LOVE ISN'T ALWAYS ENOUGH:
THE EFFECTS OF CHILDHOOD TRAUMA ON A MARRIAGE
(LITERATURE REVIEW ONLY)

by

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CHAPTER 2

LITERATURE REVIEW

Introduction and Overview

This case study examines a couple and the ways in which each partner's response to childhood abuse affected their relationship. As I noted in Chapter One, the great majority of writing on trauma focuses on treating individuals; there is little research that speaks to the impact on a marriage when both partners carry a history of trauma. This study documents how the trauma symptoms of each partner triggered reactions in the other and how we attempted to overcome damaging patterns ingrained in their marriage. First, however, it is useful to examine how trauma is understood and treated according to the key psychological perspectives available in the literature today.

Trauma has been broadly defined as an experience or series of experiences that threaten a person's psychological integrity and pose a severe challenge to their sense of themselves, their identity, and even their survival.[1] Two types of trauma are recognized: *shock* (or acute) trauma and *complex* (or developmental) trauma. Shock trauma results from a single event, often one so terrifying or life threatening that it overwhelms one's ability to respond.[2] The *fight-or-flight* reaction shuts down; neither fight nor flight are possible when one is confronted by a natural disaster, an auto accident, or a brutal assault or rape.[3] The victim of such an incident is rendered utterly helpless. As Judith Herman writes, "Psychological trauma is an affliction of the powerless." [4] Peter Levine, however, contends many survivors of shock trauma can, absent a history of other abuse, heal themselves without necessarily having to rely on psychotherapy.[5]

Not so for complex trauma, which arises from recurring abuse over time and is thus a more complicated, multifaceted condition.[6] Complex trauma was first identified in studies of child abuse and domestic violence survivors, but harrowing experiences such as armed conflict, ethnic cleansing, and human trafficking are other causes. Early relational trauma is uniquely harmful as those who are counted on for love and protection instead exact injury on children in their care. The *Complex Trauma Questionnaire* can assess nine abuse types; each can result in long term physical and mental health issues.[7]

The groundbreaking *Adverse Childhood Experiences* (ACE) study was the first to document the impact of early trauma. Data was compiled from over 9,500 HMO members regarding their family history on seven categories of adverse conditions.[8] The study found it rare to endure only one such risk as a child. Among the nearly two-thirds of those who reported at least one, 87 percent reported two or more—and over 15 percent of all those surveyed scored above three on the ACE scale.[9] Those who scored above three suffered much higher rates of alcoholism, drug abuse, depression, smoking, suicide attempts, STDs, and obesity compared to those who scored zero.[10] A strong correlation was also found between a higher ACE score and physical illnesses such as cancer, heart disease, emphysema, diabetes, and liver disease. It is important to note the abuse does not directly cause the medical issues, rather they stem from addictive behaviors adopted by trauma survivors as they try to cope with their experiences.[11]

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) does not specify "trauma" as a disorder.[12] The DSM-5 did, however, introduce a new diagnostic class, Trauma and Stressor-Related Disorders, to differentiate certain diagnoses that had earlier been categorized as Anxiety Disorders, but which now require the client to have

been directly exposed to a traumatic event as a precipitating cause of their condition.[13] Prominent among these is Posttraumatic Stress Disorder (PTSD). Beyond having been subjected to a traumatic incident, the criteria for a PTSD diagnosis includes symptoms such as flashbacks, nightmares, emotional numbness, and chronic arousal or reactivity issues like hypervigilance or exaggerated startle response.[14]

PTSD has been studied intermittently since emotionally devastated soldiers returned from World War I (when it was known as "shell shock") and World War II ("combat fatigue"),[15] but in recent years it has been the focus of thousands of articles in the professional and lay press. This upsurge in interest was driven by its inclusion in the DSM-III in 1980.[16] Once the American Psychiatric Association (APA) sanctioned PTSD as a legitimate diagnosis, researchers around the world were able to solicit funding for studies into its causes, effects, and treatment options.[17] But a diagnosis of PTSD specifies exposure to a singular event. Clinicians whose patients suffered more insidious forms of trauma like child abuse and neglect were left unsatisfied. Bessel van der Kolk led a workgroup that urged the APA to include disorders they called "Complex PTSD" and "Developmental Trauma Disorder" in future editions of the DSM. He laments the fact that their proposals went unheeded and asserts that while the victims of complex trauma are vastly more numerous than people who suffer from PTSD, the APA's role in charting the direction of research and medical care has failed to address their concerns.[18] While the clients in this case study did not present the symptoms necessary to meet the diagnosis, the literature on PTSD cited herein is relevant to treatment of complex trauma.

This Literature Review explores theories that attempt to explain how traumatic events create troubling behaviors. The biological view relies on research validating how

trauma affects brain structures in ways that predispose one to emotional dysregulation. The psychodynamic view sees maladaptive outcomes of trauma as efforts of the psyche to protect the ego from what it perceives as overwhelming danger. The attachment view contends that the bond between infant and caregiver creates a pattern that echoes throughout one's future relationships. The cognitive/behavioral view believes the lasting injuries of trauma are *cognitive distortions*, that is, negative internal messages about themselves and the world clients must unlearn in order to lead a more fulfilling life. The sociocultural view argues that society at large helps create and normalize a traumatic milieu. Finally, the imaginal approach draws from multiple disciplines to understand and address trauma with the intent of reclaiming soul as the central goal of the work.

Biological Perspectives on Trauma

Early in his seminal work *The Body Keeps the Score*, van der Kolk states that the disciplines of neuroscience, developmental psychopathology, and interpersonal neurobiology make clear how traumatic experiences cause physiological changes that help explain why survivors become hypervigilant to threat and have difficulty enjoying everyday life.[19] Hyperarousal is a natural biological response to stress; it is adaptive and automatic for a person to trigger a "fight, flight, or freeze" survival strategy when facing danger.[20] However, when this response is activated over and over again, or sustained over long periods of time, damage is done to neural networks, brain structures, and hormone levels that can cause behavioral changes that are very challenging to unlearn.[21]

Drawing on studies of fMRI scans that reveal brain activity in response to threat and fear, Frewen and Lanius suggest that trauma-induced anxiety is an inability to

effectively manage affect arousal.[22] Trauma survivors exhibit a failure to down-regulate aversive arousal and an inability to up-regulate emotional numbness or dissociation. That is to say, they are unable to calm themselves when faced with a perceived threat or to rally into action when they go into a freeze response. This hormone-driven reactivity occurs so quickly that the person is powerless to assess the situation objectively.[23]

The amygdala is a small area of the brain that constantly scans the environment to ascertain whether a threat exists.[24] The response to stress begins when the amygdala arouses the sympathetic nervous system to prepare the body for fight or flight by increasing the heart rate, muscular tone, and breathing. The amygdala then stimulates the HPA axis, which is comprised of the hypothalamus, the pituitary gland, and the adrenal glands. Hormones are released into the body, notably beta-endorphins to suppress pain, and cortisol, which plays a role in learning, memory, and emotion. Cortisol fixes events firmly into long-term memory, which is why the recall of stressful incidents, and thus one's propensity to react (or overreact) to similar events in the future, is so common. We can imagine the survival value of this when faced with, for example, a predator in the wild. But if the stimulus is a spouse airing mild dismay when one arrives home late for dinner, and one reacts as though facing a parent's uncontrollable rage, a trauma-driven move into fight or flight is likely to be an overreaction that harms the relationship.

Cortisol also helps regulate the body's response to stress. When the adrenals are triggered by the amygdala to release cortisol, a negative feedback loop begins in which increasing levels of cortisol in the body signal back to the hypothalamus and pituitary to suppress the adrenals and reduce the amounts of cortisol and adrenaline being dumped into the body.[25] The HPA axis comprises a circular system that activates in the presence

of threat and normally deactivates as the threat fades. However, this alert-and-relax cycle fails to work as it should in those who have been traumatized. Yehuda unexpectedly found cortisol levels in PTSD sufferers to be lower than expected, but she noted this has the effect of slowing the signal to the HPA axis to stop producing stress-related hormones.[26] The overload of hormones presents as agitation, panic, and fear lasting longer than needed, contributing to the negative outcomes seen in Felitti's ACE study.[27]

Dowd and Proulx note several variables that impact cortisol levels, including timing since the onset of the stressor, characteristics of the stressor, and characteristics of the individual.[28] They highlight an inherent issue with such research due to the inability to know cause and effect. They ask, do trauma and PTSD lead to lower cortisol levels, or is the person born with a system that produces less cortisol, thus making them more susceptible to developing PTSD in response to trauma? [29] Nevertheless, they conclude that while studies of this type are few and inconsistent, it does seem clear that "emotions associated with stress are linked to dysregulation of the HPA axis." [30]

Bremner cites animal studies that show exposure to early stress has lasting effects on HPA function, with the notable effect of elevated response to future stressors.[31] He adds that studies of traumatized children are consistent with these animal studies.[32] Adults with an early trauma history may have normal or low cortisol levels at rest but often have unusually high cortisol response under stress. The diminished functionality of an abuse victim's HPA axis may also reflect the fact that children with abuse histories have been shown to have smaller brains than other children.[33] Putnam notes specific regions that appear to be reduced in size as a result of early abuse, including the frontal lobes (critical to the *executive functions* of cognitive skills, judgment, and emotional

expression) and the anterior cingulate gyrus, which is involved in emotional processing, decision-making, and neuron health.

Allan Schore supports the case that children exposed to neglect or abuse suffer negative impacts on brain growth. Early relational trauma is cumulative, and the specific areas of the brain most affected play a role in sustaining interpersonal relations, responding to stress, and regulating emotional expression.[34] Schore asserts, "The loss of the ability to regulate the intensity of feelings is the most far-reaching effect of early trauma and neglect." [35] As trauma survivors go through life, their efforts to avoid re-stimulation of emotional pain lead to hypervigilance and hyperarousal, which in turn contributes to substance abuse and other obstacles to relationship and marriage.

Lane Beckes et al. published a study on altruism and empathy that, while not directly concerned with the subject of trauma, has notable implications for this review.[36] They examined fMRI scans of 100 subjects to explore the physiological response to threat and familiarity. The scans revealed the regions of the brain discussed above are the same as those that activate to arouse empathy. It stands to reason that a person in whom these areas are functionally underdeveloped would have difficulty "feeling into" the experience of their partner, as was true for the clients in this case study.

Many treatments have been developed to address the biological effects of trauma. Most commonly, *selective serotonin reuptake inhibitors* (SSRIs) and other drugs are prescribed to alleviate symptoms of depression and anxiety familiar to trauma survivors. Despite extensive research, their exact mechanism remains a mystery. They act by restricting the reabsorption of serotonin, enabling it to linger in the system, but there is no widely accepted theory of how this contributes to elevated mood and relief from anxiety.

Nevertheless, even a somatically oriented trauma specialist such as van der Kolk will resort to the use of drugs on a limited basis. He cautions against their negative side effects but concedes that SSRIs can help clients feel calmer and more able to engage in therapy.[37] He details the benefits and many drawbacks of other drug classes including tranquilizers, anticonvulsants, and antipsychotics, though most would only be used for patients with urgent and serious PTSD symptoms.[38] Bremner, however, reports notable benefits from some of these. The anticonvulsant Dilantin, for instance, appears to increase the size of the right hippocampus and the right cerebral cortex areas that help with memory, learning, and executive functioning.[39] Van der Kolk may use beta blockers to lessen the effects of adrenaline and help decrease hyperarousal and reactivity, which provides space for one's executive functioning to make clear choices about how to respond to a potential threat.[40] However, he prefers to introduce less intrusive somatic methods to achieve similar results, such as mindfulness, yoga, and meditation.

In an effort to avoid the side effects and uncertain efficacy of prescription drugs, many therapists working over the past 20 years have refined distinctive somatic practices that show promise for healing the suffering of trauma survivors. These modalities share some common goals despite differing in their techniques. Working directly with the physical body, they locate and free "stuck energy" and fear responses. By taking advantage of the inherent plasticity of our neural networks, dysfunctional patterns can be rewired at the cellular level to tame emotional reactivity and enhance the quality of one's life. This section concludes with a brief look at three of these somatic therapies.

Peter Levine's *Somatic Experiencing* (SE) defines trauma by its symptoms and eschews any effort to delve into memories or emotions directly associated with the

original incident.[41] Instead, SE attends to the client's physical responses in the current moment.[42] SE exercises safely activate arousal symptoms, then utilize awareness and body movements to reestablish a sense of balance. Shifting back and forth between dysregulation and regulation, the client learns to notice when triggers arise and to respond more appropriately to them in everyday life. Though lightly researched to date, a recent study on SE reported significant reductions in PTSD and depressive symptoms across the board, to the degree that 44 percent of subjects lost their PTSD diagnosis altogether.[43]

Pat Ogden's *Sensorimotor Psychotherapy* starts with the assumption that trauma symptoms are best addressed with a "bottom-up" approach that privileges sensory data over cognitive processes.[44] Ogden notes it is normal for people to monitor their surroundings for threat, but trauma survivors tend to register cues that remind them of past trauma and fail to notice other signs that indicate the danger is not genuine or has passed.[45] Reactions that would be fitting if a threat were present are dysfunctional when the reality of the situation does not merit a trauma response. She utilizes movement-based activities that help a client orient to current conditions rather than submit to traumatic memory and to expand their *window of tolerance* by becoming aware of somatic signs of triggering such as elevated heart rate or shallow breathing.[46] The window of tolerance is the zone between hypoarousal and hyperarousal. The wider it is, the more stimulation one can effectively process while managing one's arousal state and thus one's reactivity.

Babette Rothschild differs from Levine and Ogden in her conviction that "healing trauma requires a linking of all aspects of a traumatic event." [47] Her approach is based on the distinction between explicit and implicit memory.[48] Explicit memory includes facts and concepts that are stored in the brain and expressed via the use of language; narratives

and meaning are shaped by accessing explicit memory. Implicit memory is not associated with language. It resides in the unconscious and is employed to accomplish tasks like riding a bicycle that would be unwieldly if we had to consciously think about them step by step. Rothschild believes that traumatic memories are stored in an unprocessed form in implicit memory without links to explicit memory. Therefore, the strong emotions, sensations, and reactive impulses that stem from a traumatic event do not have access to the context in which they first emerged. She utilizes both somatic and psychotherapeutic techniques to forge implicit, traumatic memory and explicit memory into a cohesive narrative that the client can place in the context of their life story. The client becomes less apt to react in a dysfunctional way to current triggers.

In summary, the biological perspective asserts that trauma produces physiological damage that causes a survivor to have difficulty regulating emotions and reactions throughout life. Somatic therapies often focus on alleviating symptoms rather than trying to address the original injury. Van der Kolk disparages therapists who rely only on helping a client gain insight as a means of healing, writing "neuroscience research shows that very few psychological problems are the result of defects in understanding." [49] Cozolino agrees, asserting that regardless of the modality, "all psychotherapists are applied neuroscientists who create … enriched learning environments designed to enhance brain functioning." [50] To that end, he says, we utilize the therapeutic alliance, empathy, psychodynamics, attachment, behaviorism, narrative therapy, and/or somatic exercises with the ultimate aim of growing and integrating our neural networks.

Psychodynamic Perspectives on Trauma

Psychodynamic theory predates biologically oriented perspectives by many decades to form the earliest beginnings of the psychotherapy discipline. In 1862, a young French neurologist named Jean-Martin Charcot was appointed head physician at an asylum in Paris that housed over 5,000 destitute or mentally ill women. For many years he focused on straightforward, clinical observations and medical treatment of his woeful charges. By the mid-1870s, however, he began to investigate the mysterious condition known as hysteria. He soon found himself in agreement with another French physician Paul Briquet, who published in 1859 a study that concluded hysteria was not caused by the antiquated myth of a wandering uterus but was actually a disturbance in emotional expression triggered by a disorder of the brain.[51] Charcot experimented with hypnosis and found he could induce patients to exhibit the symptoms and behaviors of hysteria by the mere suggestion of it.[52] He had, in essence, shown that an idea could affect the body. In the absence of any science of psychology, this was a revolutionary discovery.

By 1885, Charcot had learned that in addition to verbal prompts under hypnosis, physical trauma could also provoke symptoms such as paralysis that were inconsistent with the physiological extent of the injury.[53] He proposed a theory of *dissociation* to explain how trauma may produce symptoms that were otherwise inexplicable, describing it as a process whereby the mind separates its experience of the trauma from any association with conscious thought.

Pierre Janet directed one of Charcot's laboratories during this period. The first major publication of his own studies came in 1889, when he laid out in great detail the means by which dissociation creates symptoms of hysteria.[54] He was the first to advance the notion that childhood trauma was responsible for a host of reactive behaviors

recognized today as indicators of PTSD. However, as his theories were built upon the use of hypnosis, a technique later repudiated by Freud and others, Janet's reputation suffered and his contributions faded from memory.[55] His work has recently been reappraised and some now view him as a founding father of psychology.[56]

Sigmund Freud had visited Charcot in Paris for a few months in 1885. Initially inspired by what he saw, he came to find hypnosis unreliable and, with Josef Breuer, developed a clinical method they termed *psychoanalysis* that let patients talk freely about their thoughts and dreams without any hint of suggestion from the analyst.[57] His patients revealed memories of early sexual abuse so frequently that, like Janet, he concluded, "At the bottom of every case of hysteria there are *one or more occurrences of premature sexual experience.*" [58] However, Freud rejected Janet's dissociation theory of hysteria and replaced it with one of his own: *repression*. Repression was understood as a defense strategy working unconsciously to prevent memories that would otherwise cause great anxiety from being available to the conscious mind.[59] *Free association* is used in psychoanalysis to unearth such memories in complete, uncensored detail and help the patient come to terms with the reality of their experience. Freud and Breuer declared this would alleviate the trauma symptoms, writing, "We found … hysterical symptoms would disappear immediately and did not recur if the patient depicted the [original] event in the greatest possible detail and put words to the affect." [60]

Much to his surprise and dismay, Freud's presentation in 1896 of his paper *The Aetiology of Hysteria* was met with disdain.[61] The implication of his *seduction theory*, that incest and molestation were rampant in society, seemed too much for his colleagues, and ultimately himself, to bear.[62] Ignoring the detailed accounts of his patients, in 1899

Freud set forth his theory of the Oedipus Complex in *The Interpretation of Dreams*, which replaced the seduction theory with the assertion that most of the women were unconsciously making it all up in what he called fantasies of wish fulfillment.[63]

While granting Freud some latitude given the social climate of the time, Herman nonetheless takes him to task for abandoning the thrust of his "brilliant, compassionate, eloquent" *Aetiology*, which detailed the effects of childhood sexual abuse so forcefully.[64] She argues that retracting his theory and denying the evidence of his patients postponed a candid psychological exploration of female sexual trauma by nearly a century. Kalsched offers a more forgiving analysis of Freud's thinking at this time. He asserts that Freud, in his study of the unconscious, was searching for a universal dynamic to explain his belief that "it is not trauma that splits the psyche, but a feared *meaning* of trauma to the individual" that leads to repression and then to the symptoms of trauma.[65] Even if some of his patients had experienced abuse, while others perhaps had not, all still displayed symptoms that Freud wanted to explain with a consistent theory of the mind.

Unlike Freud and much of the burgeoning psychoanalytic community, Sándor Ferenczi never rejected the seduction theory. He trusted the reports of his patients and their relatives that they had, indeed, been subject to sexual and other abuses as children, and believed these experiences could account for their traumatized behaviors.[66] Ferenczi was mindful of the power differential between a parent and a child and took great care to avoid replicating this asymmetry in therapy with his troubled clients.[67] Though his conclusions and practices would come to be accepted today as conventional wisdom, Ferenczi was shunned and even disparaged by Freud and his partisans for the remainder of his career after having once been considered among Freud's closest disciples.[68]

Freud's attention was later captured by a pattern he termed the *repetition compulsion*. He observed clients reenacting the circumstances of the original injury in dreams and waking hours, regarding it as an unconscious attempt to gain mastery and resolution over a repressed memory by reliving it in the present.[69] Kalsched emphasizes that the process follows the unconscious belief that persistent repetition of the trauma "in the inner world must become a *real* traumatization with an object in the world if the inner system is to be unlocked." [70] Lenore Terr sees reenactments in the play of young trauma victims, which differs dramatically from that of other children: It is repetitive, obsessive, and grim, lacking the natural fluidity and growth of normal play.[71]

A central element of the psychodynamic approach is working with reenactments through the therapeutic use of *transference*. Jung regards transference as an unconscious process whereby unintegrated childhood experiences and feelings toward important adult figures are projected, or transferred, onto the therapist/analyst.[72] Jung stated that Freud told him transference is not just essential to psychoanalysis but is "the alpha and omega … the main thing." [73] Jung views transference as an everyday occurrence in any intimate relationship and notes the projected feelings may be either positive or negative.[74]

A psychodynamic therapist will recognize when transference is present and utilize it to bring awareness and insight to the client. When the projection is negative, a therapist draws on the therapeutic alliance to provide a restorative experience by serving as a stable authority figure able to hold and make sense of the client's inner chaos.[75] When transference is positive, the therapist relies on it to form a safe container that enables the client to revisit and face their trauma without fear of being overwhelmed.[76] After many

repetitions the trauma no longer arouses such disabling intensity. It becomes part of the survivor's history but not the dominant factor in life it once seemed to be.[77]

Kalsched summarizes the psychodynamic perspective on trauma to great effect.[78] He defines trauma as any event that poses an existential threat to one's personality, thus mobilizing the unconscious self to erect defenses against the resulting anxiety. These defenses initially serve a life-saving purpose but in the long run become maladaptive and even tragic. Guarding powerfully against any new trauma, they generate resistance to a more creative experience of life. Through dreams, repetition, and other behaviors, Kalsched says, "*the traumatized psyche is self-traumatizing* … something more powerful than the ego continually undermines progress and destroys hope." [79] The challenge for both client and therapist rests in the fact that this primitive defensive system is not "educable. [It] does not learn anything about realistic danger" as time goes on; it is, he says, anti-life.[80] The goal of a psychodynamic therapy is to surface these inner conflicts by use of transference, insight, or play in order to integrate them into consciousness and facilitate the development of an intact, whole, healthy personality.

Attachment Perspectives on Trauma

The attachment perspective on trauma has gained much influence in recent years. Emerging from psychodynamic and object relations theory, attachment theory has been validated by research associated with the biological perspective as well.[81] Where psychodynamic theory sets the origins of behavior and personality in unconscious drives, object relations studies the influence of relationships in the formation of one's character. Persuaded by this and concerned that psychoanalysis minimized the impact of early

relational trauma in creating neurotic behavior, John Bowlby first advanced a theory of attachment in the late 1950s.[82] His insight was that the quality of the bond between an infant and its primary caregiver, their *attachment style*, forms a template that shapes all relationships throughout the course of that infant's life.[83]

Mary Ainsworth tested Bowlby's ideas by undertaking studies of infants and their parents that included, at the end of the baby's first year, what became known as the *strange situation*.[84] This is a research protocol that tracks the response of a toddler to the mild stress of being separated from and then reunited with its caregiver for short periods of time. From this data, along with detailed observations of the parents and child during their first year, Ainsworth classified three attachment styles: Securely Attached, Anxious Ambivalent, and Avoidant.[85] Mary Main later added a fourth, Disorganized, for those whose primary caregiver was a direct source of fear or trauma.[86] *Insecurely attached* is an umbrella category that encompasses the three styles other than securely attached.

Securely attached people are better able to modulate their emotions under stress. Being raised by what Winnicott called a *good enough mother*, that is, a caregiver who is reasonably attuned to the security needs of the child, nurtures a facility for self-regulation that enables the child to have a wider window of tolerance as an adult.[87] Evidence suggests that securely attached people are much less likely to suffer PTSD after enduring traumatic incidents later in life.[88] When faced with a traumatic event as adults, they may fight back or at least remain psychologically intact during and after the episode.

On the other hand, insecurely attached people may be predisposed to more severe psychological issues after trauma due to a diminished capacity to regulate stress.[89] A characteristic of insecure attachment is that, as with the effects of physical abuse noted

earlier, an *attachment wound* or lack of attunement between parent and child may impact the child's prefrontal cortex development.[90] The child is less able to process trauma as a result and may be easily re-triggered when faced with emotional upsets later in life. New triggers, even those one might not consider traumatic per se, such as a minor dispute with a partner, may cause insecurely attached people to react in an anxious, avoidant, or disorganized manner, thus making adult relationships difficult to maintain. Attachment therapists approach the work with an explicit intent to create a secure bond with clients in order that they may practice and learn affect regulation skills and develop their capacity for a reflective, spacious response to life. [91]

Stan Tatkin adopted the term "angry resistant" in place of anxious ambivalent.[92] He describes clients with this insecure style as being unable to rely on the self for comfort and needing external regulation from a partner in order to feel secure when under duress. But their anxious need often comes on too strong (Tatkin refers to them as *waves*), creating a habitual cycle of hope that changes to despair when their partners inevitably recoil from the intensity. An attitude of negativity follows; they grow argumentative to protect against their dependency. Tatkin says they soon become "allergic to hope." [93] In contrast, avoidant types (whom he calls *islands*) retreat from relational needs when stressed, isolating themselves in an effort to find solace. Tatkin says such people are "allergic to dependency." [94] This island/wave dynamic is a fitting metaphor for the clients in this case study and it played out often during their therapy.

An attachment approach can be quite effective in couple therapy. Tatkin and Solomon share material about the psychobiological roots of attachment with their clients and introduce practices that help a couple co-regulate one another's nervous systems.[95]

Partners begin to recognize each other's attachment styles and the specific ways each defends against pain and loss.[96] They learn to avoid behaviors that threaten their bond, attend to one another's distress, and repair emotional injuries as they arise.[97] Similarly, Campbell and Grey offer psychoeducation about relational trauma to bring awareness to *reactive cycles*, or the ways by which partners trigger one another's reactivity in patterns that are difficult to escape.[98] They provide clients with somatic and interactive practices that foster emotional security and co-regulation between partners.[99] For instance, even the simple act of spouses holding hands at stressful times has been shown in fMRI studies to be powerfully effective in reducing anxiety.[100] Campbell and Grey aim to help insecurely attached individuals become companions in a functioning, securely attached relationship.

Sue Johnson's *Emotionally Focused Couple Therapy* (EFT) is the most widely researched model in the attachment realm.[101] EFT privileges affect and attachment bonds between a couple over negotiations and transactions. Clients learn to access and articulate their in-the-room emotions and hear each other in ways that build empathy, thus creating secure connections that enable the couple to address their issues and goals. Johnson has conducted or reviewed dozens of research studies since 1985 that validate the efficacy of EFT across a variety of presenting issues.[102] Of special interest to this case study is her work with couples in which one or both partners survived trauma.[103] As noted earlier, trauma survivors face unique challenges in forging attachments, so an EFT therapist can assist a couple in rebuilding trust, overcoming shame, and feeling safer in their union.

In summary, attachment theory views complex trauma as a result of insufficiently close or inadequately aligned relations between an infant or child and its primary

caregiver. The caregiver may have been depressed, narcissistic, violent, addicted, or merely unskilled at attuning to the emotional needs of a child. Insecure attachment can follow simply from misattunement and neglect or from repeated abuse of a physical, verbal, or emotional nature. Attachment therapists aim to provide a reparative experience for clients as they learn to securely regulate their emotions. Working with couples can be both challenging and productive when both partners are insecurely attached. The prospect of intimacy and the attendant feelings of vulnerability may trigger unresolved emotions from early life, leading to clashes over differing needs for closeness, self-disclosure, affection, and sexual satisfaction.[104] Coming to terms with their attachment styles in therapy can lead to greater understanding and empathy for both partners.

Cognitive/Behavioral Perspectives on Trauma

A cognitive/behavioral orientation assumes the treatable effects of trauma are *cognitive distortions* that embed in the survivor after traumatic experiences.[105] Such distortions are irrational thoughts that take the form of self-blame and negative messages about themselves, the world, and the future. Cognitive behavioral therapy (CBT) works with the interpretations people make of their experiences rather than deeply exploring the experience itself. Aaron Beck, a founder of cognitive therapy, was clear on this point in writing, “The cognitive model states that dysfunctional, psychiatric, psychological, and behavioral disorders are characterized by dysfunctional thinking [that] accounts for the affective and behavioral symptoms.” [106]

CBT treatment focuses on a client’s thought processes and how their beliefs are expressed through their behaviors. Techniques include psychoeducation, reality testing,

cognitive restructuring, and relaxation training.[107] *Exposure therapy*, the idea that revisiting a feared object or trauma episode in increasing detail over a series of sessions will alleviate anxiety, is frequently applied in CBT.[108] The desired outcomes of CBT are to create a normative and realistic view of the world and to remove thoughts of blame and victimhood from the client. CBT research largely addresses PTSD and dissociation, and while these diagnoses were not a clear fit to the clients in this case study, the cognitive/ behavioral perspective is required for a broader understanding of trauma.

CBT methods have become so widely accepted over the past 40 to 50 years that they are now the preferred approach for a majority of practicing therapists.[109] CBT techniques are often referred to as "evidence-based," largely because the number of studies with positive results has grown enormously. The Society of Clinical Psychology in 2010 listed 60 treatments for various disorders; of these, nearly 90 percent of those with strong or modest research support were behavioral.[110] The widespread use of CBT and the availability of funding to underwrite research have been ascribed to its short-term, highly structured methodology.[111] This simplicity has multiple benefits: It is relatively easy to train research assistants to conduct CBT trials; measuring outcomes is fairly straightforward; and providing CBT treatment to research subjects and clients is reasonably uncomplicated due to the availability of detailed, step-by-step protocols.

There are a number of cautionary critiques of CBT's efficacy. Gaudiano cites *component analysis* studies that in some cases reveal the cognitive elements of CBT did not outperform treatments that contained only behavioral components.[112] He asserts CBT theory until recently lacked grounding in the emerging fields of cognitive psychology and neuroscience. Heller and LaPierre agree, stating that in the case of complex trauma, "the

new understanding from the neurosciences supports the importance of working with affect regulation over cognition." [113] They speculate that because the cerebral cortex may not have been fully developed when early trauma occurred, changing distorted cognitions is difficult because such efforts fail to address "the underlying nervous system and affective imbalances that drive the cognitive distortions." [114]

Van der Kolk affirms that CBT is quite effective at treating phobias and irrational anxieties such as fear of heights or spiders but cites research that indicates it is less successful when treating trauma victims, especially complex trauma from early abuse.[115] He references multiple studies of PTSD sufferers that show progress in only one-third of subjects and points to results of the largest study available at the time in which more than one-third of the subjects dropped out, most of the rest had manifold adverse reactions, and only 15 percent of female subjects were cured of major PTSD symptoms.[116]

The research findings are mixed, however, and others indicate successful results of CBT treatments for PTSD. One meta-analysis reviewed 38 randomized controlled studies to find that *Trauma-Focused CBT* (TF-CBT) and *Eye Movement Desensitization and Reprocessing* (EMDR) were effective at reducing PTSD symptoms.[117] Trauma-focused treatments emphasize processing the memory and/or meaning of the trauma as opposed to other CBT strategies that aim to manage anxiety and problem solving. Ehring et al. followed by conducting a meta-analysis of 16 controlled trials of PTSD treatments strictly among adult survivors of childhood abuse.[118] Their findings mirrored the earlier study, indicating that even in this distinct population TF-CBT treatments are significantly more effective than non-trauma-focused approaches. Unlike the van der Kolk reference noted above, these studies had an average dropout rate of only 22 percent.

Steven Hayes charted the evolution of CBT approaches in 2004, calling EMDR and other newer modalities a "third wave" of CBT.[119] He saw the entire field of CBT in the throes of a reorganization. Hayes described the first wave of behavioral therapy as having been spawned in reaction to psychoanalytic and humanistic theories which were viewed by early behaviorists as unscientific.[120] Behavioral specialists of the time used principles of conditioning and desensitization to focus exclusively on changing problematic emotions and behaviors and were often successful within this narrow vision. However, after some time the profession recognized that such mechanistic strategies failed to address important areas of clinical work that were central to the rejected theories, such as wide-ranging explorations of what it means to be human and alive.[121]

Hayes places the beginning of the second wave in the late 1960s, when an emerging awareness of cognitive psychology began to inform and supplant the older reliance on stimulus-response learning theory.[122] Going beyond rudimentary behavioral changes targeted in first wave practices such as replacing anxiety with relaxation, second wave practices attended to more complex cognitive issues such as "irrational thoughts, pathological schemas, and faulty information processing styles [in order to] weaken or eliminate them through their detection, correction, testing, and disputation." [123] This was the model first developed by Beck as discussed earlier.

Hayes contends that while they were an advance over early behaviorism, the assumptions and practices of second wave cognitive therapy were being questioned by the end of the century. Anomalies became apparent in research that showed for some conditions cognitive change was neither necessary nor sufficient to effect success in therapy.[124] One large study of depression indicated there was no benefit to including the

cognitive components of CBT in treatment.[125] Studies on PTSD have provided strong evidence that attempts to suppress intrusive thoughts generally fail, and later the thoughts return stronger than before.[126] Finally, Hayes points to an evolution in the philosophy of science from a mechanistic view of human complexity to a multidimensional, postmodernist view that "gradually weakened the assumptive base of … behavioral and cognitive therapies and their underlying theories." [127]

While not abandoning the evidence-based, empirical foundation of CBT, third wave modalities integrate awareness and skills in such areas as mindfulness, acceptance, spirituality, values, and emotional and interpersonal deepening.[128] Hayes observes their emphasis is not so much on changing "the *content* of thoughts, but on changing *awareness of* and *relationship to* thoughts. … They focus more on empowerment and repertoire enhancement than on pathologizing narrowly defined problem behaviors." [129] Models that seem to achieve results within this frame include *Acceptance and Commitment Therapy* (ACT), *Mindfulness-Based Cognitive Therapy* (MBCT), and EMDR. It is beyond the scope of this case study to examine each of these in detail but given the growing base of research on the use of EMDR with trauma clients, it is useful to highlight and briefly review it in particular.

EMDR was developed after a fortuitous experience in which Francine Shapiro noticed her eyes rapidly moving as she dwelled on a troubling memory.[130] She found she could revisit the memory while deliberately causing her eyes to move side to side, and each time she repeated this the intensity of the memory and its associated emotions would fade. A pilot study in 1989 showed a 30 percent reduction in symptoms, which encouraged her to continue refining the protocol and sparked further investigation into its

efficacy.[131] The EMDR protocol now consists of eight phases that contain elements of exposure therapy (recall the "D" stands for desensitization) and cognitive restructuring (the "R" stands for reprocessing) of distressing memories.[132] Later research by others suggests the eye movements may be superfluous and can be replaced with other means of bilateral stimulation such as rhythmically tapping one's knees or holding low voltage electrodes in the hands or even eliminated altogether with little effect on the results.[133]

Dozens of studies have tested the efficacy of EMDR alone, or alongside other CBT and non-CBT methods, on various populations and disorders. One large study using EMDR to treat PTSD reported it to be markedly more effective than Prozac: Eight months after the sessions, 60 percent of the EMDR group were completely cured while all those who had taken Prozac relapsed upon ceasing use of the drug.[134] However, there was a dramatic disparity between those who suffered abuse as children versus those who experienced shock trauma as adults. At eight months the cure rate was 73 percent for the shock trauma group but only 25 percent for the complex trauma group.

Other studies report similar mixed results. Davidson and Parker's meta-analysis evaluated 34 studies of EMDR with a variety of populations and modalities. They found EMDR to have significantly greater effects than no treatment or certain other treatments they termed "nonspecific," but they found it to be no more effective than other exposure therapies.[135] In addition, they explicitly disconfirmed the findings of others who claim EMDR is effective for those with noncombat PTSD, though they indicated a lack of clear evidence either way and called for additional research in this area.[136] More recent meta-analyses have revealed more promising results, though controversy remains over whether EMDR treatment is similar to or more effective than other CBT techniques.[137]

Turning our attention to another cognitive based but perhaps more sanguine approach to trauma, a theory of *Posttraumatic Growth* has been advanced by the psychologist Richard Tedeschi. He has devoted his career to exploring how a determined, deliberative struggle in the aftermath of life crises may finally result in profound, hopeful change. Tedeschi is careful to note that traumatic experiences should not be hailed as opportunities for personal growth; indeed, he cautions, they are often deeply distressing, and the effects linger even among those who ultimately create new meaning in their lives.[138] He clarifies, "It is the struggle with the trauma and the changes it has wrought, not the events themselves, that is the source of subsequent positive change." [139]

Tedeschi describes the impact of trauma on *schemas*. Schemas are thought patterns or structures of fixed ideas one holds regarding aspects of life and the world. For example, a person who has faced little adversity in life may have strong, if unexamined, beliefs that the world is a safe place and that good things happen to good people. Once formed, schemas are hard to dislodge. However, as Tedeschi notes, "trauma experiences often leave these schemas shattered, and years after surviving the events, people may continue to struggle with reconstructing schemas that accommodate the experience." [140]

Tedeschi describes the course of posttraumatic growth as one in which rumination after trauma is largely automatic, negative, and intrusive, but after some time a more purposeful contemplation may result in newly modified schemas.[141] The person may then self-identify as having achieved positive growth as a result of their struggles; they may tell a new story about what happened and what it means to them now. The changes are often described as inspiring, with a greater appreciation of relationships, spirituality, their personal strengths, and a deeper understanding of life itself.

In conclusion, a cognitive/behavioral approach to trauma will address irrational fears and crippling, negative thoughts about the self and the world. CBT therapists gauge success by a reduction in symptoms such as invasive thoughts, anxiety, and flashbacks. Techniques evolved from mechanistic stimulus-response conditioning and exposure models to more integrated methods that incorporate mindfulness, acceptance, and being in relationship with one's thoughts rather than trying to suppress or change them. The ease of uniformly providing CBT treatment under controlled conditions has built an extensive record of research data and enabled many CBT modalities to be recognized as "evidence based" by government agencies and mental health providers. While promising, even third wave approaches have shown mixed results, especially pertaining to clients with complex trauma. However, it is nonetheless true that many trauma survivors later report positive changes in their understanding of themselves, their approach to life, and relationships with others after coming to terms with traumatic experiences that caused them to struggle with and reconsider beliefs they had held earlier in their lives.

Sociocultural Perspectives on Trauma

In stark prose backed by voluminous data on domestic abuse, Bruce Perry states simply, "The home is the most violent place in America." [142] Close behind are schools and communities where bullying, gangs, intimidation, and threats abound. A sociocultural view on trauma begins with the assumption that society at large plays a role in reinforcing the root causes of trauma and traumatic events. Tolerated social norms can be seen behind such problems as child abuse, bullying, molestation, substance abuse, neglect, racism, and other forms of violence.

Writing in *The New Yorker*, the historian Jill Lepore examines the work of Child Protective Services in states across the U.S.[143] She notes budgets have been cut for years and that many are being sued for their failure to protect children. She reports that one in three children who die from maltreatment come from families that had been involved with CPS but whose cases were mishandled, neglected, or dropped by caseworkers. Lamenting the fact that the U.S. has one of the highest rates of childhood poverty in the developed world, Lepore concludes her critique by asserting that robust anti-poverty programs may have been much more successful in alleviating violence and abuse than the meager and toothless anti-abuse programs that were more politically viable in recent decades. In the epilogue to his most renowned work, van der Kolk passionately agrees:

> I wish I could separate trauma from politics, but as long as we continue to live in denial and treat only trauma while ignoring its origins, we are bound to fail. In today's world your ZIP code, even more than your genetic code, determines whether you will lead a safe and healthy life. … Poverty, unemployment, inferior schools, social isolation, widespread availability of guns, and substandard housing are all breeding grounds for trauma.[144]

The sociocultural perspective holds that trauma results not only from overt acts of abuse and violence, but from stressful environments that contribute to long-term mental health issues and complex trauma. Garbarino et al. note the damaging impact on children surrounded by political conflict, military combat, and pervasive violent crime.[145] Basham and Miehls introduce the term *culturally sanctioned trauma*, which includes such episodes as the internment of Japanese Americans during World War II, the current-day treatment of Muslims in America, and the daily prejudice enacted upon marginalized people based on race, disability, sexual orientation, or religion.[146]

The impact of racism on mental health has garnered notice in recent years. While granting the breadth of work on the social, economic, and political effects of racism,

Robert T. Carter criticizes the failure of scholars to explore how racism damages the mental and emotional health of its victims.[147] Drawing extensively on current research, he details the psychological harm experienced by people of color in the U.S., noting the majority of work on trauma fails to account for racism as a likely contributor to the higher rates of PTSD for racial minorities.[148] However, as racism and racist behavior can be subtle and reactions to it build slowly over time, he concedes that a means of clearly connecting occurrences of racism to mental health issues remains elusive.[149]

Nevertheless, Carter draws on studies that show parallels between the experience of racism with that of rape and domestic violence. All have similar effects on survivors, such as lingering fear, intrusive thoughts, hypervigilance, and a lack of psychological safety, and all are motivated by the perpetrator's desire to assert power over someone less powerful.[150] He concludes by urging the psychotherapy profession to train practitioners in recognizing and treating a new, nonpathological assessment category he proposes to call *Race-based Traumatic Stress Injury*.[151]

Delving further into the sociocultural view, the theory of *Historical Trauma* adds helpful perspective. Public health researcher Michelle Sotero describes evidence of historical trauma, noting that "populations historically subjected to long-term, mass trauma—colonialism, slavery, war, genocide—exhibit a higher prevalence of disease several generations after the original trauma occurred." [152] She cites studies of such widely diverse peoples as Palestinian, Cambodian, American Indian, and Holocaust survivors to show that descendants of those who directly suffered trauma exhibit a range of psychological issues associated with trauma and PTSD.[153]

The impact of slavery on modern-day African Americans has been widely studied since Joy DeGruy coined the term *Post Traumatic Slave Syndrome* in her 2005 book of the same name.[154] Sotero cites multiple authors who assert that "African Americans have sustained traumatic psychological and emotional injury as a direct result of slavery, perpetuated by social/institutional inequality, racism and oppression." [155] Wilkins et al. identify these effects as "behaviors associated with lower self-esteem, anger, and feelings of inferiority. … Current feelings of rage and passivity among many African Americans can be connected to the intrapsychic functioning of enslaved Africans." [156]

While acknowledging issues faced by people of color in the U.S. is essential to the sociocultural perspective on trauma, the clients in this case study are Caucasian. However, both grew up in homes they described as low on the socioeconomic scale. In this regard, Lepore briefly critiques the ACE study as flawed due to its failure to address the issue of poverty. "The medicalization of misery," she writes, "is yet another way to avoid talking about impoverishment, destitution, and inequality. … *Adverse outcomes are what happen to poor kids* [emphasis added]." [157]

A further limitation of the ACE study is its lack of proposed solutions to the problem it identified. One pediatrician laments that knowledge of ACEs alone does not provide physicians with avenues for help with the larger issues they uncover.[158] Ellis and Dietz developed the *Building Community Resilience* (BCR) model in an effort to fill that gap. The BCR approach would create local and regional partnerships across sectors in medicine, social work, public health, and community-based agencies to align services and resources with the goal of addressing the root causes of childhood adversity.[159]

Early sexual abuse, suffered by each of the clients in this case study, is among the most destructive of traumas. A sociocultural approach responds to this not only as a private violation, but as an issue for society as a whole to address. Organizations such as Stop It Now! work to reduce childhood sexual abuse by influencing public policy and disseminating educational programs. Other advocates, like Lepore, call for a stronger focus on prevention. Perry, though vague on specifics, argues for a commitment of social resources toward prevention because, he says, providing treatment for all traumatized people today "would overwhelm the entire mental health community in this country." [160] Putnam offers an example of a prevention program that has achieved great success. He describes the *Nurse-Family Partnership* as a home visiting program in use across the nation that has shown an 80 percent reduction in child abuse, a 56 percent reduction in accidental injuries, and many other positive effects on both mothers and their children.[161]

A therapy approach that embraces the sociocultural perspective takes special care not to recapitulate the power imbalance that a survivor must have felt while enduring abuse. It places the client in their cultural milieu and shows sensitivity to any historical context that may have contributed to the trauma. Many advocate a role for the broader community in healing trauma by witnessing survivors as their stories are told, by erecting monuments such as the Vietnam Veterans Memorial in Washington, and by offering public recognition of the traumatic event along with demands for accountability and restitution for the injury.[162] However, Hjul notes a limitation of this approach in that it risks losing sight of personal agency as psychological healing ultimately rests in the heart of the individual client.[163]

In conclusion, a sociocultural approach considers how the community addresses or ignores factors such as poverty that are often precursors to violence, how indications of danger might be missed or brushed off, and how a public response might be ineffectual due to poor training, limited resources, and little organizational support from social and government agencies. Trauma and its associated mental health issues can also result from a lifetime of being subjected to prejudice and from historical, intergenerational determinants. A sociocultural perspective suggests healing from trauma may depend not only on psychotherapy, but on public recognition of traumatic injury, community action for restitution and justice, and challenging institutional bias that favors the powerful over those most apt to be victimized: women, children, people of color, and the poor.

Imaginal Approaches to Trauma

An imaginal approach takes a broad, cross-disciplinary and cross-cultural view of psychology. Aftab Omer says Imaginal Psychology "draws on spiritual traditions, somatic practices, creative arts, mythology, indigenous wisdom, deep ecology, and social critique … enabling a distinctly postmodern psychology to emerge [that] reclaims soul as psychology's primary concern." [164]

The term *soul* is difficult to define concretely. Imaginal theorists rely instead on descriptions, allusions, and metaphors. Omer, for example, terms soul as "the mysterious stillness, aliveness, and otherness at the core of being." [165] Corbett describes soul as a process consisting of both a somatic element that enables archetypes to be channeled into the body and an intrapsychic element that produces imagery.[166] Hillman too invokes both process and the body in writing, "Soul refers to the *deepening* of events into experiences

… [its significance] derives from its special *relation with death*." [167] He later refers to the ambiguity of the word and describes it as an outlook on things rather than an actual thing.[168] Moore concurs, writing, "Soul is not a thing, but a quality or a dimension of life. It has to do with depth, value, relatedness, heart, and personal substance." [169]

In his essay "Peaks and Vales," Hillman draws a distinction between spirit and soul. He uses metaphors of mountain peaks and peak experiences to describe the spiritual life, which he concedes has merit but is quite different from remaining down in the valley of daily life, immersed in "such sad things as the decline of years and old age … troubles, sorrow, and weeping … the mortal, the earthly, the lowly." [170] Spirituality may seek to transcend such matters, but soul will occupy itself with love and pain, illness, mortality, and shadow.[171] He rejects the very premise of trying to strictly define the word *soul*. The attempt, he says, puts us into a rational frame and removes us from the imaginal valley.[172] Instead, he writes, "I am trying to let the *images* of language draw our distinction. This is the soul's way of proceeding, for it is the way of dreams, reflections, fantasies, reveries, and paintings." [173] Elsewhere, Hillman asserts with emphasis: *Soul is imagination*.[174]

Karen Jaenke bridges this discussion of soul into the practice of therapy by declaring the heartbeat of Imaginal Psychology to be the purview of images, imagination, and affective life.[175] Imaginal Psychology views symptoms as the essential way by which soul expresses itself. "When soul is neglected," warns Moore, "it doesn't just go away; it appears symptomatically in obsessions, addictions, violence, and loss of meaning." [176] Symptoms serve a dual purpose for client and therapist: They express something of the soul that needs attention, and they are the soul's way of drawing attention to that need.[177]

Robert Sardello poses the fundamental issue for therapy and, indeed, modern life, as, "The question of soul pain *is not what to do about it but what to do with it*." [178]

Hillman and Moore provide an answer to the riddle.[179] Their critique of most psychotherapy is that it all too often focuses on trying to fix a problem. Instead, they make a case for following the trail of symptoms to discover what is revealed about the client's soul needs. What messages, they ask, are being sent from deep within the client? Can one befriend suffering rather than make an enemy of it? Moore proposes therapists try "a homeopathic move, going with what is presented rather than against it" to find the core need or value hidden in the shadow of problematic behaviors.[180]

Jeffrey Miller says Jung believed that every idea, attitude, or image in the conscious mind is opposed by another in the unconscious, resulting in a constant struggle of opposites.[181] People too often succumb to the ease of adopting one or the other as truth, which arouses symptoms as the disowned side cries out for attention. If we can hold the tension long enough, a new insight, different from either of the opposing poles, will arise. *Individuation*, writes Guggenbühl-Craig, "implies an active, difficult, uncomfortable working-through of one's own complex psyche toward a joining of its opposites." [182] Jung's term for the mechanism that enables one to navigate this task is the *transcendent function*. He viewed individuation as the culmination of a journey toward wholeness and held that "only through a process of engaging the transcendent function can a person foster the psychological growth that leads to individuation." [183] Miller asserts the transcendent function is "crucial to the central mission of depth psychology, which is to access, explore, and integrate the unconscious." [184]

Thus, Imaginal Psychology views symptoms as an indication that the soul has unmet needs, inviting the client to engage the transcendent function and embark upon the arduous journey toward individuation. The soul offers clues in dreams, fantasies, art, and the stories clients tell about themselves. All of these sources offer images that potentially shed light on a person's psychological state. The images embody characteristics of what Jung termed *archetypes*. Archetypes, he said, emerge from the *collective unconscious*, a deeper substrate of the personal unconscious that is inborn and shared universally by humans everywhere.[185] Archetypes are images, representations, and symbolic figures that have populated myths and legends since time immemorial. They live through us as patterns of behavior, instincts, and "complexes of experience that come upon us like fate … as if the gods have claimed another victim." [186] Common examples of archetypes are the Mother, the Trickster, the Wise Old Man, and the Hero.

Jung defined *complexes* as fragment personalities or individualized expressions of archetypes that live within us and engage in their own activity regardless of our conscious intentions.[187] He saw them as the key organizing structures of human behavior with their own impulses and purposes, capable of asserting their will to impact our conduct.[188] John P. Wilson clarifies the distinction between a *Trauma Archetype* and a *Trauma Complex* as aspects of a posttraumatic self. "The Trauma Archetype," he explains, "represents universal forms of traumatic experiences across culture, time, and history [whereas] the Trauma Complex is the unique, individual constellation of the trauma experience [that] embeds a wide range of phenomena including PTSD." [189]

Some term these entities *subpersonalities*.[190] Richard Schwartz, creator of *Internal Family Systems* (IFS) therapy, calls them *parts*.[191] Schwartz identifies three

categories of parts found within each person: *Exiles*, formed as a result of childhood neglect and abuse; *Managers*, whose task is to isolate the exiles and prevent any of their emotional pain from surfacing; and *Firefighters*, whose role is to tamp down and contain any outburst of emotions that occur when an exiled part gets triggered.

Omer likens complexes to *imaginal structures*, which he defines as "assemblies of sensory, affective, and cognitive aspects of experience constellated into images that both mediate and constitute experience." [192] For Omer, the process of individuation entails "a transmutation of imaginal structures into emergent and enhanced capacities as well as a transformed identity." [193] As an example, an imaginal structure presenting as the Wounded Child may be trapped in the affect of fear, which through the utilization of certain practices or rituals may be transmuted into the capacity of courage. Or she may instead be trapped in the affect of grief, which Omer says transmutes into compassion.

Identity transforms as well, and Omer names three distinct types: *Adaptive*, *Reflexive*, and *Core* identity.[194] One's *adaptive identity* develops early in life as the soul of a child copes with excessive, premature, or traumatic stresses. Limiting self-images constellate as imaginal structures, becoming barriers to growth and psychological health. We are in *reflexive identity* when we are self-aware and able to recognize and engage those imaginal structures that constrain our experience of life; Omer calls the ability to do this the capacity of *reflexivity*.[195] *Core identity* is our authentic nature, our true self obscured by our adaptive identity.

Meridian's distinctive approach to transformative learning, that of Imaginal Process, employs practices that are in alignment with the greater subfield of Imaginal Psychology.[196] One aim of Imaginal Process is to assist students in developing their

capacity of reflexivity (a key learning outcome for the Psychology Program) as students dialogue with the imaginal structures living within their adaptive identity. Such a dialogue harkens back to Moore's inspiration to "go with" symptoms as they present. As our subjectivities are integrated, our core identity emerges, and we encounter life more fully. Omer refers to this as the *restoration of experience*.[197]

Guggenbühl-Craig identifies "factors hostile to individuation [as] rigidity, closed-mindedness, and a lack of openness to oneself and the world." [198] These traits show up as subjectivities that Schwartz categorizes as managers or firefighters. Omer's analogous term for such imaginal structures is *gatekeeper*. A gatekeeper engages in *gatekeeping*, which Omer defines as "individual and collective dynamics that resist and restrict experience." [199] Gatekeeping is seen as the primary obstacle to learning, growth, and change. The concepts and terms under discussion here, including gatekeeping, imaginal structures, adaptive and core identity, and the like, are all central to Meridian's practice of Imaginal Process.

Students at Meridian utilize learning activities entailed in Imaginal Process to elicit and identify the gatekeeping voices a person may carry inside. Mindful that gatekeepers initially arise to protect and defend a child from experiencing pain, the aim is not to eradicate them even though they may have outlived their usefulness. Instead, another entity, the *Friend*, is enlisted in the effort to know them better. Omer defines the Friend as "deep potentials of the soul that guide us to act with passionate objectivity and encourage us to align with the creative will of the cosmos." [200] The Friend may at times be curious with the gatekeeper, at other times confrontive, but will soon encourage disidentification from the gatekeeper in order to move from adaptive identity into core

identity. Gatekeeping, says Omer, imposes the past onto the present, while invoking the Friend is a move into openness and the possibilities of the future.[201]

In summary, an imaginal approach to trauma assumes that subjectivities arise and coalesce within the trauma survivor as a means of coping with overwhelming experiences of violence, neglect, or abuse. These entities split off from the self and their task is to guard against any future recurrence of trauma or the pain that was felt. They may be overly protective or harshly critical of the person. From the point of view of Imaginal Process, as a client learns to interact with and disidentify from their gatekeepers, the therapist can provide the voice of the Friend until the client is able to access their own authentic version of the Friend and finally delight in life from within their core identity. An imaginal approach to therapy utilizes practices to reveal the dreams, stories, visions, and voices we carry inside. As Omer states, "Among many ways to characterize soul, one that stands out is this: The nature of the soul is to be deeply affected—passionate—and it feels an imperative to be expressive. The more archetypal it is, the more creative and beautiful is the expression of soul." [202]

Conclusion

This chapter surveys the landscape of the major psychological perspectives regarding the impact of early trauma on survivors and their approaches to treatment. While theoretical overlap exists in some instances, notably between the biological and attachment views and between the psychodynamic and imaginal models, in practice their treatment approaches vary widely.

The biological perspective focuses on the physiological impacts of trauma. Data from fMRI studies show that trauma affects the development of brain structures that control executive functioning and emotional regulation. Trauma survivors become hypervigilant, often reacting to mild stresses as though they were reliving early traumatic events. The most common treatments for symptoms are pharmaceutical drugs to control anxiety and depression. Newly emerging somatic therapies utilize neural plasticity to help clients expand their window of tolerance and better manage their emotional reactivity. Research on somatic modalities to date is thin, but initial findings are promising.

The psychodynamic perspective views such behaviors as repression, dissociation, and anxiety as the psyche's unconscious efforts to guard against the danger of feeling, remembering, or re-experiencing traumatic episodes. Reenactments are seen as attempts to gain resolution and mastery over the events. Psychodynamic therapists utilize transference, insight, and the therapeutic alliance to help clients overcome their defenses and construct an intact, healthy personality.

The attachment perspective builds on biological and psychodynamic theories to explain how the quality of the bond between an infant and its caregiver creates a template for all future relationships. Securely attached people are more resilient to shock trauma, but complex trauma leads to insecure attachment and problematic behaviors that make it difficult to sustain intimacy. Attachment approaches are particularly effective in working with couples as demonstrated by multiple research studies on EFT. Attachment therapists focus on psychoeducation, reactive cycles, and island/wave dynamics that are especially pertinent to the clients in this case study.

The cognitive/behavioral perspective works to address cognitive distortions people create after experiencing trauma. The CBT approach has evolved through three waves or generations of theory, moving from a mechanistic view of human behavior to a more nuanced, postmodern understanding. CBT modalities are more frequently researched and accepted as evidence-based than other therapies. Studies of EMDR in particular show positive benefits for many disorders although less so for populations suffering from complex trauma. Posttraumatic growth affirms that trauma survivors may realize profoundly positive changes after wrestling with the aftermath of their experience.

The sociocultural perspective asserts that trauma is both personal and cultural and that social conditions influence the root causes of trauma. Poverty, racism, and pervasive violence are highlighted as contributors to a milieu that both enables and ignores the damage done to trauma victims. Therapy from this perspective respects individual integrity while acknowledging the client's social, economic, and cultural background.

An imaginal approach to psychology places care of the soul front and center in the journey of healing. Imaginal structures are believed to form as the person is wounded by trauma, but their protective intentions become maladaptive over time. Symptoms are viewed as the essential way the soul makes its needs and desires known. An Imaginal Psychotherapy follows cues from the symptoms rather than seeing them as problems to be fixed. Treatment engages the imagination in dialogue with imaginal structures or subpersonalities as the client learns to disidentify with them and move toward a richer experience of life from within their core identity.

Despite the voluminous literature on trauma, gaps yet remain to be explored. Research from the imaginal perspective, for instance, is largely qualitative, sparse, and

not widely published. Among the somatic therapies only Somatic Experiencing has been much studied, and even at that only a small number of participants have been involved. Studies of cognitive/behavioral techniques far outpace all other approaches, and many have come to be called evidence-based due to their success in alleviating symptoms. Within that realm, EMDR has benefited from a multitude of studies, although there is no consensus regarding its efficacy in treating certain disorders, especially complex trauma.

For purposes of this case study, the biggest gap is the dearth of research on couples. Attachment therapies appear to show the most promise in this area, and EFT has started to build a base of research that is both growing and encouraging. What is yet to be determined, for couples as well as individuals, is what might be learned from comparison studies between the various modalities. For the most part, such studies do not yet exist; most research measures a single approach against a control group receiving no treatment. We do not know if EFT with couples may or may not be more effective than, say, seeing the couple separately and working with their trauma individually using SE or EMDR followed by an assessment to gauge any improvement in their relationship.

The following chapter examines a year-long course of therapy undertaken by my clients Brett and Barbara Madigan. Their challenges illustrate many of the issues that can arise due to early childhood trauma as described throughout this Literature Review. As a novice therapist, I was able to draw from only a few of the treatment modalities noted herein. Those I was most familiar with were the attachment, psychodynamic, and imaginal models, and each in turn contributed to the Madigan's insight and growth as we navigated the therapy journey together.

NOTES

1. Richard G. Tedeschi and Lawrence G. Calhoun, "Posttraumatic Growth: Conceptual Foundations and Empirical Evidence," *Psychological Inquiry* 15, no. 1 (2004), 1.

2. Peter Levine and Ann Frederick, *Waking the Tiger: Healing Trauma* (Berkeley: North Atlantic Books, 1997), 10.

3. The origin of the term *fight or flight* has been generally credited to Walter Cannon since publishing his early investigations into the hormonal response to stress, rage, and fear, in "The Emergency Function of the Adrenal Medulla in Pain and the Major Emotions," *American Journal of Physiology* 3 (1914), 361.

4. Judith Herman, *Trauma and Recovery* (New York: Basic Books, 1992), 33.

5. Levine and Frederick, *Waking the Tiger*, 11.

6. Christine Courtois, "Complex Trauma, Complex Reactions: Assessment and Treatment," *Psychotherapy: Theory, Research, Practice, Training* 41, no. 4 (2004), 412.

7. Carola Maggiora Vergano, Marco Lauriola, and Anna M. Speranza, "The Complex Trauma Questionnaire (ComplexTQ): Development and Preliminary Psychometric Properties of an Instrument for Measuring Early Relational Trauma," *Frontiers in Psychology* 6 (2015), 1323. The nine domains of interpersonal abuse measured by this instrument are: neglect; rejection; role reversal; psychological abuse; physical abuse; sexual abuse; witnessing domestic violence; and significant separations and losses.

8. Vincent Felitti et al., "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study," *American Journal of Preventive Medicine* 14, no. 4 (1998). The seven categories of adverse experience studied were: psychological, physical, or sexual abuse; domestic violence against the mother; or living with household members who were substance abusers, mentally ill or suicidal, or ever imprisoned.

9. Bessel van der Kolk, *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma* (New York: Viking, 2014), 145.

10. Felitti et al., "The ACE Study," 245.

11. Frank W. Putnam, "The Impact of Trauma on Child Development," *Juvenile and Family Court Journal* 57, no. 1 (2006), 1-2.

12. *The Diagnostic and Statistical Manual of Mental Disorders (DSM-5),* 5th ed. (Arlington, VA: American Psychiatric Association, 2013).

13. Anushka Pai, Alina Suris, and Carol S. North, "Posttraumatic Stress Disorder in the DSM-5: Controversy, Change, and Conceptual Considerations," *Behavioral Sciences* 7, no. 1 (2017), 2.

14. DSM-5.

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18. van der Kolk, *The Body Keeps the Score*, 143, 159.

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27. van der Kolk, *The Body Keeps the Score*, 30.

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29. Ibid., 4. Pat Ogden, Kekuni Minton, and Clare Pain make the same point specifically with regard to hippocampus size, in *Trauma and the Body: A Sensorimotor Approach* (New York: W.W. Norton, 2006), 151.

30. Dowd and Proulx, "Neurology and Trauma," 4.

31. Bremner, "Traumatic Stress," 446.

32. Ibid., 448.

33. Putnam, "The Impact of Trauma," 5.

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41. In *Waking the Tiger*, Levine and Frederick explicitly state that trauma symptoms are not caused by the event itself, but by "frozen" energy that was never "resolved and discharged" (p.19). They further declare that an "endless search for traumatic memories will interfere with the organism's innate wisdom to heal" (p. 34).

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1. Imaginal Process: An approach to transformative learning, understood as the emergence and cultivation of capacities by individuals, organizations, communities, and societies.
2. Imaginal Inquiry: A methodology for participatory research that weaves together both inquiry and transformation.
3. Cultural Leadership Praxis: A creative and collaborative approach to fostering cultural transformation within organizations, communities, and societies."

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