FAMILY PROCESS

Couples Therapy with Childhood Sexual Abuse Survivors (CSA) and their Partners: Establishing a Context for Witnessing

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This article proposes a clinical practice for therapy with couples in which one partner suffered sexual abuse in childhood. Such couples often encounter unique difficulties with physical contact, intimacy, sexuality, communication, and trust, and their relationship dynamic may be marked by reenactments of past traumatic relational patterns. This clinical practice is founded on the assumption that establishing the witnessing lacking during the traumatic event in childhood can break the traumatic reenactments in adulthood, and spur recovery. The suggested practice may facilitate twofold witnessing: the couple's therapist witnesses the reenactments of the trauma in the couple's relationship; and the survivor's partner witnesses the trauma's effect on the survivor's personal life and relationship. Twofold witnessing can help break the cycle of traumatic reenactment and help the survivor integrate the events of her life into a more coherent, continuous narrative. The partner's presence also facilitates acknowledgement of what happened to the survivor, and helps the survivor elaborate on her stories of resistance, survival, and strength. Finally, each of the partners is able to appear more wholly and fully, and together to tell the preferred stories of their life as a couple, replete with the multiple relational patterns they wish to live, which may contradict the characteristics of the original trauma.

Keywords: Couples Therapy; Childhood Sexual Abuse (CSA); Narrative Therapy; Relational Psychoanalysis

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The phenomenon of sexual abuse in childhood is a societal one shrouded in secrecy; the victim is often silenced by the abuser, her family and community, and society at large. Being silenced engenders in the victim feelings of shame, guilt, and confusion. Even when the childhood sexual abuse survivor (CSA) breaks her silence she is often at risk of being retraumatized, depending on the nature of the response. A disclosure that is met with a dismissive or nonprotective response can be traumatic in itself (Feiring, Taska, & Lewis,

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We wish to acknowledge, with deep gratitude, the couples we have seen in therapy over the years, who, despite enduring horrible events in childhood, were able to find a place in their hearts to trust us, themselves, and their partners. In so doing, they not only brought hope into own their lives but also imbued our personal and professional lives with hope.

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2002). The practice presented herein provides a context for witnessing what was not witnessed at the time of the trauma. It is used in the setting of couples therapy with the CSA survivor and her partner, which in itself provides a context for both partners to experience each other differently.

This article is divided into three sections. After reviewing theoretical aspects of CSA and its influences on romantic relationships in adulthood, we propose a clinical practice, illustrated by clinical cases. We then summarize and discuss the contribution of this work to the field, as well as issues for further consideration.

THE EFFECTS OF CHILDHOOD SEXUAL ABUSE ON ROMANTIC RELATIONSHIPS IN ADULTHOOD

Sexual abuse in childhood is differentiated from other types of trauma because it takes place in the context of interpersonal relations, and as such is relationally based. Unlike other forms of interpersonal violence, CSA mingles exploitation and assault with what may be evidence of love and affection (Briere, 1989). Research in the field indicates that CSA may have significant negative implications for multiple aspects of the survivor's adult life (Evans, Hawton, & Rodham, 2005; Kendall-Tackett, 2002; Ullman & Brecklin, 2003). Meta-analyses have found a significant association between CSA and the following outcomes: PTSD, depression, suicide, sexual promiscuity, and the victim-perpetrator cycle (Paolucci, Genuis, & Violato, 2001). The literature also delineates the characteristics of CSA (e.g., continuous vs. single event, family vs. nonfamily perpetrator, age of the child when it happened, and gender of the abused child), each of which has different implications for the survivor's life in adulthood (O'Leary, Coohey, & Easton, 2010).

One notable implication of CSA is its influence on romantic relationships in adulthood (Godbout, Sabourin, & Lussier, 2009). Compared with individuals who report not having experienced CSA, survivors report higher levels of distress in relationships and lower levels of overall relationship satisfaction (DiLillo & Long, 1999); lower levels of relationship stability (Cherlin, Burton, Hurt, & Purvin, 2004); and problems of sexuality (Leonard & Follette, 2002). Nevertheless, CSA survivors demonstrate a striking longing for relationships with others and for stable attachment relationships (Allen, Huntoon, Fultz, & Stein, 2001). Moreover, studies have found that interpersonal relationships have the potential to moderate and mediate the long-term distress displayed by the CSA survivor (Runtz & Schallow, 1997; Whiffen, Judd, & Aube, 1999).

Yet the romantic relationships of the CSA survivor are often characterized by a relationship dynamic in which traumatic patterns are reenacted (Buttenheim & Levendosky, 1994; Maltas, 1996). Such traumatic patterns of reenactment encompass self and object representations, which are frequently split off from consciousness. Powerful unconscious processes of identification and projective identification then act to reveal and express the distinct and sometimes dissociated self-states of each partner (Bromberg, 1998).

THE LACK OF A WITNESS AND THE EXPERIENCE OF ABUSE IN CHILDHOOD

When a survivor of CSA is unable to fully acknowledge what happened to her and cannot tell her story with specificity, the abuse tends to be experienced as fragments of sensory and motor experiences (Laub, 1995). This is assumed to be a result of sensory and emotional flooding at the time of abuse (Caruth, 1995). These fragments of experience are not integrated with other experiences, and lack symbolic expression (van der Kolk, 1989). Neither verbalized nor expressed, the fragments remain as distinct islands of differing states of consciousness, which are inaccessible associatively to conscious thought (Bromberg, 1998). Consequently, the ability of the survivor to bear witness to what she endured may be reduced.

The ability of the survivor to bear witness to herself is further diminished by the absence of external witnesses to her abuse. Many times, the child's environment tends to deny and silence the abuse, both passively and actively. The abusive adult cannot acknowledge the victim or his crime, and others in the child's environment tend to refuse to do so for him (Seligman, 2004). Nevertheless, survivors tend to feel a continuous need to tell their story. Current consensus is that telling the story in the safety of a protected relationship can actually produce a change in the abnormal processing of the traumatic memory and spur recovery (Caruth, 1995; Herman, 1992; van der Kolk, 1989). However, actually being able to tell the story of the abuse is impeded by the impossibility of knowing that it happened. Consequently, many abuse victims "tell" their story by reenacting their traumatic experience in the relationships they create (Maltas, 1996)—including in any therapeutic relationship they may enter into (Davies & Frawley, 1994).

In discussing the therapeutic relationship formed with CSA survivors, Davies and Frawley (1994) identified eight relational positions, expressed within four relational matrices that are alternately enacted by therapist and survivor in the transference and countertransference. Each relational matrix involves two complementary roles of the abuse victim and the significant other (in this case, the therapist): (1) the unseeing, uninvolved parent and the unseen, neglected child; (2) the sadistic abuser and the helpless victim; (3) an idealized omnipotent rescuer and the entitled child; (4) seducer and seduced. Davies and Frawley (1994) claim that these positions are not static, but rather change over time, and may be exchanged between the parties to the relationship, such that either of the roles may be played by the client or the therapist at any given point during the therapy. For example, the client may enact a sadistic, abusive, intrusive, and demanding parent while the therapist takes the role of the helpless victim, *or* the client may play the role of the helpless victim, while the therapist becomes the abusive, intrusive, demanding, and controlling parent (position 2).

Like client and therapist, romantic partners may play different complementary roles over time, and may alternate roles. For example, during a given period, one partner may enact the "omnipotent rescuer," trying different therapeutic frameworks and intruding into all aspects of his survivor-partner's life in an attempt to heal her, while she plays the entitled child (position 3). At another point in time, or in a different context—that of intimacy, say—these same partners can find themselves in a situation in which one of them is a frightened, paralyzed "helpless victim," while the other enacts the complementary role of the aggressive "abuser" (position 2). It is important to note that reenactments do not always occur, nor do people and their partners always fit into the matrices described above. Rather, we think of this schematization as offering the reader what might be considered points of orientation for making sense of the survivor's (reenacted) story of childhood abuse.

CREATING A PROCESS OF WITNESSING IN THERAPY

If there is a need to tell that cannot be met, what is the victim to do? How is she to tell her story? It is suggested that through the presence of another person who is willing to bear witness to her story, the victim can know it herself, and find peace (Herman, 1992). For example, relational psychodynamic therapy for CSA survivors is based on the assumption that the witnessing that did not occur in the initial traumatic experience can be established in treatment. This is believed to happen through the enactment of dissociative states in the therapeutic interaction (Davies & Frawley, 1994). In this way, the victim who could not herself witness what befell her, and who had no witnesses to it, can through therapy gain access to what was denied her (Seligman, 2004). Another form of this witnessing process can be established with the survivor and her family of origin using a family-based

approach to treatment (e.g., Sheinberg & Fraenkel, 2001). We believe that a similar process can be effected in couples therapy, in which traumatic patterns are reenacted in the relationship between the victim and her partner in the presence of the therapist.

PRACTICES OF WITNESSING IN COUPLES THERAPY

Couples therapy has been found to be suitable to confronting the relationship difficulties reported by CSA survivors, as well as to be powerfully healing (see MacIntosh & Johnson, 2008). However, few clinical perspectives have addressed couples therapy for CSA survivors, in particular. Among those that have are Behavioral Marital Therapy (BMT; see Compton & Follette, 2002); the psychoanalytic perspective (Buttenheim & Levendosky, 1994; Maltas, 1996), and Emotional Focused Therapy (EFT; see Johnson, 2002).

In our work with couples, we have come to acknowledge the opportunity it presents for the process of witnessing, which can occur on two levels: on one level, the couple's therapist witnesses the reenactments of the trauma that surface in the couple's relationship; and on the other level, the survivor's partner witnesses the trauma's effect on her personal life and on their relationship. As a consequence, the CSA survivor gains two "others" who can be a/the third (Aron, 2006; Benjamin, 2004), who will listen to and believe her, thereby helping her integrate the events of her life into a continuous, whole narrative. Moreover, this process encourages the development and strengthening of preferred narratives of resistance, survival, and strength. This is especially true in cases where both partners have suffered childhood abuse.

THE THERAPIST AS A WITNESS TO REENACTMENTS OF TRAUMATIC RELATIONSHIP PATTERNS

The first level of witnessing is the therapist's witnessing the existence and effect of traumatic relational patterns on the couple's romantic relationship. This may be achieved by objectifying the problem as an entity separate from either partner, which the partners can work together to resolve. To achieve this goal, we import the narrative practice of "externalization," which is based on the idea that problems are external to people and exist in relationship to them (White, 1984, 2007). This practice is not exclusive to narrative therapy, and can also be found in other approaches (e.g., "unified detachment" [Jacobson & Christensen, 1996], or "itify'ing" [Ippolito-morrill & Córdova, 2010]). In our couples practice, we use externalization to objectify traumatic relational patterns. We view the reenacted traumatic patterns described by the couple as a continuous process, in which problems "interfere" with their relationship. To be attuned to a couple's problematic relational patterns, the therapist may tentatively be helped being aware of the four reenactment positions identified by Davies and Frawley (1994). Moreover, the very presence of the therapist as someone who sees, hears, and identifies the trauma as intruding on the couple's life may help break the cycle of reenactment (Maltas, 1996).

During externalization, the therapist joins the couple's insider knowledge (Dickerson, 2011), and examines the reenacted elements of the traumatic relational pattern and this pattern's influences on the couple's relationship. Externalization of the traumatic relational pattern invites the couple to stop accusing each other of being the cause of the problem and start cooperating in confronting it. The couple identifies the traumatic pattern and "names" it; the name may change during the course of the therapy. For example, couples we have seen in therapy have given their problematic patterns names such as "yelling-calmness"; "suspiciousness-disengagement"; "trust-mistrust"; "demanding-absence"; "seductiveness-invisibility." In some cases, the partners may not share the same view of

the problem. In such cases, it is important that the therapist help each partner witness and compassionately understand the other's struggle (White, 2009).

Together with the couple, the therapist tries to understand the role of each partner in the infiltration of the reenacted pattern into the relationship; together, they address other factors (social, cultural, gender norms, etc.) in the couple's life (Anderson, 2012), which may also be encouraging the insertion of the reenactments. We see both partners as party to the "insertion" of these reenactments into the relationship, and strive to help them recognize and share responsibility for them—that is, to establish a "shared-couples' position" in confronting the influence of the trauma. In so doing, we are trying to escape the danger of seeing the survivor as the identified patient (IP) who draws her partner into the traumatic reenactments—an attitude that we believe does not promote the couple's dialog toward growth or healing, but rather may reinforce the survivor's conclusions about herself, which are, in any case, negative.

For example, Mickey[1] (45) and Karen (35) entered couples therapy after four and a half years of marriage. They have one child together (who is 3 months old), and are raising Karen's daughter (15) from a previous marriage. Karen fell victim to ongoing incest by her sadistic and abusive father from a very early age. Mickey grew up in a poverty-stricken neighborhood with a tough, taciturn, authoritative father. At 16, he began taking heroin, from which he had been able to wean himself only in the past half year.

The couple called their traumatic relationship pattern "suspiciousness-disengagement." Karen said she felt that, given Mickey's history of lying, she really distrusted him. Mickey said Karen had become "obsessive about him," spying on and interrogating him about every telephone call or friend he met. Her behavior made him feel suffocated and distant.

By externalizing this traumatic relational pattern (Freedman & Combs, 2008) as intruding on and damaging Karen and Mickey's relationship, I (R.N.) was able to ask about the pattern's effect on aspects of their life in externalized language, such as: "When 'suspiciousness-disengagement' intrudes on your relationship, how does it make you feel, think, act?" In response, the couple reported that "suspiciousness-disengagement" led again and again to conflict—including shouting, cursing, and volatile behavior—which usually culminated in Mickey's leaving the house. The tension at home had become insufferable, and caused immense despair and a desire to separate. Externalizing this problematic pattern helped Mickey and Karen feel less like each of them and each other were "problematic." Karen, in particular, noted that by this stage of the therapy she had realized that she was not solely responsible for the catastrophic state of their relationship—a realization that diminished her feelings of being damaged and guilty, which had been ascribed her since childhood by her environment.

In response to our quest to understand the reenacted elements of this pattern, Karen explained that Mickey had become less predictable since he had been "clean" of drugs. This made her feel that matters were getting out of hand—a situation which resembled her experience of growing up in a house with no boundaries, suffused with sex, violence, and lies, where she had no ability to control or even anticipate what would happen and learned to mistrust herself and everyone else in her world. When she pointed out something that had really happened (e.g., Mickey's lying) but was told that it had not really happened, she said she felt "crazy." This apparently triggered the elements of suppression and denial inherent in the protracted abuse she had survived.

Mickey said that for him, "suspiciousness-disengagement" reenacted the restrictions on his freedom that his father had imposed on him in childhood, and against which he had rebelled by taking drugs. He admitted that being hemmed in ("I can't breathe") made him feel vulnerable; to escape these feelings, he would become uncooperative, not share, and

[1]All names and identifying details have been changed to protect the clients' privacy.

eventually lie. Mickey's lies and disengagement stoked Karen's feelings of wariness and suspicion, which led her to spy on and scream at Mickey, who then felt suffocated—and so on in an endless cycle. Mapping the effects of "suspiciousness-disengagement" helped Karen and Mickey see this traumatic pattern clearly, and change their attitude toward it. At some sessions, Mickey heard Karen say that she realized her outbursts eroded her sense of self-worth. This was not how she wanted to be in her adult life: "I don't need to shout to be understood." She also described not experiencing Mickey as a "partner" to her or in raising their infant son. At other sessions, Karen heard Mickey say that his lies and uncooperativeness were related to his years of drug use. The farther he got from her and from being a father, the farther he got from the warm, honest, respectful family man he wanted to be.

Mapping the influences of "suspiciousness-disengagement" and establishing a counterposition created ever more openings for other, counter-traumatic and nonreenacting narratives: an evening when Karen spoke calmly and avoided an outburst, a family weekend when Mickey proved he could protect her, and did not disappoint her when she needed to feel he gave her security. Mickey took a larger role in caring for their infant son, getting up at night and letting Karen show him how to give the child a bath. In this way, he validated and expanded her identity as a mother who could care for and protect their child, and showed her that she could trust him. In subsequent sessions, we formulated and strengthened a preferred relational pattern for Mickey and Karen, one characterized by less wariness and suspicion and fewer outbursts from Karen, and by Mickey's feeling less restricted ("I can breathe free") and showing more cooperation. This cycle expanded to encompass other preferred aspects of their life as a couple (e.g., calmness, security, and mutual respect).

This example illustrates how the witnessing of the existence and effect of traumatic relational patterns by the therapist, accomplished through the practice of externalization, promotes a shared couple's inquiry into a traumatic relational pattern, its history, and each partner's role in maintaining it. This practice enables each member of the couple to recognize his or her contribution to the reenactment, thereby lessening the intensity of blame and guilt and encouraging shared responsibility and cooperation in overcoming the traumatic patterns. No less important, this practice helps the couple develop multiple, preferred relational patterns that reflect their preferred stories about their individual and shared identity.

THE PARTNER AS A WITNESS TO THE EFFECTS OF ABUSE, AND PREFERRED STORIES OF IDENTITY

The second level of witnessing can be reached by positioning the survivor's partner as an outsider-witness who listens to the therapeutic conversation and is asked to echo it in a unique and structured way (Kotze, Hulme, Geldenhuys, & Weingarten, 2012; Russell & Carey, 2003; White, 1997, 2004). For the CSA survivor, this therapeutic practice can serve as a "definitional ceremony" (Myerhoff, 1982), which enables her to reappear "in her own way" to herself and others and thereby be recognized for and expand her preferred identity (White, 2007). This practice also significantly stretches the boundaries of the original story, heretofore painted from the palette of trauma, in a way that contributes to a richer depiction of the victim's identity.

In this practice, the therapist interviews one of the partners while the other partner, who is present in the room, listens. It does not necessarily involve direct communication between partners. Through this practice, the therapist helps the witnessing partner position him- or herself as an outsider-witness to the first partner's story, which he or she tells the therapist (White, 2009). This clearly defined structure ensures that the listening partner holds the position of an "other," and helps create a safe space for sharing (MacIntosh & Johnson, 2008).

Listening without interrupting or interfering can be especially complex for CSA survivors and their partners, given the intensity of the reenactments and their reciprocal and mutually activated patterns. It is therefore advisable for the therapist to help the partner who is the outsider-witness reposition and distance himself from his usual response to his partner and, for the duration of the session, separate himself from the feeling that he is in a relationship with his partner (White, 2007). We have found that it is effective to invite the outsider-witness partner to adopt a different kind of listening, to listen from a "different place" (see below). Establishing the listener's position prior to the telling helps create a safe, sensitive, and attentive space for sharing the effects of the trauma.

For example, Dan (28) and Iris (26), a victim of incest by her brother in childhood, came for couples therapy when Iris began to have strong feelings that Dan did not understand and even blamed her for letting the abuse concern her so much. From the first session, it was clear that Dan and Iris had a good bond but that the trauma, some of which was not acknowledged or discussed between them, was having a huge effect on their relationship. The principal effect of the trauma on Iris, which happened on repeated occasions in her early childhood, was a retreat into dissociative states and overwhelming feelings of helplessness, which Dan interpreted as meaning that Iris was "unstable," "gave in to herself," and "should demand more of herself." This got them into "fights"; once these were externalized in therapy, Dan and Iris were able to understand the intrusion into their relationship of, in their words, a "victim-abuser" position. At one of our first sessions, I (R.N.) asked Iris if she would be willing to let me interview her about the implications of the abuse for her life. I then asked Dan to listen from a "different place" by asking him to think of someone who had listened to him in a way that had felt right and safe to him. I then asked him, "What sort of listening was that? What characterized it?" Dan recalled that a family member he had been friendly with when he was younger used to listen "just for me." He said that her listening had been characterized by her "not interrupting him, remembering what he had said, and relating to it." I asked Dan if he could try and listen to Iris in such a way, and he consented.

I asked Iris when she had begun to notice the effect on her life of what had happened to her in childhood. Iris said that as early as age 11 she had realized she preferred to be alone, and made fewer and fewer friends. When she did meet friends, she would not completely "be there," but rather would dissociate to a certain extent. "[I would] respond to a girlfriend but be in another world…over the years, the ability to dissociate myself became an art. I remember asking myself how I could disengage like that without people noticing. I understand today that that was my way of taking back control of what had happened to me…nevertheless, I know today that this leaves parts of me unknown to my partner. Being fully understood in my current relationships is crucial to me."

At this stage I again turned to Dan, and invited him to bear witness by asking: "What touched you, what stood out for you, what grabbed your attention or moved you when you listened to Iris? What ideas did it give you about what is important to her in life or in a relationship?" Dan said that he had been astonished to hear that dissociation had been a part of Iris's life from such a young age. He understood that while the dissociation had been protecting her, it also had really distanced her from people. Dan said that he had not been able to understand whether "that disengagement" was good or bad because on one hand he had heard Iris say that she wanted to be detached, but on the other he had also noted how important it was for her to be understood by others.

I then once again interviewed Iris, who was very moved to hear Dan describe, in a nonjudgmental way and without blame, the dilemma that was currently the focus of her individual, personal therapy. At a subsequent session, she said: "I felt really good at the end of that session, and that it had been the first time that anyone had asked me to focus on the effect of the traumatic events and not to describe them in infinite detail…the fact

you were asking while Dan just listened gave me a lot of confidence, and enabled me to touch on the points that were hardest for me to talk about with Dan."

We practiced this form of listening, with Dan and Iris alternating roles throughout the therapy. Gradually, they told me that the ability to listen to one another was being carried over into their daily life. This evidently made room for them to describe how they preferred to relate to one another: "To talk to each other calmly, intimately, like human beings, to get less insulted and hurt, to try to understand each other." They agreed that they both wanted more "understanding and devotion" in their relationship. Clearly, these values reflected something of what the trauma had tried to rob from Iris; they therefore constituted an alternative story to the story of the trauma. In their words, it was "a safe, shared place, more respectful and loving… [where we don't] blame each other, and we both take responsibility for whatever happens." Once this place had been created, they could discuss the problems with physical contact and sexuality that were interfering with their intimate relationship.

For Dan and Iris, as for other couples, our work concluded with a referral of the non-abused partner (Dan) to individual treatment. We believe that it is very important for the couples' therapist to propose sexual therapy, body-focused therapy, referring one partner to individual therapy or psychopharmacological treatment, as needed. This is especially true if during the couple's work it becomes apparent that the partner has an abuse history of his or her own.

DISCUSSION

The clinical practice described herein is based on the rationale that establishing a context for witnessing in couples therapy with CSA survivors can contribute to their healing process. Twofold witnessing can help break the cycle of traumatic reenactment, and help the survivor integrate the events of her life into a more coherent, continuous narrative. It may also improve the survivor's well-being, and especially her romantic partnerships, sexuality, interpersonal relationships, and parenthood. Moreover, it may contribute to her lifelong struggle to free herself from a unified identity defined by the trauma.

By establishing a context in which the victim can tell her story of trauma and its effects while gaining a platform for witnessing, the victim is helped not to be "sentenced" to (only) repeating traumatic relational patterns with her partner. Complementarily, neither is the partner "sentenced" to being experienced (only) as someone abusive and hurtful, as an attacker who negates the survivor/partner's existence. Rather, identifying and analyzing these traumatic patterns has the potential to bring to conscious awareness what were once distinct and dissociated self-states, and thereby to break the cycle of reenactment.

We perceive this suggested practice as enabling dialectic in the three-way meeting of therapist–client–partner. One part of the dialectic involves (the couple's) recognizing and taking responsibility for entering into reenactments. This was not possible at the time of the (unwitnessed) abuse, and therefore has dramatic importance. The other part of the dialectic involves (the therapist's) encouraging the couple to speak and listen to the multiple voices and stories that represent each other's subjectivity and "otherness" as they work to free themselves from traumatic relational patterns. Through this process, each is able to appear more wholly and fully, and together to tell the preferred stories of their life as a couple, replete with the multiple relational patterns they wish to live. These may include their values, aspirations, and intentions (e.g., an equal balance of power, openness, trust, respect), which may well contradict the characteristics of the original traumatic relationship. In the words of one couple: "The joint meetings enabled us to realize how important we were to each other.… It showed us that the new unit we were creating posed an opportunity for a corrective emotional experience, and embodied hope."

In light of the above, we wish to highlight the following issues to be considered when applying this practice.

First, establishing a context for witnessing does not necessarily imply holding on to the romantic relationship at all costs. In fact, the witnessing itself may give legitimacy to separation. Especially with this population, even acknowledging that separation is possible can loosen a couple from their traumatic relational pattern. In cases in which the externalization and identification of problematic relational patterns leads one or both partners to realize that separation might be preferable, we suggest accompanying them through the process of separation.

Second, in focusing on the effects of the trauma, we are not ignoring or silencing the story of the trauma itself. Rather, we wish to highlight the immense importance of creating a shared couples' context in which the story of the trauma can be told. In ongoing couples' therapy, after the outsider-witness position has been established (repositioning), the survivor is given the opportunity to tell the story of the abuse or add details that were not known to her partner (e.g., the abuser's identity, the duration of the abuse, the response or lack of response of others in the environment). The couples we have seen indicate that the ability to share the story of abuse and bare its complexities is extremely significant, and gives them a renewed opportunity to grow closer.

Third, it is possible that the therapist, like either of the partners, may find himself or herself in a reenactment position. The relational approach posits that powerful unconscious processes make this inevitable, and that the therapist must therefore be able to identify this when it happens. He may find himself "joining" the survivor's partner, with both of them in the position of the survivor's "abuser"; or "joining" the survivor, with both of them in the position of the partner's "helpless victim." It is also possible for the "romantic partnership" to be playing one of the roles in a position, while the therapist is enacted in the other role. By listening and being sensitive to these unconscious elements of the couple–therapist interaction, the therapist can help preclude repetition and reenactment. He can draw the couple's attention to their having entered into positions, analyze with them what led to this, take responsibility for his part in it, and formulate with them a way to extricate themselves from it. In this way, the therapist both models the alternative to automatic reenactment and helps the couple find their way to new ways of relating.

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