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Two's Company, Three's Not a Crowd: A Relational Approach to Couple Intervention After Trauma

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This article considers that trauma to one or both partners disrupts a couple's relationship in a way that compromises safety, assaults definitions of self and other, locks partners into patterns of defensive pain, impairs mutual regulation of needs, interferes with the capacity to mourn, and makes strangers out of intimate partners. As such, the author establishes a rationale for intervention and offers a relational approach to couple intervention after trauma. Drawing on trauma theory and relational perspective, the author discusses interventions and techniques throughout the stages of trauma recovery and exemplifies it by application to clinical cases. It is also demonstrated that interventions from a relational perspective address the isolation and disconnection caused by trauma and foster restoration, remembering, and couple reconnection.

KEYWORDS: Couple therapy; trauma; posttraumatic stress disorder; relational theory; self psychology.

> Traumatic events have primary effects not only on the psychological structures of the self but also on the systems of attachment and meaning.
>
> —Herman (1997, p. 51)

The impact of trauma on partners as a result of war, illness, or other loss has been well documented (Armstrong, Best, & Domenici, 2006; Bennett, Litz, Sarnoff-Lee, & Maguen, 2005; Dekel, Goldblatt, Keidar, Solomon, & Polliack, 2005; Fals-Stewart & Kelley, 2005; Kramer, Ceschi, Van der Linden, & Bodenmann, 2005; Matsakis,

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2005; Riggs, Byrne, Weathers, & Litz, 1998; Skerrett, 2003). On February 23, 2007, a *New York Times* headline read, "Long Iraq Tours Can Make Home a Trying Front." The article reported that "most families and soldiers cope, sometimes heroically. But these separations have also left a trail of badly strained or broken unions" (Alvarez, 2007, pp. A1, A14).

LITERATURE REVIEW AND FURTHER EXPLORATIONS

The literature that addresses the impact and treatment of trauma on a couple often focuses on the posttraumatic stress disorder (PTSD) of the survivor and the secondary traumatic stress on the partner (Dekel et al., 2005; Figley, 1998; Matsakis, 1966, 2005). There has been far less focus on the recognition or treatment of the impact of trauma on relationships. Riggs and colleagues (1998) indicated that more than 70% of the Vietnam veterans with PTSD and their partners reported clinically significant levels of relationship distress. Kramer and colleagues (2005), suggesting that the literature on trauma has paid too little attention to the coping processes in intimate relationships, found that those who had experienced a trauma reported a general lack of dyadic coping, that is, the capacity to maintain supportive behaviors or attitudes towards one's partner in response to a stressful situation.

In her use of emotionally focused therapy with couples, Johnson (2005) underscored the necessity of restoring and strengthening the attachment bonds of couples in the aftermath of trauma. Recognizing the complex interaction between the trauma of veterans and the functioning of their partners and families, Sherman, Zanotti, and Jones (2005) recommended addressing relationship problems by utilizing couple therapy. They proposed a framework of couple strategies linked to the three cluster symptoms of PTSD: reexperience, avoidance, and increased arousal. Sherman et al. (2005) suggested that the focus on a couple's relationship fosters movement beyond the veteran as identified patient and instead assists both the veteran and spouse in perspective-taking behaviors that improve sensitivity and restore a healthier balance in their relationship.

This article expands on these sentiments. It will address the impact of current adult trauma on committed relationships. Defining a committed relationship as one shared by two people who acknowledge a commitment for at least a year, I consider that whether one or both partners have suffered the impact of trauma, it assaults both partners and the relationship they share. Informed by trauma theory (Boulanger, 2002; Herman, 1997; van der Kolk, McFarlane, & Weisaeth, 1996) and relational perspective (Aron, 2006; Aron & Harris, 2005; Benjamin, 1999; Fosshage, 1992; Kohut, 1984; Mitchell, 2000, 2002; Stolorow & Atwood, 1992; Zeddies, 2000), I will consider the use of couple interventions to restore safety; transform and integrate memories; facilitate mourning; and foster reconnection to self, other, and the shared relationship. I will also draw on clinical examples of couples that have suffered a trauma. While all examples are based on actual case material, they have been disguised and fictionalized to ensure confidentiality.

THE NATURE AND IMPACT OF TRAUMA

A *trauma* is defined as an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of self or others. It is one that engenders intense fear, helplessness, or horror (American Psychiatric Association, 1994). According to Janoff-Bulman (1985), traumatic events destroy the victim's fundamental assumptions about the safety of the world, the positive value of the self, and the meaningful order of creation. Boulanger (2002) spoke of someone who has been traumatized as being "wounded by reality" (p. 45). She suggested that in the moment of trauma, everything that is psychically familiar—a sense of agency, affect, self-reflection, cognition, time, interpersonal trust, belief in humanity, belief in God—is abruptly called into question. Combat duty, a vehicle accident, the loss of a child, the destruction of one's home, and so on are traumas that impact people physically, emotionally, and socially.

Most people initially respond to trauma with the cluster symptoms of reexperiencing, numbing and constriction, and hyperarousal. *Reexperiencing* of the event refers to unwanted recollections of the event in the form of images, nightmares, and flashbacks. Symptoms of *avoidance* involve attempts to avoid reminders of the event, including people, places, or thoughts associated with it. Symptoms of *hyperarousal* include physiological manifestations such as insomnia, irritability, impaired concentration, hypervigilance, and increased startle reactions. To receive a diagnosis of PTSD, these symptoms must persist for at least 1 month (Yehuda, 2002). Once symptoms have emerged, the individual's capacity to cope with them is critical as distress from the symptoms can create the same threat of powerlessness and disintegration as the trauma itself (McFarlane & Yehuda, 1996).

THE IMPACT OF TRAUMA ON RELATIONSHIPS

If we recognize that those in an intimate relationship are connected interpersonally and intrapsychically, then trauma to one or both must impact each of them and the relationship they share. From a relational perspective, each partner's conscious and unconscious experience is not only determined by his or her own mental processes, but also by his or her interpersonal relating and communicating (Aron & Harris, 2005; Mitchell, 2002; Zeddies, 2000). If we consider the intersubjective definition of a couple's relationship, then we recognize that their relationship is a co-creation of the reciprocal interactions of their interactive subjectivities, that is, the mix of what they each consciously and unconsciously stir in the other. Overall, their relationship or marriage is a function of not only who they are and who they were before they connected, but who they are as partners and what they consciously and unconsciously share (Zeddies, 2000).

From a relational perspective, if the sense of self and trust in the world has been shattered by trauma, then the view of the partner is inevitably altered. For a couple, what is needed, what is feared, and how one copes will impact and be impacted by

the relationship. If one or both partners feel lost, disempowered, angry, haunted, or immobilized in the aftermath of trauma, their relationship changes.

Trauma and the symptoms of distress that unfold in its aftermath disrupt the patterns of attachment and care that a couple has developed over time. As Stolorow (1999) suggested, there is a "dreadful sense of estrangement and isolation" (p. 464) inherent in the experience of psychological trauma that compromises relationships. For some, there is the capacity to redefine, draw on coping skills, and find a way to recover. For others, it is as if trauma erects a wall that locks them into the traumatic event. Suddenly, there is no past, and the future feels impossible. Caught in the symptoms of distress, anxiety, or depression, they fear being damaged or that their partner is damaged. What they believed before and how they cared for each other no longer feels possible or even relevant (Phillips & Kane, in press).

COUPLE INTERVENTION AFTER TRAUMA

Resonating with Herman's (1997) stages of recovery, I consider that recovery for couples must include restoration of safety, remembering and mourning, and reconnecting. As will be seen, these stages take on broader implications when applied to couples. Drawing on a relational perspective further expands recovery work with couples as it affords consideration of selfobject needs, attachment, mutual regulation of affect, patterns of organization, listening–experiencing stances, complementarity, the use of the third in intersubjective relatedness, and the relational unconscious (Aron, 2006; Benjamin, 1999; Fosshage, 2003; Zeddies, 2000).

Restoration of Safety

This first stage of recovery must account for establishing safety, physically and emotionally, within and between the partners. Basic to the safety needed for recovery is the therapist's need to establish a working alliance with each partner and with the couple that validates and normalizes experience, helps in the containment and regulation of emotion, and restores trust and hope in the couple's capacity to mutually meet needs and recover together.

Clinical Example: Jean and Fred

Jean and Fred considered it something of a miracle that she was working and he had gone to the store at the time of the gas explosion that destroyed their home of 30 years. A tall and attractive couple in their 40s, without children, Jean and Fred had devoted their lives to their careers and their love of travel. Their home had contained artwork and collected items from their many trips and had always been a source of great pride to both. They were in the midst of constructing a sunroom when the natural gas line was nicked, causing the explosion.

In shock for a while and buoyed by the outpouring of hospitality and help by friends and neighbors, Jean quickly went back to her job as a high school vice principal, and Fred returned to his practice as a certified public accountant. It was 3 months later, after moving into a rental home, that the trauma reverberated between them in a way that left them angry, bereft, and emotionally isolated from each other. Jean insisted they seek couple therapy. Fred hesitated, but agreed.

While Jean, who had called for the appointment, briefly mentioned the explosion, I began my first session with them by asking their reason for coming. Jean began by implicating Fred.

JEAN: He just doesn't know what I'm going through. He thinks I'm just supposed to get over losing everything we ever worked for.

Glancing at Fred while she is talking, I see that he is looking out the window. While I nod at her, I turn to Fred.

THERAPIST: Fred, I wonder if you could fill me in on what happened so I have a sense of what you both have been through.

Immediately, Jean responds.

JEAN: He really didn't want to come.

Whether to retaliate or dismantle her accusation, Fred turns to me.

FRED: It was a nightmare. I came back from the store to find a war scene. At first I couldn't grasp it. I still can't get the picture out of my head. Sometimes I'm even afraid to close my eyes because I'm going to see it.

Jean is crying.

THERAPIST: Fred, to hear you describe it and see Jean here crying—this was a horror for both of you.

Fred nods his head.

FRED: The thought that we could have been home when it happened . . .

His eyes fill up. Blinking away tears, he turns to me.

FRED: Listen—you have to go on—people were amazing. They took us in. They fought over having us stay in their homes. The insurance money will kick in.

Jean is suddenly moved back to anger.

JEAN: I can't go on so easily.

She turns to me.

JEAN: This is what he doesn't get.

THERAPIST: What do you mean?

JEAN: I need to talk about what happened—I feel totally alone.

FRED: You are not the only one who feels alone.

JEAN: Then why don't you tell me how you feel?

Fred looks out the window as he talks.

FRED: Because if I start, you won't let it go—it will be the only thing we talk about.

JEAN: A tragedy happens and you are criticizing me for wanting to talk about it? Something is wrong with him.

I intervene to restore a feeling of safety in the session by normalizing their feelings and reactions.

THERAPIST: You know they say that a major impact of trauma is to make a person feel powerless and alone. So much of what you are both saying is very common to people who have suffered from trauma. That scene, Fred, that keeps popping into your head, and Jean, the feeling of loss and isolation, they are very understandable reactions. Physically and emotionally, you are trying to make sense of something unexpected and terrifying . . . and it often happens that couples, who have suffered the same trauma, experience it in different ways.

JEAN: You know, we really hung together when it first happened. It was like Fred says—we were so relieved that we were both alive. I think it's this rented house. I can't sleep. I feel anxious. I look around and feel our life was stolen—all the beautiful things we collected on our trips.

THERAPIST: Moving in there really hit you with the loss you have both suffered.

FRED: I miss our house, too, but by now, Jean should be feeling better, not crying all the time.

JEAN: I can't help how I feel.

THERAPIST: You know, it is actually very common for the reality of the loss to hit a person months later. Someone said that "it's when the smoke clears and the press goes home, that's when the people will need help."

JEAN: It's true. We actually need more help now.

THERAPIST, *looking at both*: Tell me—how many years have you been married?

FRED: Twenty years.

THERAPIST: Wow—have you faced other crises as a team?

FRED: Oh, yeah. We pull together. We both came from dysfunctional families, if I can use that word, anyway—we deal with them pretty well, and it's not easy.

Jean is nodding her head in agreement.

Serving as Selfobjects to One Another

Intrinsic to a couple's relationship are patterns in which the partners serve as selfobjects to each other in a way that serves mature selfobject needs for mirroring, inclusion, support, and motivation (Hagman, 1995). After trauma, patterns are disrupted, and couples often present with shifting selfobject needs, protective operations, and activation of problematic patterns of organization between them.

In this case, Jean and Fred came for help because they could not regulate their

reactions to a traumatic event in their lives without hurting each other. Jean's rage was likely a protective defense against the enormity of loss and feelings of failed protection by her partner. Safety-attachment needs are fundamental and come to the forefront during times of experienced danger, abandonment, and loss (Fosshage, 2003). Unconsciously, there is the expectation that the idealized selfobject partner will prevent anything bad from ever happening. Once the traumatic event has occurred, anger is further fueled by the need for the partner to become the rescuing, soothing selfobject. Unfortunately, it is in the aftermath of trauma that the capacity to meet the partner's needs is often compromised. Fred was himself trying to reorganize in the aftermath of their trauma. There are glimpses of his tearful loss and his struggle with traumatic memories of coming home to the "war scene." It is likely that Jean's angry demands that Fred share feelings and empathize with hers threatened his own self-regulation of pain. Closing down became a necessary defense for him. The problematic pattern of her rage and his shutdown was counterproductive to both.

By becoming the empathic listener, the therapist steps in to be the transient selfobject, to serve the selfobject-regulating needs of each partner in the presence of the other. This attunement and containment restores some safety, reduces hyperarousal, and disrupts their painful pattern. In a sense, the therapist models a way of responding, while at the same time taking pressure off the dyad. Given the ambivalence of couples in pain, there is often gratitude on the part of one partner that someone else (the therapist) can care for the other partner, who he or she loves and is worried about, but can no longer cope with.

Normalizing Posttraumatic Reactions

With Fred and Jean, as with many couples, the normalization of their responses to trauma (his intrusive images, numbing, and avoidance; her immobility, insomnia, and emergence of increased stress 3 months later) brought visible signs of relief. It is likely that Fred's criticism of Jean for her intensified feelings on moving into the rented house masked his worry that something was wrong with her. Her angry response may well have masked a similar fear, coupled with panic that he was going to be critical and not helpful to her. One can see that it is the interaction of their subjective reactions to trauma symptoms that impairs their ability to mutually regulate their fears and coping as a couple. It was after hearing that others often begin to suffer months after a traumatic event that Jean may have felt safer and able to align with Fred: "We actually need more help now."

Remembering and Mourning

Essential to the recovery from trauma is the integration of traumatic memories and the feelings associated with them. Because trauma is registered in the right

hemisphere, with a high degree of activation of the amygdala and related structures, traumatic memories are not stored as coherent stories, but as intense images and somatosensory impressions. These occur when the victim is aroused or exposed to reminders or triggers of the trauma (van der Kolk et al., 1996). Traumatic memories need to be modified, transformed, or reconstructed in a meaningful way to become integrated into a person and a couple's life story. Van der Kolk (1996) tells us that the recovery of traumatic memory needs to be an "act of creation rather than the static recording of events" (p. 19).

The Relational Unconscious

Resonating with this, I suggest that the process of remembering and transforming trauma is a function of the therapist, the couple, and the conscious and unconscious experience they share. Zeddies's (2000) formulation of the *relational unconscious* offers a way of conceptualizing the couple's shared unconscious and the therapist's interactive experience with it. Intersubjectively, the couple's interaction with each other and the therapist's interactive process with them influences the generation, awareness, and transformation of the individual partner's and couple's memory.

As seen in the case of Jean and Fred, couples may overtly disagree and differ, but unconsciously, their positions and patterns are interrelated. The revelation of such unconscious positioning will be influenced by both the therapist and the couple. For example, although I asked Jean and Fred how they had handled crisis in the past, they colluded in the denial of earlier shared trauma. Perhaps doubting both their and my capacity to handle more loss, neither Jean nor Fred revealed their earlier traumatic losses.

It would not be until the fourth session, almost a month later, that Jean and Fred would reveal that they had suffered the loss of three babies in miscarriages in the first 4 years of their marriage. Jean reported that after the explosion, she started thinking about that time in their lives and was surprised to hear that Fred was also thinking about it. What Jean and Fred would explain in the sessions that unfolded was that the early years of the marriage were fractured by cycles of hope, disappointment, fertility interventions, and loss. At some point they stopped trying and, without discussion, just went on with a marriage defined by careers, travel, and the collection of precious things.

Against the backdrop of this history, the explosion of their home and the loss of the things they loved took on a different meaning. In a sense, their lifestyle reflected necessary defense, unresolved loss, and resiliency. After the session in which they revealed the fertility problems and many miscarriages, Jean and Fred reported increased tension and fighting at home and were agitated and at odds in the sessions. Their memory and shared revelation of loss ushered in pain that had been walled off. In this regard, it is not uncommon for a present trauma to activate memories of previous trauma as well as the attendant feelings of loss, anger, betrayal, and helplessness (van der Kolk et al., 1996).

The Integration of Past and Present Trauma

The problem for Jean and Fred was that then, and now, their patterns did not permit the expression of such feelings nor the possibility of mourning. It was very difficult for Jean to be empathic with Fred. Her depression manifested as rage and, as such, disrupted any possibility of empathy or soothing from Fred. It was striking that Jean and Fred's exchanges about the past trauma were so similar to those they had presented after the explosion. No sooner would Jean mention the losses, then she would attack Fred.

Clinical Example: Jean and Fred

Turning to me, Jean speaks.

JEAN: I can't get him to talk about it. What is wrong with him?

Feeling the impact of her judgmental tone, I look at Fred and then back at Jean and decide not to confront her pattern but to intervene with empathy at the couple level.

THERAPIST: It sounds like you both suffered quite a bit back then.

JEAN: Month after month, you hope. Other people are having babies all around you. No one says anything.

I turn to Fred, wanting to recognize his loss.

THERAPIST: It was a very rough time.

FRED: Well, you don't want to say anything to people. You hate to feel their pity. It was bad because I know Jean wanted a baby.

JEAN: Well, didn't you?

FRED: Yeah, but it wasn't meant to be.

JEAN: See what he does—I'm not supposed to have feelings about never having a child because he doesn't.

THERAPIST: I'm not sure that Fred doesn't have feelings—but he handles the pain in a different way. Fred, I can see that you push the pain away—maybe to protect both you and Jean . . . but it leaves you at a distance from each other. This is a rough place for both of you—it is a lot like the struggle you were having after the explosion.

They are both quiet. Fred looks down; Jean looks at me.

THERAPIST: Let me ask—in the families you grew up in—how did you handle crisis? Who did you turn to?

Fred looks at me like he wants to answer.

FRED: I took care of myself. My dad took off when I was a baby and I never saw him. It was only my mom and me. She was struggling to make a living.

THERAPIST: So you were used to figuring things out for yourself?

Fred nods his head.

JEAN: Yeah, but you can come to me.

THERAPIST: I know you want to be there for him. I think Fred knows it, too,

but let's try to understand how you handled crisis in your young years. Let Fred and me know—how did you manage if there was a crisis when you were a child?

JEAN: My mother was diagnosed with MS when I was 10. I don't remember much of my childhood. My father was my hero, and I think my mother resented it.

THERAPIST: So neither you nor Fred had moms you could really go to—but you could go to your dad.

JEAN: Yes. He was a school principal. He was a good problem solver.

THERAPIST: Jean, I actually think you married another good problem solver. Fred's been solving problems on his own since he was a kid.

JEAN: Then why won't he talk about losing the babies, and why can't he understand that I just can't get over losing our beautiful home?

FRED: I don't want to talk about something that can't change—I can't feel what you want me to feel when you want me to feel it.

THERAPIST: Jean, I can see that you feel such loss and heartache about the babies and the house.

JEAN: I do.

THERAPIST: Your pain is so clear, but I think in your desperate attempt to get Fred to verbalize his feelings, you are pushing away the one person who really knows what you have been through.

I look back and forth at both.

THERAPIST: I want you folks to try something—Jean, will you look directly at Fred and tell him a feeling about the loss of those babies so long ago? Fred, all I want you to do is make eye contact with Jean, listen, and take it in. It is called containment—it involves listening and holding the feelings of someone you love. Then, Fred, if you would, let Jean know in any way you can that you have heard her.

Jean looks at him and starts crying. She doesn't say anything; she just sobs. Fred's eyes fill up. A few minutes pass.

THERAPIST: Jean, your tears are telling Fred about the pain of losing those babies, and his tears are there, too.

Fred grabs her hand.

Discussion

A couple's remembering and mourning happens in incremental steps because the therapist must recognize that there are times when revisiting for one may equate to retraumatizing for the other. As seen with Jean and Fred, the aftermath of trauma often brings with it an escalation of historical survival patterns, transferential self-object expectations, demands, and fears that are displaced onto the partner with a greater intensity, greater than under ordinary circumstances.

This means that even as the therapist is walking a fine line between one partner's need to remember and the other's need to forget, it is necessary to understand their positions as integral to their clash or connection. As much as we say that trauma freezes people in time, we might consider that it often freezes a couple into complementary positions that epitomize the dialectic of trauma. One is hyperaroused, while the other is numb; one chooses to remember, while the other tries to forget; one clings, while the other needs to avoid. Illuminated by Benjamin's (1999) concept of *complementarity*, we understand that the couple is unable to move—in this case, to mourn—because the partners are locked into positions that cancel each other out and make mutual understanding impossible.

The Use of the Third

Aron's (2006) recognition of complementarity in analytic impasse, and his use of the third in an application of intersubjective theory to clinical practice, offers the couple therapist a point of formulation and intervention. Using Aron's (2006) image of the seesaw, we can consider that one partner may be up and the other down, but like Fred and Jean, they are locked into a pattern of relating, unable to come together. They are at the end of a line that has no open space. By joining and co-creating a new experience with the couple, the therapist becomes the third. In other words, the therapist opens up triangular space for the partners to move and think in a more spontaneous way.

To do this, the therapist can offer another perspective that alters the positions of the couple by reason of their consideration of the therapist's input—a third position. For example, at some point in this work with Jean and Fred, I shared that many couples struggle with and carry the traumatic loss associated with miscarriages because they involve mourning the loss of children never seen. I justified the clash of their positions to talk or not talk about the losses by pointing out that the world rarely notices, validates, or realizes a couple's pain following a miscarriage. Often the couple is not certain how or if they have the right to mourn such loss. On hearing this, having someone else bear witness to the loss as well as make sense of its denial, Fred and Jean seemed better able to move to a shared emotional position. As such, they could begin to enter a place where they could mourn for the past and present losses together.

Addressing Selfobject Transferences

My invitation to Jean and Fred to share childhood patterns was also aimed at addressing their problematic patterns in the here-and-now through some understanding of the repeated survival patterns of there-and-then. Given that trauma assaults and often leaves the sense of self feeling shattered, early selfobject needs for affirmation, mirroring, and protection from an idealized other, may become urgent transferential

demands. Hearing about childhood experiences and survival patterns for handling trauma invites the self-reflection and consideration of the other in a way needed to loosen transferential expectations. The listening and experiencing shift often helps the partners provide more soothing and vitalizing functions for each other.

Bearing Witness

The stage of remembering and mourning involves bearing witness. Often overlooked by couples is the importance of silently bearing witness without demands, expectations, or words. In the session described earlier, Fred and Jean were not yet able to verbally bear witness to their losses or to soothe each other with words without disruption. By asking Fred to contain and respond to Jean's feelings without words, I offered a safe opportunity for him to show his care and for her to feel his care. The invitation for them to make eye-to-eye contact is an invitation to attach in a neuropsychological as well as an emotional way. Neuropsychologically, we now know that the earliest template for the capacity to deal with stress is a function of the earliest attachment to mother, specifically, the right hemisphere to the right hemisphere attunement, or eye-to-eye connection (Schore, 2003). If we recognize that the same nonlinguistic right hemisphere of the brain is activated in trauma, and that couples do share unconscious attachment, then another reason for the eye-to-eye exercise is the creation of a new neuropsychological experience of wordless reattachment (Schore, 2003).

Reconnection

According to Herman (1997), the most difficult stage of the recovery process from trauma is reconnection because it necessitates reconnection to self, other, belief systems, the world—essentially, the future. The complexity and importance of this stage is particularly reflected in work with couples. Given the physical, emotional, and social impact of trauma on the definition of self, partner, and the relationship they share, it is not surprising that there is continued evidence of trauma's assault on the intimacy and sexual relating of couples (Dekel et al., 2005; Riggs et al., 1998).

Clinical Example: Brian and Lisa

It was after the first anniversary of 9/11 that Brian and Lisa sought couple therapy at the suggestion of his individual therapist. Brian was worried that he was losing his marriage, and Lisa was feeling that she could not wait for him anymore, both facing a level of despair.

At the time of 9/11, Brian and Lisa were in their late 30s, had been married for 8 years, and had two daughters ages 6 and 2. Brian, a firefighter for 10 years, was one of the few men in his company to have survived the collapse of

the second tower. For a number of months following the atrocity, he had been struggling with guilt, nightmares, intrusive thoughts, and anxiety, and sought individual counseling. Lisa hoped it would help him with his seemingly physical and emotional unavailability.

In the months after 9/11, Lisa waited patiently in the background. She realized how many friends Brian had lost, but with time, she came to feel that she had lost him. After ground zero was closed in June 2002, and Brian was home a little more, Lisa would try to tell him how much she and the kids had missed and needed him. Brian responded to this with anger or avoidance, which would spark her anger. Whatever time they spent together was so tense and negative that it drove them further apart. They hadn't been together sexually since 9/11. When Brian was promoted to lieutenant and sent to a new firehouse, Lisa thought things might improve. Instead, Brian seemed more edgy, worried about his men, was unwilling to socialize with family and friends, and was irritable and avoidant of the kids. Shortly after the first anniversary, Lisa told Brian that she could no longer stay alone in a nonmarriage.

Discussion

The earliest work with Lisa and Brian revealed that they were two people who loved each other but had lost each other in the aftermath of 9/11. Having them find each other emotionally and physically would involve creating a safe enough venue with me to permit the process of recovery. Initially, the experiences they presented—fear, rejection, guilt, desire, and loneliness—were being masked by avoidance and anger.

Listening–Experiencing Stances

Fosshage's (2003) proposed *listening–experiencing stances* represent an integration of the contributions of self psychologists and relational therapists concerning how to listen to and experience both analyst and patient. It involves movement between three stances: an empathic stance that involves understanding and validating the experience of the patient; an other-centered stance that registers the patient's impact on the analyst and others; and the analyst's subjective stance or experience as a separate person. It has particular suitability to work with couples.

In the work with Lisa and Brian, I used, modeled, and fostered movement between the three listening–experience stances or vantage points. In my exchanges with them, I both modeled and invited empathy for the other, awareness of their impact on the other, and self-reflection of their own subjective experiences. Until couples like Lisa and Brian feel understood, listened to, and aware of their impact on each other as well as on a therapist, they are often not safe enough or close enough to reclaim their intimacy.

Accordingly, in the course of the work, I modeled and underscored Lisa's expressed empathy for Brian's feelings of guilt about not having saved his buddies, his new fears of being a lieutenant, his guilt for not being with his children, his shame for his persisting PTSD symptoms, and his guilt for not feeling comfortable in his home. Reframing what she had shared, I invited Brian to empathically consider how Lisa, like many of the firefighters' wives, was herself traumatized. With the exchange of memories about what had unfolded for her when he was away, Brian began to understand how Lisa's life was also assaulted by the 9/11 atrocity. Seeing the tears and concerned looks on each other's faces began to lower their expectations of being misunderstood and blamed. As they began to realize that, as a couple, they both had experienced considerable loss, an understanding of the tragedy from a we perspective could emerge.

I also invited the respect and understanding for their differences, underscoring that even as both were traumatized, each, by virtue of personality, gender, personal history, and so on, might suffer and cope in different ways. They began to realize that such differences were not intended to reject or rebuff the other, but were likely part of the reason for their initial attraction, and now were opportunities for acceptance and growth.

Sharing Dreams

If we apply the idea of a relational unconscious to couples, then we can consider that they have a reciprocal influence on the generation, awareness, and expression of their unconscious experience. Given that trauma is registered both consciously and unconsciously and in ways that make integration difficult, another vantage point I invite couples to consider is attunement to their shared unconscious. Teaching couples about the organizing function of dreams (Fosshage, 1997), and the nature and function of trauma dreams, I ask them to remember, share, and discuss their dreams and then bring them to the couple session. As such, I am inviting intimate exchange as well as fostering the integration of individual and shared trauma. When couples begin remembering and recording dreams, they begin engaging each other in a different way. As they find that their shared ideas and associations are far more pertinent than the therapist's in understanding the dreams, they gain a feeling of knowing and being special in each other's eyes. In a sense, the dreams and their images become "their dreams."

When I invited Brian and Lisa to remember and share their dreams, Brian, at first, refused, saying that he did not want to impose his nightmares on Lisa. With her expressed interest in wanting to be let in and her willingness to begin with her dreams, he eventually risked sharing. He was surprised to realize that he had many other dreams in addition to the trauma nightmares, something which lowered his anxiety about being permanently damaged. His risk of sharing his nightmares with Lisa at home, and then in the couple session, allowed for a collaboration and

deconstruction of trauma images into associations, shared memories, and eventual narratives. The fact that Lisa could hear them and talk about them with him served to detoxify them and increased closeness with her. In a sense, the shared trauma could be mediated by their shared unconscious and renewed interpersonal connection.

Finding Intimacy and Sexual Relating

Johnson (2002) noted that "we are truly bonded only with those we touch" (p. 44). We know that for touch to be safe, it must be underscored with trust and respect. As seen with Brian and Lisa, trauma and its symptoms of distress turn intimates into strangers. Safety is a major issue for couples in pain. Not recognizing the other, couples stop knowing how to be or what to share when they are together. Often they feel rejected or dismissed by the other's attempt to avoid the memories or traumatic reactions associated with any emotion. Frequently, they grasp solutions, such as alcohol, drugs, or other partners that further jeopardize the recovery and mutual affirmation that sexual relating can bring.

The couple intervention has to make them known enough to one another to be safe as lovers. It is often helpful when developing intimacy to invite couples to look backward to the pretrauma relationship to find their familiar partners. How did they meet? What did he think? What was the first thing she said? Did he ask for her number? What was she wearing the first time he saw her? What place reminds them of a wonderful time together?

Most couples respond positively to the invitation to step out of the traumatic moment to connect with the memories of who they were and what they felt for each other in the past. Brian and Lisa began to laugh as they talked about going to the apartment he shared with two other guys and their scheming to have it to themselves. Perceiving them touch on their sexuality, I asked if they were physically attracted to each other back then. Following their affirmation, I asked if they felt the same way now. They both seemed reassured by the answer. Such questions may bring a couple's sexuality back into their awareness and actually stimulate sexual desire. Emotionally as well as neuropsychologically, it invites connection with one's sexual self and that of the partner's. The therapist's ability to underscore the verbal and nonverbal looks, jokes, body language, and so on that gives a glimpse of this sexual interest offers them an important vantage point—how they see themselves as a sexual couple in the eyes of an outsider, the therapist.

Helpful in fostering sexual connection is freedom to access the imaginative—the illusion necessary for sexual relating. According to Mitchell (2002), it is the ability to suspend reality, to consider what is unknown and unpredictable in the other, that drives passion. This is often very difficult for couples after trauma. For them, life has become too real, illusions have been shattered. It has become unsafe to relax one's guard. Considering the other as mysterious and a bit unknown is not enticing, it is frightening. Some aspect of the known and familiar has to first be restored. Often

a couple will need the therapist's help to maintain a sense of safety, by addressing changes and differences in them as partners. These changes and differences are often due to symptoms, physical changes, limitations, or different roles, caused by the trauma and its aftermath. By providing a venue to air the fears, sexual difficulties, guilt, and shame so often associated with intimacy after trauma, the couple work makes it possible for couples to risk finding each other again.

A crucial aspect of facilitating the intimacy and sexuality of a couple is the regulation of anger. As with Brian and Lisa, it is greatly relieving for couples to know that anger often masks anxiety, grief, and fear of falling apart. This awareness reduces guilt, blame, rejection, and need for defense. At the same time, a couple's fear of and inability to express anger preclude intimacy. Couples need to know that if it is not safe enough to differ, disagree, argue, and even fight, they are not truly related—they are simply on hold (Phillips & Kane, in press). An important part of couple intervention after trauma has to do with modeling and supporting the expression of negative feelings in a way that informs, rather than threatens or destroys.

Over the course of the couple therapy, in incremental steps that did not occur in a linear fashion, Brian and Lisa began to feel safer. They integrated the images and meanings of 9/11, addressed its impact on their lives, looked into their dreams, redefined themselves, and reestablished a sense of trust and intimacy.

SUMMARY

As seen here, trauma, whether experienced by one or both partners, disrupts the relationship they have shared. It freezes partners into the traumatic experience, obscuring their past and future, locking them into patterns of defensive pain, precluding mutual regulation of needs, and impairing shared intimacy. Moving through the stages of trauma recovery, the author has drawn on relational perspective and applied relational concepts to intervene with couples in a way that fosters safety, selfobject regulation of needs, expansion of experiencing and listening perspectives, access to a shared unconscious, and a reclaiming of intimate connection. The goal of couple intervention in the aftermath of trauma is a restoration of the relationship as an invaluable resource in recovery:

> But in matters of love, deeper, more authentic commitments can be made and maintained only with an awareness of change and transformation outside our agentic control. (Mitchell, 2002, p. 199)

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