ACA-PBs
American Counseling Association Practice Briefs
The Center for Counseling Practice, Policy, and Research
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June 8, 2015

Counseling Couples with a Trauma History

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DESCRIPTION OF COUPLES WITH A TRAUMA HISTORY

Couples with a trauma history are those in which one or both partners have a history of trauma -that is unrelated to combat since there is a separate literature on combat trauma- and has led to significant traumatic symptom displays. The trauma may have preceded or followed the couple formation. A traumatic event is defined by the *DSM-5* (American Psychiatric Association [APA], 2013) as an actual or threatened death, serious injury, or sexual violence, or witnessing in person or learning indirectly that a close relative or close friend was exposed to violent, accidental, actual, or threatened death. About 8% of those who experience a trauma develop chronic PTSD (Kilpatrick, Resnick, & Milanak, 2013). Chronic PTSD is more persistent, difficult to treat, and impairing than acute PTSD (Norris & Slone, 2007). Survivors of a broad spectrum of traumas deal with difficulties with intimate relationships and often experience higher separation and divorce rates (Brown-Bowers, Fredman, Wanklyn, & Monson, 2012; Colman & Widom, 2004; Compton & Follette, 1998, 2002; Watson & Halford, 2010) and difficulties in forming intimate relationships with others (Alexander, 2008). Many couples with a trauma history seek couple therapy to address the effects of traumatic experiences on their relationship.

Resources:

Effects of Complex Trauma. The National Child Traumatic Stress Network. http://www.nctsn.org/trauma-types/complex-trauma/effects-of-complex-trauma

Trauma and Relationships. The International Society for Traumatic Stress Studies. http://www.istss.org/AM/Template.cfm?Section=PublicEducationPamphlets&Template=/CM/ContentDisplay.cfm&ContentID=1465

IDENTIFICATION/ASSESSMENT STRATEGIES

One of the first tasks when working with couples is to determine if trauma is a component of the couple's difficulties (see Basham & Miehls, 2004). This is not always easy, particularly when clients have childhood sexual abuse histories, and feel shameful and reluctant to disclose (Cobia, Sobansky, & Ingram, 2004). Zala (2012) stated, "Clients sometimes express dissatisfaction with couple therapists for not considering the impact of past childhood sexual assault" (p. 220). The client may not disclose such information or, even if disclosed, may not recognize that the trauma affects couple functioning. Thus, the counselor must determine how the traumatic history is affecting couple functioning, and how to address such issues without making the abuse survivor the "identified patient" and the designated "problem" within the couple (Compton & Follette, 1998, 2002). When asking about trauma history, it is important not to use the word abuse, because use of the word results in underreporting (Briere, 2004). Instead, behavioral descriptions of experiences can be used to better get at trauma and abuse histories.

Self-report instruments that assess for trauma include the Trauma Symptom Inventory (TSI) or Trauma Symptom Inventory - Alternate Form (TSI-A; Briere, 1995), Posttraumatic Stress Diagnostic Scale (PDS;

Foa, 1995), Detailed Assessment of Posttraumatic Stress (DAPS; Briere, 2001), Cognitive Distortions Scale (CDS; Briere, 2000a), Inventory of Altered Self-Capacities (ISC; Briere, 2000b),Trauma and Attachment Belief Scale (TABS; Pearlman, 2003), Multiscale Dissociation Inventory (MDI; Briere, 2002), and Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998). Interviews that assess for trauma include the Structured Clinical Interview for *DSM-IV* (SCID-PTSD; First & Gibbon, 2004), Structured Interview for Disorders of Extreme Stress (SIDES; Pelcovitz et al., 1997), and Childhood Maltreatment Interview Schedule—Short Form (CMIS-SF; Briere, 1992). In addition to looking for a history of trauma in each partner, it is important to explore violence in the relationship (Alexander, 2008), since couples counseling should be discontinued if there is relationship violence (Basham & Miehls, 2004; Johnson, 2002). The Conflict Tactics Scale (CTS; Strauss, 1979) may be used to assess for the occurrence of violence in the relationship.

Assessing couple functioning can help determine the impact of trauma on couples and functioning can be assessed via self-report instruments such as the Dyadic Adjustment Scale (DAS-Revised; Busby, Christensen, Crane, & Larsen, 1995), RELATE (Busby, Holman, & Taniguchi, 2001) and Couples Satisfaction Index (CSI; Funk & Rogge, 2007).

Resources:
Collection of Assessment Resources. The International Society for Traumatic Stress Studies. http://www.istss.org/AssessmentResources/4435.htm

The Relate Institute. https://www.relate-institute.org/

INTERVENTION STRATEGIES

There are two empirically supported couple's therapy approaches that have demonstrated efficacy when working with couples with histories of trauma: integrative behavioral couple therapy (IBCT; Compton & Follette, 1998; Jacobson & Christensen, 1998; Leonard, Follette & Compton, 2006; Wiedeman, 2011) and emotionally-focused couple therapy (EFCT; Johnson, 2002; Johnson & Courtois, 2009; Johnson & Greenberg, 1985; Johnson & Williams Keeler, 1998). These two empirically supported treatments are reviewed below. Several other approaches have been suggested for the treatment of couples with a history of trauma, but since these models are not based on empirically supported couple therapy approaches, they will not be discussed in further detail. These additional approaches include Basham and Miehls (2004) integrative model of couples with a trauma history; Buttenheim and Levendosky's (1994) object relations model for child sexual abuse (CSA) couples with a trauma history; and Maltas's (1996) psychoanalytic model for CSA couples with a trauma history.

Integrative Behavioral Couple Therapy (IBCT)

Compton and Follette (1998) discussed the limitations in effectiveness of traditional behavioral couple therapy for working with couples with issues of severe relationship stress (Baucom & Hoffman, 1986), emotional disengagement and conflict avoidance (Gottman & Krokoff, 1989; Hahlweg, Revenstorf & Schindler, 1984), or psychological difficulties in one partner (Jacobson, Fruzzetti, Dobson, Whisman, & Hops, 1993). Compton and Follette (1998) recommended the use of integrative behavioral couple therapy (IBCT; Jacobson & Christensen, 1998) which combines traditional behavioral couple therapy with acceptance therapy. Compton and Follette included a pretreatment stage in which safety issues, such as suicide, homicide, violence, child abuse or neglect, and other high risk behaviors, such as drinking and driving or those that are associated with the risk of HIV, are addressed. If safety issues do not exist, they recommended determining the couple's commitment to the relationship and to counseling. The

focus of IBCT with couples with a trauma history is to resolve relationship conflicts through individual change, and to facilitate acceptance by each partner when individual change is not possible. The model interweaves change and acceptance throughout treatment. Interventions for change include behavior exchange; receptive and expressive communication skills training; problem solving training; mindfulness, distress tolerance and emotion regulation training (Linehan, 1993); and videotaping communication. Acceptance strategies include empathetic joining, turning the problem into an "it," tolerance building, and self care (Jacobson & Christensen, 1998). At the end of counseling–and no matter what the source of trauma—Compton and Follette (1998)address sexual issues, intertwined with intimacy and emotional expression.

Using various principles drawn from functional contextualism, radical behaviorism, and experiential avoidance theories, Leonard et al. (2006) modified their approach to counseling couples with a trauma history. This approach relies on treatment principles (rather than a manualized approach) as Leonard et al. (2006) believe a manualized approach is too prescriptive for couples with a trauma history. The first principle is *effectiveness*, and these techniques include mindfulness practice and chain analyses of problem situations. The second principle is *consistency* in the therapy environment, and the primary technique used is validation. The third principle is *contingent responding* which focuses on the use of praise as positive reinforcement, shaping, and negative reinforcement or punishment. The technique used with *contingent responding* is behavior exchange, which is a process where a each partner identifies behaviors he/she would like his/her partner to increase. Each partner then increases those behaviors and acknowledges his/her partner for increasing the identified behaviors. The fourth principle is *modeling* and uses in-session role playing with the counselor acting as one of partners to demonstrate a skill. The fifth principle is *tacting* (i.e., interpersonal effectiveness skills), and *manding* (emotion regulation skills) which pulls on dialectic behavioral therapy techniques. The sixth principle is *exposure* to feared feelings, topics, objects and/or thoughts. Emotional exposure is not as structured as other exposure techniques and involves encouraging and facilitating experiencing and tolerating emotions in the session. The final principle is *acceptance* of internal events, one's history, and oneself and others, and involves identifying problematic controlling strategies for internal experiences by using metaphors and exercises from acceptance and commitment therapy.

Resources:
Integrative Behavioral Couple Therapy. http://ibct.psych.ucla.edu/about.html

Emotionally-Focused Couples Therapy (EFCT)

Recent studies (Dalton, Greenman, Classen, & Johnson, 2013; MacIntosh & Johnson, 2008) indicate that EFCT is effective for couples in which the female partner in a couple is an intrafamilial childhood abuse survivor. EFCT is a three stage model based on attachment theory (Johnson, 2002). Stage 1, *stabilization*, involves: (a) creating a safe place and trusting therapeutic relationship, and (b) clarifying interactional patterns and the emotional responses that shape these patterns. Interventions for the first goal include empathetic reflection, validation, empathetic inference, and collaborative problem solving about safety issues. Interventions for the second goal include tracking and summarizing interactions and reflecting and expanding underlying emotions. The second stage, *restructuring* bonds through building self and relational capacities, includes (a) expanding and restructuring emotional experiences, (b) expanding self with others, and (c) restructuring interactions toward accessibility and responsiveness. The third stage, *integration,* occurs on three levels: self-definition, relationship definition, and each partner's resilience to traumatic stress. Interventions include constructing an empowering story of change process, fostering pragmatic problem solving of divisive issues, and heightening bonding responses and events that define the relationship as a secure attachment.

Resources:
The International Centre for Excellence in Emotionally Focused Therapy. http://www.iceeft.com/

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