty defining the self, and how this concept of self fit into the relationship. Alex felt shamed for having normal sexual needs. Kim would struggle when she defined herself based on her interests because it would not be congruent with the expectations in the relationship.

In contrast to parent-child attachment, adult attachment is reciprocal. Both Alex and Kim needed to be in a strong adult place in order to connect to what they need and be able to articulate this. Their past history reflected their need to be attachment objects for each other, not in an adult relationship based on adult attachment. They both struggled with developing a sense of self and other which was made it too risky to connect and trust.

Couple Two

Background Information

Jennifer and Brad were referred for couple therapy by Jennifer's therapist at the Laurel Centre. Jennifer had been involved in individual therapy for two months before starting couples therapy. She continued to work with her individual therapist throughout the process of couples work.

Jennifer and Brad are both under the age of twenty-five and have been married for under a year. They had been friends since early adolescence. At the time they began couples therapy Jennifer was six months pregnant. This pregnancy although welcomed.

was unplanned. Jennifer was feeling an urgency to resolve their couple issues before the baby was born. Jennifer and Brad grew up in the same small rural town. As an adolescent, Jennifer would connect with Brad and share what was happening in her home. It was through his reporting this to the proper authorities that Jennifer was removed from home. Initially Jennifer was upset that Brad would disclose what been told to him in confidence. She did not speak to him for two years. As an adult she has a better understanding of this and gives him credit for her father being charged. He had given a detailed report that was pivotal in charges being laid against her father. They described their connection at that time as powerful. Brad would seem to sense when Jennifer was in distress and always call at the right time. After the two year period of no contact they reconnected and maintained a friendship. They became romantically involved two years ago.

Jennifer experienced emotional, physical, and sexual abuse in her home. She was sexually abused by her father and her older brother. Child welfare authorities were involved with Jennifer's family since she was in grade seven when she had reported that her brother sexually abused her. He was charged and removed from the home. Authorities were aware of other abuse in her home but her family was placed in a family preservation program. Her father continued his abusive behaviour throughout that time and continued to sexually and physically abuse Jennifer. Both Jennifer and a brother were apprehended from the home after Brad reported the abuse to the authorities. Jennifer refers to her foster family as her family, referring to them as mom and dad. With the exception of her younger brother, Jennifer has cut off contact with her biological family.

Jennifer experienced a difficult time during her adolescence that manifested in depression and suicidal ideation. Currently these are not problems for her. Jennifer is a strong individual who is functioning well in her life. She recognizes, however, that she has difficulty with self-esteem. At the time of referral, Jennifer was concerned about how her history of childhood abuse would impact on her parenting.

Brad identified that he came from a "dysfunctional family". Brad's parents divorced when he was a toddler and when his father left Brad developed a mysterious undiagnosed illness from which he nearly died. When his dad returned, his symptoms disappeared, and returned when his dad left again. His mother eventually relinquished custody of him to his father and kept his younger brother. Brad describes his father as an alcoholic who has gone through the recovery and relapse process several times. Brad's father remarried and Brad considers his step-mother his mother. Eventually his younger brother came to live with them. Brad does not have contact with his biological mother. The new family consisted of Brad, his brother, his step-mother, and her daughter. Brad described his blended family as chaotic; everyone fought all the time. Brad maintained distance from the ongoing family disputes. He maintains regular contact with his father and step-mother and keeps in contact regularly. They offer support to Brad and Jennifer, although Brad has difficulty asking them for help.

Brad experienced a time in his life when he used gambling to cope. This put him into serious financial trouble that is still having an effect on their family finances. He admits that he was feeling hopeless about his life at that time. Brad received some help for

his gambling. Currently, he does not gamble and has not done so for about two years. Jennifer is concerned that he has not resolved the issues that led to his gambling and will lapse back as a way of coping when he gets stressed. He disagrees with her and feels he has the issue under control.

Analysis of Couples Intervention

As a couple, they identified that they were having difficulty communicating, were not feeling emotionally close to each other, and seemed to disagree about everything. Jennifer was concerned that they were drifting apart. In the past they were able to talk for hours and she would feel safe about sharing everything with Brad. She said Brad always stood by her and was supportive of her. Jennifer still cherishes a letter Brad wrote to her about how he felt about her. She yearns for him to connect with her in that way. Jennifer wonders what has happened in their relationship. She said Brad is unable to hear her anger and is uncomfortable with her venting her feelings about the sexual abuse. She is aware that she has to protect him from her feelings. Brad experienced the relationship as frustrating. According to him, she does not agree with him on anything. Both agreed that their core issues were their lack of communication and not feeling close to each other.

According to the pre-treatment scores of the DAS, Brad's score for dyadic adjustment was slightly below average category while Jennifer's score was average for dyadic adjustment. The scores supported their need for improvement in their relationship. It also pointed to the strength of their relationship which was their commitment to each

other. They both felt that any level of tension in their relationship needed to be taken seriously. Further discussion of the pre- and post-treatment scores will occur in the evaluation section.

Cycle De-escalation

The therapeutic tasks of the first shift are building a therapeutic alliance, identifying the core issues, identifying the cycle of interaction, and accessing the underlying emotions of the interactional positions. As with most people who experience childhood sexual abuse, trust is an issue to be aware of in building the therapeutic alliance. Initially, Jennifer was guarded and reserved, presenting information in a direct fashion. Brad was more engaging but would fidget when he felt uncomfortable. With Jennifer a shift in trust occurred after she was convinced I knew what I was doing and when I continually kept validating her experience. For Brad the connection seemed to happen sooner. The core issues for this couple were difficulty communicating, finances, sexual intimacy, and their lack of connection.

The negative interaction cycle for this couple consisted of Jennifer pursuing and Brad withdrawing. When he did not respond she would then blame or accuse and Brad would further withdraw. Jennifer stated that she felt frustrated that Brad was not emotionally accessible or responsive to her. Brad was confused when Jennifer was not clear about what she wanted. He felt uncomfortable with the tension this created. This parallelled the feeling he had growing up with his blended family. He felt if he responded, he would not do the right thing so therefore it is better to play was safe and do nothing.

Both had difficulty connecting with their underlying emotions. Jennifer connected with an emotion but was only able to sustain that for a brief moment. When Brad connected with an underlying emotion he became increasingly uncomfortable and began to fidget. The interactional cycle was then framed with respect to their attachment needs: Jennifer pursues to connect and wants to experience Brad as being emotionally accessible and responsive; Brad experiences the ambiguity in her connection, and the confusion of that makes him pull away. When her security felt threatened, her attachment behaviours of angry protest were activated and she reacted by blaming and being critical. In despair, Brad would react by further withdrawing. As we explored what their interactional cycle was like, it became clear to Jennifer that she pursued for connection but would back off because she was scared. She would continually test Brad with requests for connection, however she ignored him when he made efforts to connect with her. This completely confused Brad and he would experience tension as a result of Jennifer's ambiguity.

Withdrawer Engagement

In the next shift, withdrawer engagement, the work is to change interactional patterns. The goals are to promote identification of disowned needs and aspects of self and to integrate these into relationship interactions, to promote acceptance of the partner's new construction of experience in the relationship and new responses, and facilitate expression ofthe specific needs and wants and create emotional engagement. Jennifer was clear that she was not reaching out until Brad was more emotionally accessible to her. Jennifer

identified how difficult it was to be vulnerable and not have him there. This demonstrates the importance of having an accessible and responsive attachment with him. This was difficult for Brad because he felt he could never get it right. Jennifer admitted to testing and retesting him, questioning if he would be there for her. Brad felt that he took a big risk reaching out to her and when she shut him out he was terrified. He talked about his physical reactions to fear, the knots in the stomach, and his dry mouth. .

Often this process was thrown off track by the couple's difficulty connecting to emotions. As I would try and restructure interactions in session around the difficult underlying emotions this became clearer. For example, when Jennifer was sad her eyes would momentarily tear, she would visibly stop her tears, and her body would tense. She would then laugh or act indifferent. It was difficult to access the sadness, and what was under there. That was when the sessions would shift to content. Jennifer and Brad were most comfortable practising roleplaying in session. It appeared that we had reached an impasse and at this point I explored for any attachment injuries in this relationship.

Jennifer identified a time when she really needed Brad to be there for her and he let her down. This is know as an attachment injury and for Jennifer she experienced this as abandonment in a crucial moment. Brad was able to connect and listen to her as she expressed her disappointment that he did not go to court with her last year when her father was charged. That was difficult for him to do. Brad did not know that Jennifer wanted him to go to court with her. In the past when they talked about this he had difficulty with the intensity of Jennifer's emotions. She would debrief this with a friend instead and Brad

thought that since this person was going to court with her and that he was not welcome. He was prepared to go, but was not invited. Jennifer explained how paralysed she felt when it came to issues with her family. To resolve this incident, I used evocative responding to have her articulate the injury and the impact on her. She told Brad how difficult it was to face her father in court. When she initially gave the police statement she was able list of the details of the assaults. When she heard the statement read in court, she experienced a visceral response. Brad responding by paraphrasing and validating her experience. He stated that he felt excluded from her experience and did not know what the right response was. Jennifer accessed her attachment fears, revealing how she never had anyone to support her. Brad took responsibility for not going, expressed regret, and stayed engaged with her at an empathic level, reflecting how difficult it must have been for her to face this alone. He asked her if he could hold her now. She initially was uncomfortable with this but settled into a comforting hug with him. Brad again reassured her to keep direct with him and ask for what she needed. He assured her that he wanted her to feel safe with him. After resolving this incident, both of them discussed how he could be helpful to her in those times.

The impending arrival of their baby created a sense of urgency about Brad being able to be there for Jennifer. This was a crucial time for her and to be abandoned again could further threaten the security in their relationship. The baby arrived two weeks early, and fortunately for them Brad's scheduled business trip was changed. He was able to support Jennifer through the birth of their child. As a therapist, I knew that he had to be

able to come out of his withdrawing pattern for this occasion. The therapeutic process was sidelined after the birth of their child. We were in the process of ending the first shift and moving into the second. The second shift is a difficult emotional place where people must identify with their disowned needs, integrate this into the relationship, validate and accept their partner's experience, and create new ways of interacting.

When Brad and Jennifer returned to therapy from their six week break, it seemed that there was tension in their relationship again. Jennifer astutely pointed out that previously she thought they just had trouble communicating. She now realized that they have trouble connecting. Brad was having difficulty reaching out and connecting. Attempts in the past were spurned by Jennifer's indifference. When Brad reached out to Jennifer and shared what he found difficult with her responses, she responded defensively. She told him that if he reacted to how she said things because of his experience in the past, that he needed to access individual therapy. Jennifer told him that she would compromise and change her language half of the time, but that she was not willing to do it all the time. Through evocative responding, I attempted to access what was under resistance to his request. She said that he would have to prove to her that he would be there for her all the time. This repeated a rigid mini-cycle in their interactional pattern. She would pursue for connection, he would reach out but she would respond indifferently. Jennifer stated that she was aware that she tested, tested, and tested him. At this point, Brad further withdrew by working harder at work and school. Jennifer then reacted to this response by pursuing him and demanding to know what was wrong. Currently, this is the rigid pattern they

seemed to be locked into.

Jennifer and Brad are continuing with couple work. Brad would most likely benefit from individual work at this point and this may expedite their connection process. It appears that Jennifer is having a difficult time taking responsibility for the part of herself and that desires intimacy and conversely fears closeness. This is evident in her testing behaviour.

Evaluation

Comparison of the pre- and post-scores of the DAS for Jennifer and Brad indicate an improvement in their relationship (Table 3). The pre-test T- test scores increased to from 41 to 46 for Brad and from 46 to 52 for Jennifer. Brad's T-test score of 46 placed him in the average range for dyadic adjustment. Jennifer's T-test score of 52 placed her in the average range for dyadic adjustment. Although it remained it the same range, there was a slight increase. Jennifer's scores reflect an increase in dyadic satisfaction, affectional expression, and dyadic cohesion. Interestingly, her scores reflected a slight decrease in dyadic consensus; perhaps this was reflective of her reaction to Brad asserting himself more. Brad's scores reflect an improvement in dyadic consensus, dyadic satisfaction, affectional expression, and dyadic cohesion.

Table 3

Pre- and Post-Scores in the Dyadic Adjustment Scale (T scores) for Couple Two

	dyadic consensus		dyadic satisfaction		dyadic expression		dyadic cohesion		dyadic adjustment	
	J	B	J	B	J	B	J	B	J	B
Pre-test	54	41	37	36	7	6	17	16	108	99
T-Score	(52)	(37)	(45)	(44)	(42)	(37)	(59)	(56)	(46)	(41)
Post-test	51	42	40	39	9	7	18	20	118	108
T-Score	(49)	(38)	(49)	(48)	(50)	(41)	(61)	(66)	(52)	(46)

The client satisfaction survey accurately reflected their experience in therapy as I observed it to be. Jennifer and Brad both found the couples therapy experience to be usually helpful. They both identified that their communication has improved and that they communicate more openly. Jennifer identified that what she found helpful was having insight into how they shut off their emotions from each other. In response to the question of what has stayed the same, Brad reflected that some issues have not been discussed and some remain unresolved. In response to the same question, Jennifer identified that they still have not opened up to their emotional feelings. One thing she would change about her therapy experience is taking more risks and being more open. These responses accurately reflect where they were in the process of EFT before the birth of their child. The thing he would change about the therapy experience was to make more time to work on issues away from the therapy session. In session, I would facilitate new ways of them interacting. I would encourage then to take risks outside of session. Overall, their responses to the client feedback survey were congruent with my clinical observations.

My Learning

Working with this couple I was able to integrate the information on how people react when their security is threatened. I was aware of how difficult it is to reach out and connect when one has a partner who withdraws. Evident with Jennifer was her refusal to become vulnerable until Brad could prove he would be there for her. Although she desired intimacy, conversely fear of closeness was evident. For Brad. It was terrifying for him to

reach out and be tested all the time.

This clarified the importance of creating new interactional experiences in therapy to facilitate this shift. I learned the importance of using the basic skills required in EFT - reflection, validation, evocative responding, heightening, empathic conjecture, and interpretation to accessing emotion. For restructuring interactions, the skills of tracking and reflecting, reframing, and restructuring and shaping interactions were applied. I used these to reflect and track Jennifer's behaviour of testing Brad whenever he took a risk and reached out. To create a new experience of connecting, I would have her practice staying connected to Brad for about thirty seconds. I would then reconnect her with what she was experiencing inside and have her be aware of how that was for her. Being consciously reacquainted with these skills has been a beneficial experience which has expanded into my individual counselling practice.

In my work with this couple who both experienced difficult attachment issues I wondered if I needed to slow the process down or if needed to heighten their emotional experiences. I was aware of Jennifer's unplanned pregnancy and her need to process this event. I was aware of the balancing act of challenging to shift things and keeping things safe. The post evaluation reflects an improvement in their connection and the dynamic of them skirting emotional issues.

CHAPTER FIVE

THEMES

In this chapter I will discuss five themes that are identified in the literature as clinical issues that are relevant for trauma survivors and their partners, and relate points in the couple treatment that highlight these clinical themes.This chapter will identify and discuss the relevant themes of ambivalence, dual trauma couples, depression, trust, and attachment injury that emerged from my work with the couples in the practicum process.

Ambivalence

Most childhood sexual abuse occurs in the interpersonal context of close relationships. Connection in adult relationships is characterized by emotional intimacy and sexual intimacy. The impact of childhood sexual abuse impairs one's ability to connect in emotionally and sexually intimate ways. This can result in many forms of disturbed relatedness. Trauma survivors experience ambivalence and fear with interpersonal attachment and vulnerability (Briere, 1992).

In my work with women who have experienced childhood sexual abuse, this dynamic is demonstrated in individual therapy when clients continually shift the focus of therapy from themselves to their intimate relationship. It is difficult to get a clear understanding of the troublesome dynamics of their relationship with the other partner absent from the therapy. Since there is no resolution of the issues, the client presents this as an issue of concern in each session, creating an impasse in the therapy. These

experiences have motivated me to develop my couple counselling skills.

This ambivalence was evident with Nadine in her work with her individual therapist. Nadine was referred to the couple program by her individual therapist because the uncertainty in her relationship consistently dominated the individual therapy. In couple therapy we worked towards understanding their pattern of interaction. Although Nadine admits she is not attracted to Don, she is afraid to be alone.

Rene was referred to the couples therapy program by her individual therapist. She had worked diligently to resolve the impact of childhood sexual abuse and made many positive changes in her life. Rene's experience with her significant other was marked by her need to connect with him when she was lonely and her need to create distance from him when he was verbally abusive to her. Although she was clear that she did not want to be in an abusive relationship, she reached out to him when was lonely. Through couple therapy she came to understand why she stayed with her partner. Rene chose to end her relationship when she realized that he was unable to provide her with the safety and security she needed.

It is through relationship with others that we encounter ourselves. As we understand our own attachment needs and behaviours, we can make safer choices for ourselves. I encourage clients to attempt to resolve relationship issues before ending a relationship. Working through this in relationship provides us with awareness on how we respond when we do not feel close or secure. We are able to articulate this and ask for what we need. When were are able to connect with, identify, and clearly ask for what we need to feel connected we can avoid repeating hurtful interactional patterns of avoiding,

withdrawing, clinging, and protesting.

Dual trauma couples

The term dual trauma couples is used to describe couples in which both partners have experienced trauma in their lives that continues to impact their individual and relationship functioning. Since four of the couples I worked with during this practicum were dual trauma couples, it has been a relevant theme that warrants further discussion. With dual trauma couples, trauma responses dominate the interaction of these couples and disrupt normal relationship exchanges. Either one or both may be in crisis. Interpersonal reactivity, transference, emotional withdrawal, and associated responses may potentially complicate an already distressed relationship. Successful treatment needs to include a wide range of techniques addressing the major themes, characteristics, and patterns and distinguishing the past trauma from the current relationship (Balcom, 1996).

Linda and Shane sporadically attended twelve therapy sessions. Linda was sexually abused in childhood by a family member and Shane was abandoned by his mother, and subsequently lived in several foster homes. As a child Linda had been responsible for the care and the safety of numerous siblings. She would often feel the need to run away when she was overwhelmed. When Linda experienced intrusive flashbacks she needed to withdraw, not wanting to be touched or held. Shane experienced this as total abandonment, just as he had experienced as a child. This reaction resulted in him monitoring her daily activities. As a couple, they had decided that he would be at home with their two children while she worked and went to school. With those demands she was

often away for long periods. Shane reacted by constantly calling her at work, school, and her study group. When things got too intense and unmanageable they would both use recreational drugs to numb. This spiralled them into financial and spiritual crisis. In therapy, Shane's constant pursuing in response to Linda's physical absence and distancing was framed as their cycle of interaction. Their use of drugs to numb was included in this cycle as a distancing response for both of them. As we tracked their inner emotional experience through their interactional style, they were able to learn new ways of connecting. When Linda worked long hours she would call often and touch base with Shane. They would take time to connect when she got home from work. Shane was able to respect her need for quiet time and keep her grounded when she experienced a flashback. It was helpful to understand their couple distress as a failure of the attachment relationship to provide a secure base for both partners. In the past I would have framed Shane's clingy stalking behaviour as abusive and controlling. Attachment behaviours such as protest, clinging, and avoidance in response to their couple distress resulted in them both not being responsive or accessible to each other.

Jennifer and Brad, previously discussed in the case analysis, are a dual trauma couple. Brad's experience of being caught in the middle of intense family battles made it difficult for him to cope with Jennifer's debriefing of intense emotions from her childhood sexual abuse. In reaction to his unavailability and unresponsiveness to her, Jennifer escalated her attachment behaviour of protesting and being critical. This pushed Brad further away. Jennifer re-experienced this as an attachment injury - "he is never there for me". These behaviours of reaching out and pushing away were incorporated into the

description of their interactional cycle. As their inner emotions were tracked, Brad was able to reach out and be emotionally accessible and responsive to her. When her attachment needs for safety and protection were met, she was able to back off.

Balcom (1996) identifies that the work with dual trauma couples is most challenging when both are in crisis. My work with Nadine and Don highlights the other extreme of crisis, which is when learned helplessness dominates interactions. Throughout our work together there were times when one or the other would fluctuate through a period of complete despair. For example, at one point Nadine was feeling good about her life because she was involved with a work training program but then she failed at that program. This program was too demanding for the limited physical energy she had because of her medical condition. She would experience herself as a failure which would translate into other areas of her life. Nadine would then feel powerless about making positive changes in her life. Don was also involved in an adult education program and was determined to get his life back on track. Often there were setbacks that he would experience as obstacles. When it was only one of them experiencing a setback, they would distance from each other for a short period of time. At one point they ended their relationship, only to get back together a few days later. Most recently they both experienced a down period. It is interesting how they responded to their cycles by either distancing or creating closeness.

A complicating dynamic for Kim and Alex, another dual trauma couple, is how the sexual abuse impacted on their capacity for sexual intimacy. At one point in Kim's healing process she was flooded by intrusive images. These were triggered by sexual contact and

touch. If she maintained the sexual activity she had to dissociate. When this happened she felt disloyal to herself. It was necessary to distance from Alex during these times. This was further complicated by Alex's reaction to his sexual abuse history. Kim described Alex as a sex addict. The validity of this was difficult to assess. In the therapy it was clear that Alex sexualized touch as a way of connecting with her. This made her feel objectified. Balcom (1996) refers to this dynamic as one of the patterns of dual trauma couples. One of the partners experiences trauma responses and the other one experiences trauma reactivity. When Alex could not connect with Kim through sexual intimacy, he would experience abandonment. If she dissociated during sexual intimacy, he would experience feelings of abandonment. This was a core issue in their couple dynamics.

Dual trauma couples was a relevant theme in my work with couples during the practicum. The dynamics of dual trauma couples highlighted the complicating factors that can make up the experience of couples' interactional cycles. The inner emotions experienced in the interactional cycles are generally quite intense. Although each couples' experience may be different it is helpful to have a framework to clarify the dance.

Trust

The act of sexual abuse is the ultimate betrayal of trust. Many individuals who experience childhood abuse are impaired in their ability to trust others due to this betrayal (Courtois, 1988). Our ability to trust is essential in order to establish interpersonal relationships. The betrayal of trust can manifest itself in a number of ways, including intense fear of betrayal or abandonment, rage and anger towards past or potential partners.

lack of trust in self, isolation, and withdrawal (Courtois, 1988; McCann, Pearlman, Sakheim, & Abramson, 1990). With this generalized mistrust there is the expectation that others will misuse them to meet their own needs or abandon them or not protect them (Russell, 1986). This distrust complicates the therapeutic relationship when these feelings are generalized to all people (Courtois, 1988). These feelings of distrust are intensified in close relationships and can be generalized to the therapeutic relationship (Courtois, 1988).

In the process of my work with couples, trust was a critical issue that manifested in may ways in the intervention. For example, Alex was distrustful of me and of the therapy process. He had difficulty accepting new information about the couple process. When Alex started couples therapy he was feeling unsafe and anxious about the conflict in his relationship with Kim. He talked about feeling ganged up on when I validated Kim's experience. Eventually, Kim ended her relationship with Alex. Within a month, Alex was in a new relationship and talked about feeling safe and nurtured. He was able to integrate what he had learned from the couples therapy and reflect on what was helpful. I was aware of how overwhelmed Alex felt as a little boy being left in charge of the house when his father left. He functioned cognitively higher than his mother and older siblings and had to figure things out on his own. For him to distrust me made perfect sense. Interestingly, it was only when he was feeling connected to his new girlfriend that he was able to reflect on our work.

The theme of trust was present when I worked with Jennifer and Brad. Jennifer constantly tested Brad's attempts at reaching out to connect with her. We reflected on that dynamic in therapy and she talked about needing to experience that he would keep trying

and trying to connect with her. She wanted to be sure he would not give up on her and that he would always be there.

In my work with Wendy and Peter we had worked for twelve session, and had de-escalated the cycle a little. In their interactional cycle Wendy was critical and blaming of Peter, and Peter withdrew from her. The lack of trust she experienced was projected in the therapy process. It was painful to witness the terror and insecurity Wendy experienced in her interpersonal relationships. After Wendy and Peter had attended twelve sessions, she cancelled subsequent sessions, eventually not returning. I did not know how she felt about the therapy until I had called her to come in and fill out necessary paperwork. She said she felt unsafe in the therapeutic relationship.

Depression

Depression was a prevalent theme for the couples in this practicum. Briere (1992) names depression as a common symptom of individuals who have been sexually abused in childhood. Working with this population is challenging because depression narrows individuals' self-worth by contributing to feelings of worthlessness. Previous research of a couples therapy program (Trute et al., 2001) identifies depression in this population. Women who experienced depression in this sample also experienced childhood sexual abuse and previously used addictions as a way of coping. Therapy would reduce their depression levels from high to moderate. Depression was characterized by withdrawal behaviour in the interactional cycle. Underlying emotions were low self-esteem, feelings of worthlessness, and hopelessness. This was evident in the work with Nadine and Don

who both experienced depression. They often did not have the energy to deal with issues of conflict and couple distress in their relationship. When both partners in a couple withdraw it is difficult to maintain safe connection. For couples with one partner experiencing depression, this is experienced as withdrawal in their interactional cycle. The other partner experiences rejection and abandonment. Johnson (2000) suggests that when a partner has given up hope of sustaining an emotionally responsive and accessible bond with their partner, they detach and experience depression. Kim's depression reflected this pattern. When she experienced powerlessness and hopelessness in the relationship she experienced bouts of depression. Depression affects the connection couples need to experience to feel safe, nurtured, and protected. This presents challenges in couple therapy. It is difficult to sort out if the depression was due to the impact of the childhood sexual abuse or to the distress in the relationship. In sessions, I learned it was effective to address the unsaid things in the couple relationship. This shifted the feelings of powerlessness to a sense of achievement for articulating the issues.

Attachment Injury

An important theme that has relevance to the intervention of EFT is attachment injury. An attachment injury is a betrayal of trust or abandonment at a crucial moment of need (Johnson, 2000). The theme of attachment injuries was relevant in most of the couples I worked with in the practicum.

Lori and Max attended three highly intense sessions of couples therapy. In the assessment phase, Lori identified an important issue she wanted to resolve between her

partner Max and herself. She brought up a painful intense incident for which she wanted Max to apologize and take ownership. Years earlier Lori had been sexually assaulted by Max's brother in their home. At that time, she had wanted to legally charge his brother and wanted Max's support. In the session she was able to repeat in near perfect detail their exact conversation about that. The incident itself was traumatic enough but what Lori experienced as unforgivable was Max's refusal to support her in contacting the authorities. Max was emotionally unresponsive and unavailable to her at a crucial moment after a traumatic incident. Max's response to this in the therapy session was to deny any recollection of this conversation. Lori abruptly ended the session and called later to terminate the therapy. She said that all the therapy in the world would not fix what Max had done to her. This is an extreme example of attachment injury.

A presenting issue in sessions with Nadine and Don was Nadine's experience of Don not being there for her and choosing the needs of others over hers. All of the presenting scenarios seemed innocuous, such as Don driving his adult daughter to the laundry mat, or taking her to the bank. In session, it was Nadine's disproportionate reaction of clingy behaviour that provided the clues about the significance of these events to her. In the process of tracking her inner emotions to her experience in their interactional cycle, she was able to connect to her experience of not having anyone there for her needs. Nadine's mother died at age three and she went to live with relatives. She was sexually abused by her uncle. Nadine said she knew that she was not part of that family because the needs of her cousins were always more important than hers. When Don would do things for other people, she experienced that as him not being emotional responsive or available

for her. Part of the process in therapy was having Don connect with her in ways that she felt like she was a priority in his life. I collaborated with Nadine's individual therapist about focusing the work in session on ways that Nadine could begin meeting some of her own needs. Attachment injury in this situation was about the significance and emotional experience Nadine placed on seemingly minor events in their relationship.

The concept of attachment injury is also discussed in the two cases analyses in the previous chapter. A relationship injury must be resolved or it may result in an impasse in the therapy process. In the resolution of an attachment injury safety and trust must be restored.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

This chapter provides conclusions of the couples therapy for women who have experienced childhood sexual abuse and the intervention of EFT. The learning benefits that resulted will be discussed and recommendations that come from the practicum experience will be outlined. The primary goal of the practicum was to gain knowledge and comfort in an intervention in couples therapy that would be beneficial for adult females who experienced childhood sexual abuse and their intimate partners.

Critique of the model

The intervention of EFT as a model of intervention with couples where one of the partners has been impacted by sexual abuse can be adapted to work effectively for couples therapy with trauma survivors. It would be important to build in the trauma dance the couple re-enacts in their relationship as part of the interactional cycle. After working through the practicum experience I felt I gained a level of expertise with which I am comfortable. What was helpful about this model is the clear framework that integrates systemic and experiential perspectives. The systemic perspective that looks at a particular context as a whole allows for an understanding of the impact of childhood sexual abuse. To look at that in isolation limits how sexual abuse impacts on relationships and how those who experience trauma interact. The concept that causality is circular and behaviours are linked in a circular chain to other behaviours fits the concept of attachment theory

well. This was evident in the interactional patterns of the couple work.

The experiential perspective of this model allows for the limiting emotional schemes that trauma experiences create - desire for intimacy and fear of closeness. This limits how women who experience childhood sexual abuse experience relationships. The emotional impact of this can be explored and reprocessed in couples therapy.

This model provides a clearly outlined map for intervention, with information on the process shifts necessary in couples therapy. It is grounded in attachment theory and the part that I found most helpful was understanding that when "security is threatened, attachment behaviours are activated. If these behaviours fail to evoke responsiveness from the attachment figure, a prototypical process of angry protest, clinging, despair, and finally detachment occurs" (Johnson, 1996, p. 19). This respectfully frames a couples experience in a context that validates both of their experiences. Throughout the practicum there were times when the behaviour of a partner who was blaming and accusing was not endearing. Understanding their responses from this perspective ensured my position of neutrality in this process.

An important concept in EFT is attachment injuries. An attachment injury is a betrayal of trust or abandonment at a crucial moment of need. This was a helpful concept for exploring attachment blocks. In the work with women who experienced trauma, my observation is that this attachment block also serves as a way of keeping distance that one does not have to take responsibility for. Trust is a critical issue that plays out in divergent positions of desire for intimacy and the fear of closeness. An unresolved attachment injury justifies the need for distance. It may also enforce a pattern of re-enactment. No one is to

be trusted and if you let people close, you will be hurt. This was a pattern I observed with the women I worked.

A limitation of the EFT model is its presentation in sequential steps. The Laurel Centre Counselling Model is designed as a circular model which more accurately represents the healing process for individuals who have experienced childhood sexual abuse. The three shifts that occur in EFT require cycle de-escalation, withdrawer engagement, and blamer softening. The withdrawer engagement shift may occur but when the client is feeling unsafe, s/he may slip back into familiar behaviours. What if it's unsafe for the withdrawer to engage with the blamer's behaviour? For example, in my the work with Kim and Alex, Kim would engage only to placate Alex. This pattern kept them trapped in their impasse. Just the normal demands of day-to-day living and stressors escalate the behaviours of both the withdrawer and the blamer. It would be interesting to adapt the model from a sequential format to a circular one. This may also incorporate the concept that healing occurs episodically. It was my experience that couples wanted to back off after the cycle de-escalation shift. At this point, the tension between them had decreased. Perhaps an integration period is necessary just as it is in individual therapy.

The process of identifying the interactional cycle and tracking the underlying emotional experiences seems to decrease the level of marital stress. In the cycle de-escalation stage couples generally experienced an increase in their communication skills. One couple were quite happy with their increased ability to communicate. They came back later and stated that they realized that their problem was not in communication but in their inability to connect. It may be beneficial to integrate changes before continuing on without

having those changes solidify.

A limitation of the model is that it does not clearly state how to work with clients to have them attend to their own traumatized parts from their strong adult self, and then asking for what they need from their partner from this adult place. It's unclear if the expectation is for the partner to do that for the traumatized person. Although the area of trauma has grown in terms of research and clinical techniques, it is critically important to address these issues in the framework of the model. My values as a feminist social worker addressed the concept of power in the therapy sessions, most especially how power is constructed in intimate relationships. If each partner does not learn to self-soothe and respond to their hurt parts from their adult place, there is the danger of having each responding from their hurt child parts. This may inadvertently maintain and entrench traditional gender relations. This may repeat the patriarchal pattern of a female giving her power away to a father figure and a male expecting nurturing from a mother figure. Adult attachment requires that both be adult to achieve equality and symmetry. Authors Vatcher and Bogo (2001) recommend a feminist integrated model that would make gender more visible, and address how couple issues create imbalances of power that negatively affect the relationship. This integration would expand couple work from a micro (individual) and mezzo (family and small groups) level to a macro (society at large) level, thus addressing social change and making it congruent with social work practice.

To further address social change, the EFT model would benefit by adding a cultural sensitivity component. Our experiences in society regarding cultural acceptance or rejection insidiously shape our concept of self. The reality of oppression marginalises

individuals, families and communities. These power dynamics are also reflected in our intimate relationships. Explicitly valuing different cultural perspectives would enhance the EFT model.

Although the authors of this model refer to it as a short term model, the multiple, complex issues with individuals who experience trauma extends the length of couple work required. This is not so much a limitation of the model as it is the complexity of the impact of childhood sexual abuse trauma. This complexity is intensified when this is the experience of the partner too. In this practicum experience there was only one couple that neatly had their issues worked through in twelve sessions. The rest of the couples had many more sessions or needed many more sessions but had to stop for their own reasons.

Evaluation of My Learning

I was keenly aware of how this model kept me anchored in process, not the content of what the couple brought to session. When a couple experiences a high level marital distress, this is critically important. Part of the learning curve for me was being able to stay in process and not in content in the heat of a session.

The author of this model suggests slowing down the process for people who have experienced trauma. I learned that it was important to slow down considerably for couples with a high level of marital distress. With the impasse encountered with the couple I worked with for the longest period of time, this learning could have perhaps decreased the frustration level. I now understand that Kim needed time to build herself and feel strong enough to leave. Alex represented a safe attachment figure for a long period of time in

adult life. To leave when she was not ready would have added to her experience of not being able to do anything right.

As a couple therapist with the relationship being the client I was challenged with how to address the emotional concerns of male partners. An agency such as The Laurel Centre has as its mandate to look after females who have experienced childhood sexual abuse. How do we interweave couple work and address concerns of their intimate partners? Individual work for both partners in conjunction with couple work would resolve the impact of sexual abuse more effectively.

For couples with high marital distress that display highly chaotic behaviours, I would agree with the findings of authors Trute, et al. (2001) that behavioural self-management skills, listening skills, and impulse control are important groundwork that needs to occur as a prelude to couples work. Gottman (1994) describes the most pernicious patterns (criticize/complain, express contempt, defend/distance, and stonewall) as the four horseman. These patterns will destroy connection and communication in relationships.

What I have learned has expanded my understanding of individual work. Unresolved sexual abuse manifests in relationships by generating distrust and despair. It is important to understand the other side of the dyadic relationship pattern. Asking the question, what do you see as your role in this, could begin the awareness of how their behaviour impacts on a situation. This broadens the context of relationships issues that are presented in individual therapy sessions. The relational interaction that occurs out of the desire for intimacy and fear of closeness can be expanded to other significant close relationships. For example, an awareness of how withdrawing behaviour creates distance in

relationships may lessen the experience of feeling rejected.

What I have learned about the strengths of the couples I worked with has further inspired me and renewed my passion for this work. The determination they all had to improve the quality of their lives, their relationships, and the lives of their children, in spite of the adversity they experienced was powerful to witness. This was strongly reflected in their dedication to their children. For the couples with children, it was critically important to end the cycle of violence. Providing a safe nurturing environment where their children could be curious, explore the world safely, and have their physical, emotional, and spiritual needs met was what anchored them in their day to day lives. I was surprised how most of the couples used humour in sessions and were able to step back to laugh at themselves and the adversity of life. They all displayed creativity in dealing with their daily struggles. I will be forever touched by their resiliency. What was most heartfelt was the courage they showed in letting me into the privacy of their struggles and vulnerabilities. The words determination, resilience, courage, humour, and creativity are the heartfelt reminders I will always carry with me when I reflect on the strengths of the couples with whom I worked.

I have far exceeded the learning goals for the purpose of my practicum. One of my learning goals was to increase my knowledge of how the trauma of childhood sexual abuse impacts on the couple relationship. After reading through the literature I have been able to integrate how sexual abuse impacts on a couple relationship and the dynamics in that relationship. Understanding how attachment factors into this process and asking the questions: what is it people do to stay connected? what makes them feel safe? what do they do when they are terrified? puts into context how couples interact and the underlying

emotions. I have increased my understanding of the ways that clients respond in relationships because of past trauma and how to create new experiences. Witnessing this in session has been an "a - ha"experience for me.

Another one of my goals was to develop my assessment and clinical skills in working with couples where one partner has experienced childhood sexual abuse. In my work with couples, I was reluctant to directly talk about the impact of sexual abuse for fear of further pathologising the female partner. After this practicum I know that this can be done by assessing the impact of childhood experiences for both partners. This can provide further information into each person's interactional stance.

Part of my learning goals was to increase my understanding of the use of evaluation in clinical practice. I found the use of the Dyadic Adjustment Scale relevant and non-intrusive. The fact that it is so easily administered was welcome relief from the anxiety and tension in the first session. In couples therapy I would continue using the DAS for evaluation. I would concur with Trute, et al. (2001) that the administration of the post DAS needs to allow couples time to integrate what they have learned in couple therapy. I learned that the client satisfaction survey was a valuable tool that captured the couples' subjective experiences. It was another source of information that added value to data collection.

I learned that often the goal of couple work is not just to improve the relationship but to be able help individuals to disconnect when their needs are not being met. Maybe it is because of traumatic bonding or the ambivalence people experience about relationships that they find themselves in relationships that do not facilitate healing. Regardless, it is important to help individuals assess if this relationship is working.

I learned that some couples are familiar with marital distress and their fear of being alone was the bonding experience that kept them together. This was evident with Nadine and Don. Their scores reflect high levels of martial distress but they remained together. With Rene and John, it took several more destructive cycles before she was able to end the relationship.

I learned the importance of assessment regarding compulsive coping behaviours. I would include a questionnaire that specifically asks pointed questions regarding these behaviours. This could be to develop a couple protection plan regarding the use of these compulsive coping behaviours. It would be helpful to explore how each partner responds when the other uses a compulsive coping behaviour. This information could be integrated into the couple's interactional cycle.

I learned that some people cannot handle the responsibility of an intimate adult relationship. They prefer attachment objects to relationships, someone to feel close and safe with. Adult love is reciprocal and requires responsibility and commitment. It is often confused with the unconditional love that is characteristic of a caregiver and child relationship.

Recommendations

I would recommend couples therapy as part of the healing journey for people who have experienced childhood sexual abuse and are in an intimate relationship. A couples therapy program offered with individual counselling may expedite the healing process for clients. The clear framework with the EFT model that concisely outlines the necessary

shifts in the process of couples therapy into nine steps was beneficial in keeping the therapy sessions in process and not being pulled into the whirlwind content. Its anchor in attachment theory fits the experience of clients who have experienced childhood trauma.

I would recommend that couples therapy continues to be part of the programming at The Laurel Centre. It is important for therapists doing individual therapy to have an understanding of the dynamics of couple relationships and how that would present in individual therapy. An understanding of the way people behave when their security is threatened could further focus the individual work. Working collaboratively as a team is effective and necessary when working with clients who have experienced childhood sexual abuse.

I would recommend that partners of women who have experienced sexual abuse in childhood access individual therapy if childhood sexual abuse or physical abuse has been their experience also. It is difficult to shift deeply embedded attachment reactions of distancing, withdrawing or blaming behaviours when these issues have not been addressed. Any change in individual therapy shifts the dynamics in a relationship. For example, if the role of the intimate partner is rescuer this may no longer be required as the woman gets stronger and is able to establish clear boundaries for herself. It would be ideal if the partner was able to resolve past childhood trauma also and connect in safe and nurturing ways.

I would strongly recommend that continued government funding be available for services that address the needs of women, children and men who have experienced childhood sexual abuse. I would strongly urge societal recognition of the prevalence and

impact of childhood sexual abuse. Herman (1992) describes the impact of childhood sexual abuse as the violation of human connection. This limits our connection to self, our connection to intimate others, and our connection to community and society as a whole.

References

American Psychiatric Association. (1994). Diagnostic manual of mental disorders (DSM IV. (4th ed.) Washington, DC: American Psychiatric Association.

Anderson, G., Yaesenik, L., & Ross, C. A. (1993). Dissociative experiences in disorders among women who identify themselves as sexual abuse survivors. Child Abuse and Neglect, 17, 677-686.

Balcom, D. (1996). The interpersonal dynamics and treatment of dual trauma couples. Journal of Marital and Family Therapy, 22, 431-442.

Briere, J. (1992). Child abuse and trauma: Theory and treatment of the lasting effects. London: Sage Publications.

Briere, J. (1996). Therapy for adults molested as children. (2nd ed). New York: Springer Publishing.

Briere, J., & Runtz, M. (1987). Post sexual abuse trauma: Data and implications for practice. Journal of Interpersonal Violence, 2, 367 - 379.

Briere, J., & Runtz, M. (1993). Childhood sexual abuse: Long-term sequelae and implications for psychological assessment. Journal of Interpersonal Violence, 8, 312-330.

Browne, A., & Finkelhor, D. (1986). Impact of child sexual abuse: A review of the research. Psychological Bulletin, 99, 66-77.

Busby, D. M., Glenn, E., Steggell, G. L., & Adamson, D. W. (1993). Treatment issues for survivors of physical and sexual abuse. Journal of Marital and Family Therapy, 19, 377-392.

Byng-Hall, J. (1995). Creating a secure family base: Some implications of

attachment theory for family therapy. Family Process, 34, 45-68.

Carlson, E. B., & Furby, L. (1997). A conceptual framework for long-term psychological effects of traumatic childhood sexual abuse. Child Maltreatment, 2, 383-390.

Carey, M. P., Spector, I. P. , Lantinga, L. J., & Krauss, D. J. (1993). Reliability of the dyadic adjustment scale. Psychological Assessment, 5, 238-240.

Chauncey, S. (1994). Emotional concerns and treatment of male partners of female sexual abuse survivors. Social Work, 39, 669-676.

Connors, M. E., & Morse, W. (1993). Sexual abuse and eating disorders: A review. International Journal of Eating Disorders, 13, 1-11.

Corcoran, K., & Fischer, J. (1987). Measures for clinical practice: a sourcebook. New York: The Free Press.

Courtois, C. (1988). Healing the incest wound: Adult survivors in therapy. New York: W.W. Norton.

Courtois, C. (1997). Healing the incest wound: A treatment update with attention to recovered memory issues. American Journal of Psychotherapy, 51, 464-497.

Dandeneau, M .L., & Johnson, S. M. (1994). Facilitating intimacy: interventions and effects. Journal of Marital & Family Therapy, 20, 17-33.

Denton, W. H. , Burleson, B. R. , Clark, T. E. , Rodriquez, C. P. & Hobbs, B. V. (2000). A randomized trial of emotion-focused therapy for couples in a training clinic. Journal of Marital and Family Therapy, 26, 65-78.

Dolan, Y. (1991). Resolving sexual abuse: Solution-focused therapy and

Ericksonian hypnosis for adult survivors. New York: W. W. Norton & Company, Inc.

Douglas, A., Matson, I., & Hunter, S. (1989). Sex therapy for women incestuously abused as children. Sexual & Marital Therapy, 4, 143-159.

Dye, E., & Roth, W. (1991). Psychotherapy with Viet Nam veterans and rape and incest survivors. Psychotherapy, 28, 103- 120.

Eddy, M., Heyman, R. E., & Weiss, R. L. (1991). An empirical evaluation of the dyadic adjustment scale: exploring the differences between marital "satisfaction" and "adjustment". Behavioral Assessment, 13, 199-220.

Follette, V. M. (1994). Survivors of child sexual abuse: Treatment using a contextual analysis. In S. C. Hayes, Jacobson, M. J. & Dougher, D. (Eds.), Acceptance and change: Content and context in psychotherapy. Reno, NV: Context Press.

Follette, V. M. , & Pistorello, J. (1995). Couples therapy. In C. Classen & I. D. Yalom (Eds.), Treating women molested in childhood (pp. 129-161). San Francisco: Jossey Bass.

Gelinas, D. J. (1983). The persisting negative effects of incest. Psychiatry, 46, 312-332.

Goldman, A., & Greenberg, L. (1992). Comparison of integrated systematic and emotionally focused approaches to couples therapy. Journal of Consulting and Clinical Psychology, 60, 962-969.

Gordon-Walker, J., Johnson, S., Manion, I., & Cloutier, S. (1996). Emotionally focused marital intervention for couples with chronically ill children. Journal of Consulting and Clinical Psychology, 64, 1029-1036.

Gottman, J. (1994). Why marriages succeed or fail and how you can make yours last. New York: Fireside Books.

Greenberg, L. S., & Johnson, S. M. (1986a). Affect in marital therapy. Journal of Marital & Family Therapy, 12, 1-10.

Greenberg, L. S., & Johnson, S. M. (1986b). When to evoke emotion and why: process diagnosis in couples therapy. Journal of Marriage and Family Therapy, 12, 19-23.

Heller, P. E, & Wood, B. (1998). The process of intimacy: similarity, understanding and gender. Journal of Marital and Family Therapy, 24, 274-288.

Henderson, A. J. Z. , Bartholomew, K., & Dutton, D. G. (1997). He loves me; He loves me not: Attachment and separation resolution of abused women. Journal of Family Violence, 12, 169-191.

Herman, J. (1992a). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. Journal of Traumatic Stress, 5, 377-391.

Herman, J. (1992b). Trauma and recovery. New York: Harper Collins.

James, P. S. (1991). Effects of a communication training component added to an emotionally focused couples therapy. Journal of Marital and Family Therapy, 17, 263-275.

Johnson, S. M. (1989). Integrating marital and individual therapy for incest survivors: A case study. Psychotherapy, 26, 96-103.

Johnson, S. M. (1996). The practice of emotionally focused marital therapy: Creating connection. New York: Brunner/Mazel

Johnson, S. M. (1998). Emotionally focused couple therapy. Case studies in couple and family therapy: Systemic and cognitive perspectives. (Ed.) Dattillio, F.

450- 472. New York: Guilford Publications.

Johnson, S. M. (2000). Emotionally Focused Therapy for Couples Conference. Ottawa, Ontario.

Johnson, S. M., & Greenberg, L. S. (1988). Relating process to outcome in marital therapy. Journal of Marital and Family Therapy, 14, 175-183.

Johnson, S. M., & Greenberg, L.S. (1985a). Differential effects of experiental and problem solving interventions in resolving marital conflict. Journal of Clinical and Consulting Psychology, 53, 175-184.

Johnson, S. M., & Greenberg, L. S. (1985b). Emotionally focused couples therapy: A outcome study. Journal of Marital and Family Therapy, 11, 313-317.

Johnson, S. M., Maddeaux, C., & Blouin, J. (1998). Emotionally focused family therapy for bulimia. Psychotherapy, 35, 238-247.

Johnson, S. M., & Talitman, E. (1997). Predictors of success in emotionally focused marital therapy. Journal of Marital & Family Therapy, 23, 135-152.

Johnson, S. M.., & Williams-Keeler, L. (1998). Creating healing relationships for couples dealing with trauma: the use of emotionally focused marital therapy. Journal of Marital and Family Therapy, 24, 25-40.

Knudson-Martin, C. (1997). The politics of gender in family therapy. Journal of Marital and Family Therapy, 23, 421-437.

Kung, W. W. (2000). The intertwined relationship between depression and marital distress: Elements of marital therapy conductive to effective treatment outcome. Journal of Marital And Family Therapy, 26, 51-63.

Kurdek, L. (1992). Dimensionality of the dyadic adjustment scale: Evidence from heterosexual and homosexual couples. Journal of Family Psychology, 6, 22-35.

Maltas, C.P. (1996). Reenactment and repair: couples therapy with survivors of childhood sexual abuse. Harvard Review of Psychiatry, 3, 351-355.

Maltas, C., & Shay, J. (1995). Trauma contagion in partners in survivors of childhood sexual abuse. American Journal of Orthopsychiatry, 65, 529-539.

Maltz, W. (1991). The sexual healing journey: A guide for survivors of sexual abuse. New York: HarperPerennial.

Maltz, W. & Holman, B. (1987). Incest and sexuality: A guide to understanding and healing. Massachusetts, Lexington Books.

McCann, I. L., & Pearlman, L.A. (1990). Psychological trauma and the adult survivor: theory, therapy and transformation. New York: Brunner/Mazel.

Mennen, F. E., & Pearlmutter, L. (1993). Detecting childhood sexual abuse in couples therapy. Families in Society: The Journal of Contemporary Human Services, February, 74-83.

Nelson, B. S., & Wampler, K. (2000). Systematic effects of trauma in clinical couples: An exploratory study of secondary trauma resulting from childhood abuse. Journal of Marital and Family Therapy, 26, 171-184.

Pearlman, L. A. & Saakvitne, K. W. (1995). Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors. New York: W. W. Norton & Company.

Pistolle, M. C. (1994). Adult attachment styles: some thoughts on closeness -

distance struggles. Family process, 33, 147-159.

Pistorello, J., & Follette, V. M. (1998). Childhood sexual abuse and couples' relationships: Female survivors' report in therapy groups. Journal of Marital & Family Therapy, 24, 473-485.

Polusny, M. A., & Follette, V. M. (1995). Long-term correlates of child sexual abuse: Theory and review of the empirical literature. Preventative Psychology, 4, 143-166.

Reid, K. S., Wampler, R. S., & Taylor, D. K. (1996). The "alienated" partner: responses to traditional therapy for adult sex abuse survivors. Journal of Martial & Family Therapy, 22, 443-453.

Rodriguez, N., Ryan, S. W., Vande Kemp, H., & Foy, D. W. (1997). Posttraumatic stress disorder in adult female survivors of childhood sexual abuse: a comparison study. Journal of Counselling & Clinical Psychology, 65, 53-59.

Roth, S., & Newman, E. (1993). The process of coping with incest for adult survivors: Measurement and implications for treatment and research. Journal of Interpersonal Violence, 8, 363-377.

Russell, D. (1986). The secret trauma: Incest in the lives of girls and women. New York: Basic Books.

Spanier, G. B. (1976). Measuring dyadic adjustment: new scales for assessing the quality of marriage and similar dyads. Journal of Marriage and the Family, 2, 15 - 28.

The Laurel Centre (2000). The Laurel Centre: 15th Annual Report. Unpublished.

Trute, B., Docking, R., & Hiebert-Murphy, D. (2001). Couples therapy for

women survivors of child sexual abuse who are in addictions recovery: A comparative case study of treatment process and outcome. Journal of Marital and Family Therapy, 27, 99-110.

Van Buskirk, S. S. , & Cole, C. F. (1983). Characteristics of eight women seeking therapy for the effects of incest. Psychotherapy: Theory, Research, and Practice, 20, 503-514.

van der Kolk, B. A. (1996). The complexity to the adaptation to trauma: Self-regulation, stimulus discrimination, and characterlogical development. InB. A. van der Kolk, A. C. McFarlane, & L. Weisaeth, (Eds.) Traumatic Stress: The effects of overwhelming experience on mind, body, and society. New York: The Guilford Press.

Vatcher, C., & Bogo, M. (2001). The feminist/emotionally focused therapy practice model: An integrated approach for couple therapy. Journal of Marital and Family Therapy, 27, 69-83.

Vaughn, M. J., & Matyastik Baier, M. E. (1999). Reliability and validity of the relationship assessment scale. The American Journal of Family Therapy, 27, 137-147.

Walker, L. E. (1995). Abused women and survivor therapy. Washington, D.C.: American Psychological Association.

Walker, M. (1998). Feminist psychotherapy and sexual abuse. In I. B. Seu, & M. C. Heenan, (Eds.), Feminism and psychotherapy: Reflections of contemporary theories and practices. London: Sage Publications.

Appendix A

CONSENT FOR PARTICIPATION AND RECORDING OF COUPLE SESSIONS

- **I understand that the Couple Therapy sessions are being offered as part of Deborah Palmer's Masters of Social Work degree.**
- **I understand that I will not be identified by name in the practicum report and that any identifying information will be modified to protect my confidentiality.**
- **I give permission for the therapy sessions to be videotaped with the understanding that the therapy session tapes may be viewed by a clinical supervisor.**
- **I understand that the video tapes will be evaluated only for the therapists effectiveness and to assist in treatment planning.**
- **I understand that the video tapes will be stored in a secure location at The Laurel Centre and will be erased at the end of the couple therapy work.**

Signed: _____

Therapist: _____

Date: _____

Appendix B

CLIENT SATISFACTION SCALE

In order to help improve the services we provide at the Laurel Centre, please answer the following questions. We are interested in your honest opinions, whether they are positive or negative.

PLEASE ANSWER ALL THE QUESTIONS. Thank-you very much for the time you have taken in completing this survey.

1. What was the main reason for coming for therapy?

_____

_____

_____

2. How often did you feel you got the kind of help you needed in therapy sessions?

Circle one: a) always b) usually c) sometimes d) rarely

3. Was the therapy helpful in providing ways for you to understand your problems better?

Circle one: a) always b) usually c) sometimes d) rarely

4. What has changed since you came for help?

_____

_____

_____

_____

_____

5. What has stayed the same?

_____

_____

_____

6. What was most helpful?

7. Overall how helpful was the therapy experience?

Circle one: a) helpful all the time b) helpful most of the time c) helpful a little of the time d) not helpful at all

8. If you need help in the future would you come back to Te Laurel Centre?

_____ Yes _____ No

Please explain? _____

9. If you could change one thing about your therapy experience, what would it be?