A QUALITATIVE ANALYSIS OF
CONJOINT THERAPY WITH ADULT SURVIVORS
OF CHILDHOOD SEXUAL ABUSE AND THEIR PARTNERS

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A QUALITATIVE ANALYSIS OF
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The purpose of this research was to understand the lived experience of childhood sexual abuse survivors and their partners who participated in conjoint therapy as a part of the treatment protocol for addressing issues related to the abuse. Theorists have been proposing models of therapy to address abuse recovery issues, but little evidence exists regarding the efficacy of conjoint therapy with this population and even less is understood about change mechanisms that are meaningful to the individuals who are being served.

A phenomenological research model was utilized to understand the experience of four couples who had participated in conjoint therapy as part of a larger therapeutic process. Conjoint therapy as a specific approach with this population is a relatively new phenomenon and the exploratory nature and rich information gathered through the use of qualitative methods made it the most appropriate research model.

Participants were interviewed using a two step approach whereby in-depth conjoint interviews were completed and then one to three weeks later individual interviews with each participant were conducted. Including two interview formats provided triangulation of information and allowed meaning creation to happen individually and in the context of conversation between the two partners.

Participants experienced transformation as the core essence of experience with conjoint therapy. Three transformative dimensions of experience and one facilitative
dimension of experience were extracted from the data. Participant narratives reflected significant transformation in the level of trust within the couple, the effectiveness of communication, and their ability to set boundaries both within their relationship and between their relationship and outside systems such as the survivors’ families of origin. The fourth dimension was the facilitative dimension of therapeutic fit. Participants consistently focused on their relationship with their therapist as the most meaningful change mechanism in therapy and identified a multitude of therapeutic factors which influenced the strength and direction of this fit.
DEDICATION

I would like to dedicate this dissertation to the love of my life, my grandmother Mrs. Janet Heberling. I have had the privilege of loving and being loved by many wonderful and amazing people, but no one has inspired me more than “Grams”. She has graced this world for the last 99 years secure in the love of the Lord and giving selflessly to everyone around her. Her serenity and peace are constant reminders to focus on our blessings and forget our trials. Her unconditional love and support have never wavered and I can only hope to make her proud. Thank you Grams. I love you.
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CHAPTER I

INTRODUCTION

Childhood sexual abuse (CSA) is a tragic phenomenon believed to directly affect a current estimate of four million women in the United States (Reid, Taylor, & Wampler, 1995). The impact on survivors can be devastating. Though the actual abuse may cease before the survivor enters adulthood, the consequences of the abuse often persist for the rest of their lives (Browne & Finkelhor, 1986). Although the majority do not exhibit severe psychological disorders, research indicates that most female survivors experience a much higher degree of depression, low self-esteem, substance abuse, suicide attempts, self-mutilation, eating disorders, and severe sexual dysfunction (Courtois, 1988; Gelinas, 1988; Turrell, 2000). These symptoms are often experienced in addition to characteristics of post-traumatic stress disorder (PTSD), which can be carried from childhood into adult functioning (Banyard & Williams, 1996). Symptoms of PTSD may include intrusive re-experiencing of the trauma, numbing and avoidance, hyperarousal symptoms, and difficulty regulating emotions (APA, 2000; Johnson, 2002).

The most prevalent symptoms reported by survivors, and often cited as the presenting problems in therapy, are sexual dysfunction and/or a lack of trust in the primary intimate relationship (Bacon & Lein, 1996; Pistorello & Follette, 1998). Child sexual abuse is not just a sexual violation. For a child victim, conceptions of trust, love, family relationships, guilt, shame, and pain intertwine into a mixture of overwhelming
confusion. This is especially true when the abuse is incestuous. Intrafamily sexual abuse usually occurs between children and family members with whom they share a strong attachment bond (Johnson, 2002). Survivors can lose the ability to differentiate between love and shame, nightmares and reality. Translated into their adult intimate relationships, sex and betrayal of trust are jumbled together such that disassociating the two and establishing healthy functioning with a committed partner is often difficult or even impossible.

Survivors who share their lives with a committed and loving partner do not usually suffer alone. Upon first hearing about their mate’s abuse, partners may experience a number of reactions including anger (at the perpetrator and/or the survivor), fear, inadequacy, intense loneliness, betrayal, or a strong sense of loss (Bacon & Lein, 1996; Davis, 1991; Maltz & Arian, 2001). Partners may feel disconnected from a survivor who is traversing his or her way down the long, hard road to recovery. It is not uncommon for them to feel isolated and helpless, much like survivors themselves during their initial victimization (Davis, 1991). Maltas and Shay (1995) defined the emotional turmoil experienced as “trauma contagion” and discussed how partners may “display behavior, feelings, and attitudes similar to those of the survivor” (p. 530). Unfortunately, trauma contagion, or the “vicarious victimization” (Johnson & Williams-Keeler, 1998) of partners, often occurs just at the time when survivors are struggling the most with their own recovery. As the couples traverse the recovery process both members can be desperate for comfort and intimate connection. However, their mutual suffering often precludes emotional availability and the security of their attachment bond can be threatened (Johnson, 2002). For partners, the frustration of feeling unable to express their
needs or have them addressed by the survivor is often accompanied by guilt for experiencing such needs in the first place. As the outwardly non-victimized member of the couple, they may view their rightful position as that of rescuer and experience shame for feeling frustrated sexually and emotionally needy and lonely (Davis, 1991).

Though researchers have begun to explore partners’ needs and examine the process of incorporating partners into the treatment protocol, this area of inquiry is mostly theoretical and relatively new. Individual and group therapies still dominate as the primary treatment modalities for addressing the process of CSA recovery. Individual therapy with CSA survivors often focuses on increasing survivors’ awareness of and expression of their own needs, as well as exploring intensely painful emotional experiences (Davis, 1991; Jehu, 1988). Survivors, partners, and therapists all agree that individual treatment is important to the CSA recovery process and is the best place for survivors to begin to explore the intense emotional and psychological pain that can be associated with childhood sexual abuse (Follette, 1991; Reid, 1993; Trute, Docking, & Hiebert-Murphy, 2001; Wilson & James, 1992). Over the course of treatment the therapeutic process and the changes taking place in survivors’ lives necessarily have a dramatic impact on their intimate relationships. In addition, when they are excluded from the therapeutic process, partners often feel threatened and fearful of being painted as a perpetrator or as abusive themselves (Follette & Pistorello, 1995). This fear is not ungrounded. Survivors can maintain a powerful drive to project onto someone the role of abuser who will absorb the rage and pain which cannot be directed toward the original perpetrator (Bass & Davis, 1988; Maltas, 1996). Often the role of abuser is assigned to
the survivor’s intimate partner. This can be overwhelmingly frightening to partners who do not know how to protect themselves and also support their hurting mate in the process.

Group therapy often follows individual survivor treatment, or is gradually introduced as an adjunct to on-going individual therapy (Drauker, 1992; Jehu, 1988; Maltz & Arian, 2001). Group experiences facilitate survivors’ awareness that they are not alone and can dramatically reduce the feelings of shame and stigmatization felt by many survivors (Bass & Davis, 1988; Zupancic & Kreidler, 1998). Group therapy can also help survivors continue to explore new constructions of self in relation to others as they share their abuse experiences in an atmosphere of openness and acceptance. Partners, however, may experience frustration and alienation as they perceive the survivors as able to openly share their stories, experiences, and emotions with other group members, but remain unwilling to confide with their own mate (Davis, 1991).

Until recently, the roles for partners of CSA survivors have been limited to acting as support persons in the survivors’ recovery and their involvement in therapy was generally limited to receiving psychoeducation perceived as providing them with the knowledge needed to facilitate the survivor’s recovery (Reid, 1993). Several recent qualitative studies, however, explored the value of including partners more directly in CSA treatment protocols. Bacon and Lein (1996) interviewed six men who were participating in therapy groups for partners of CSA survivors. These men reported feeling isolated, confused, and even fearful of the changes their wives were going through during individual treatment. Though none had participated in conjoint treatment with the survivors, all advocated for an “abuse-focused therapy that included them (the partners)” (p. 13). Another study included both survivors and their partners in the interview process.
with similar qualitative results (Reid, 1993). Both the survivors and their partners indicated that couples therapy as a component of treatment for CSA recovery would be beneficial, however, several concerns with the process of conducting joint therapy were raised, and again none of the couples had directly experienced conjoint therapy as part of the treatment for CSA issues. In the final qualitative study, Trute, Docking, and Hiebert-Murphy (2001) interviewed six couples and their therapists who were addressing both addictions and CSA recovery issues. Primary themes identified as therapeutic outcomes included “communication training, mutual problem solving, and anger management” (p. 108), however, the incorporation of both the abuse recovery issues and the addictions recovery may have confounded the results making it difficult to interpret the results and incorporate the information into treatment concepts for CSA recovery.

Though the research regarding the process of addressing the couples’ needs when one partner is a CSA survivor is limited, some authors have outlined the potential benefits of using a couples counseling approach (Bacon & Lein, 1996; Button & Dietz, 1995; Follette & Pistorello, 1995; Johnson, 2002). When partners are included in therapy, the couple can potentially discover untapped strengths and form a partnership in the mutual healing process (Button & Dietz, 1995). They can begin to share their personal stories and emotions with one another in the context of a safe holding environment and find the resources in each other to overcome their mutual pain and loss (Alexander, 2003; Johnson & Williams-Keeler, 1998). Therapists can facilitate communication between the partners focusing on direct expression of themselves and their needs in an accepting and validating way (Pistorello & Follette, 1998). A strong intimate relationship can provide
survivors with a place where it is safe to be vulnerable and a space in their lives where they know they are loved and are free to love in return.

Two models of conjoint therapy specific to addressing the needs of couples in which one partner is a CSA survivor are currently being advocated for in the marriage and family therapy literature. Johnson (2002) advocates for an attachment approach to working with couples and incorporates primarily conjoint treatment with interspersed individual sessions. She frames treatment as a “creation of new interpersonal connections” (p. 31) between the couple which can provide “an antidote to the traumatic experience and restore hope that life can be worth living” (p. 34). The combination of intrapsychic and interpersonal change she proposes allows relationships to be redefined as nurturing, protective, and accepting while individual partners establish a stronger and more positive sense of self worth (Johnson & Williams-Keeler, 1998).

Follette (1991) takes a social learning approach to conjoint treatment for CSA recovery. Focusing on communication, problem solving skills, and assumption of personal responsibility in problem creation and resolution, he works towards creating a partnership between the couple in which each learns ways of supporting the other and becoming aware of the role they play in relationship difficulties. In a recent qualitative study, the words of survivors and partners themselves supported this more behavioral approach to CSA couples therapy (Trute, Docking, & Hiebert-Murphy, 2001). The authors cautioned, however, that the outcome goal of a more behavioral approach was still clear and direct communication of affect within the couple dyad.

Though the methodological foundations differ, it is clear that the treatment paradigm in the area of childhood sexual abuse has expanded over the last decade to
include a much stronger presence of CSA survivors’ partners in the therapeutic process. Hughes (1994) indicated that couples counseling was a “critical component of the healing strategy” (p. 119) and Maltas (1996) stated that “couples therapy should be considered a necessary component of treatment when a survivor is in a serious relationship” (p. 355). Unfortunately, though authors are stating the potential benefits of including partners in treatment and models have been created, an exhaustive search for empirical evidence supporting the efficacy or value of including a couples component into the treatment process for CSA revealed little evidence of support.

Proposing or advocating for the inclusion of couples counseling as a treatment component for addressing CSA recovery issues without evidentiary support for its safety and efficacy is risky at best. There are several potential issues, which may play important roles in a therapist’s decision to use conjoint therapy with these couples. One must first consider that revictimization is a common experience for CSA survivors (Pistorello & Follette, 1998; Russell 1986). Survivors of childhood sexual abuse are twice as likely to be raped as adults and have a higher likelihood of being physically abused or raped by their partners (Pistorello & Follette, 1998). Of battered women seen at domestic violence shelters approximately 65% report a CSA history (Follette, Polusny, Bechtle, & Naugle, 1996). Serafin (1996) has suggested that as children, survivors internalize a definition of self identifying them as deserving of punishment or abuse and they seek out adult relationships, which validate this internalization. Others have suggested that CSA survivors are unable to differentiate between dangerous partners and those that are safe (Compton & Follette, 2002). Although an assessment for potential domestic violence is always a concern when engaging in conjoint therapy, a very thorough exploration of
potentially abusive interactions may be even more important when working with this vulnerable population.

Emotional revictimization may be a concern even when unintentionally enacted by the partner. It is proposed that benevolent blame, or partners overtly supporting the recovery of the survivor while covertly attributing all of the relational difficulties to the trauma history, may be a concern when conducting conjoint therapy with survivors and their partners (Pistorello & Follette, 1998). When experienced as part of therapy, a pattern of benevolent blame could reinforce the stigmatization of CSA leaving survivors feeling more ashamed and hopeless than before the onset of therapy (Serafin, 1996).

Secondary victimization of partners and the intensity of emotions assaulting survivors as they deal with their recovery may also lead to both partners being overwhelmed by the conjoint process. Survivors may initially welcome the inclusion of their partners into the healing process, but may eventually find their presence to be too intrusive or distracting (Reid, 1993). Partners on the other hand may experience guilt, depression, or demoralization as they are unable to endure the pain of their partners’ experiences or are unable to respond in a manner that they perceive as helpful or effective (Johnson & Williams-Keeler, 1998). During times of high emotional intensity in the partnership, individual treatment sessions for one or both partners may need to be interspersed with the conjoint treatment in order to address the immediate emotional or psychological needs of the individuals (Maltas & Shay, 1995). Reid et al. (1995) concisely framed the challenge of balancing the pros and cons of conjoint therapy. They indicated that “unstructured partner involvement would pose a threat to the victim’s recovery, however, the total absence of partner involvement and support would also
impede therapeutic progress” (p. 40). With these ideas in mind, research is called for to increase our understanding of this newest addition to childhood sexual abuse treatment paradigm.

Statement of the Problem

One major problem with the current literature base is that researchers are advocating for the inclusion of conjoint therapy in the treatment paradigm for CSA recovery with little empirical support for its effectiveness, with scant attention being given to the potential dangers inherent in this approach, and extremely limited input from the participants in this treatment (Johnson, 2002, Bacon & Lein, 1996, Trute et al., 2001). In addition, little is known about how CSA survivors and their partners actually experience conjoint therapy as a treatment paradigm. We are at a time in the profession where conjoint therapy has been incorporated into clinical treatment of CSA on a limited basis, but with enough intensity that research on the process is now possible. The time has come to ask the experts themselves to help us as a profession to clarify our conceptualization of this treatment intervention and provide the data we need to create efficient and effective treatment models.

Purpose and Significance of the Study

The purpose of this study is to gain a better understanding of conjoint therapy as a treatment component in addressing the needs of childhood sexual abuse survivors and their partners. As outlined above, little is known about the impact conjoint therapy has on the recovery process for survivors and on the experience of partners as they work through their own healing journey. The researcher will attempt to generate descriptive, detailed and contextualized answers to the following questions (a) how effective do CSA
survivors and their partners perceive conjoint therapy to be as a treatment approach in addressing their individual and relational needs (b) what is the perceived impact of conjoint therapy on the relationship of CSA survivors and their partners (c) what are the risks and benefits of conjoint therapy as perceived by survivors and their partners when utilized in the treatment of CSA recovery (d) what process variables do CSA survivors and their partners identify as most or least effective mechanisms of change (e) what is the perceived impact of individual and/or group therapy on the relationship of CSA survivors and their partners (if applicable).

The focus of this research is both on the process and outcome of conjoint therapy as a treatment modality for addressing CSA issues. The information garnered from this study may provide researchers and practitioners alike with confidence that incorporating couples counseling into an overall treatment protocol for CSA recovery can be more beneficial than traditional individual and group treatments alone or it may lead to a more cautionary approach to prescribing conjoint treatment. Additionally, the detailed and rich qualitative data gathered from participants will help theoreticians construct treatment frameworks highlighting mechanisms of change specifically identified by participants as important. This information regarding process variables is invaluable to the construction of high quality and empirically supported treatment interventions.

The mental health profession as a whole is being challenged by the public, critics, and particularly third party payers to provide outcome studies validating the usefulness of certain treatment approaches (Sprenkle, 2002). Given the potentially devastating impact of childhood sexual abuse on both survivors and their partners, it becomes essential to understand the experience of couples therapy from participants’ perspectives. It is vital
for us as practitioners and researchers to understand how CSA survivors feel about themselves, their partners, and the therapeutic process as they struggle to overcome the deleterious impact of CSA. Practitioners need to understand what clients experience when they are working together in session and how the conjoint treatment experience impacts their relationship and individual healing process. Finally, as treatment paradigms continue to be refined information regarding the import of process variables becomes vital to the construction of effective models of therapy.

Definitions

1. *Childhood Sexual Abuse Survivors:* Individuals who have experienced coerced or forced sexual activity imposed on them as a child, or sexual activity imposed on them as a child by a much older individual regardless of the presence of any clear force or coercion (Browne & Finkelhor, 1986; Millwood, 2003). For the purposes of this study, the sexual abuse must have occurred between the child and a perpetrator who was at least five years older than the survivor.

2. *Partners of Childhood Sexual Abuse Survivors:* Any individual who has maintained a monogamous and committed (self-defined) intimate relationship with a CSA survivor for the duration of at least two years.

3. *Conjoint Therapy:* Treatment of two or more persons in session together (Nichols & Schwartz, 1998). Conjoint treatment is differentiated from survivors’ individual treatment by the distinction of having been conducted by a therapist other than the survivors’ primary individual therapist or by having taken place at a different time than individual counseling. Survivors and their
partners who are to be included in this study must have experienced conjoint therapy within the last five years, during which issues related to the survivors’ childhood sexual abuse history must have been identified as a primary presenting problem. The five-year limit was established based on the acknowledgment of data being retrospective, and therefore, more accessible if experienced in the recent past.

Delimitations

1. **Survivors:** Survivors will be limited to those individuals who have experienced childhood sexual abuse, but who have not also experienced physical abuse in order to limit the confounding of the two separate types of abuse.

2. **Partners:** Partners will be limited in this study to individuals who are not also self-identified survivors of childhood sexual abuse. Those couples in which both partners are survivors will likely experience interactions, joint healing processes and therapeutic modalities differently from couples in which one partner has had no experience with childhood sexual abuse.

3. **Couples:** Couples will not be included where either partner has a current substance abuse or addiction problem or has been in treatment for a substance addiction issue within the last six months.

Author Statement

As an advanced doctoral student working towards a degree in marriage and family counseling I am increasingly aware of the impact larger systems have on the individual recovery of people struggling with traumatic personal experiences. I initially
became interested in the area of childhood sexual abuse recovery over a decade ago while working in the college setting. Following workshops I presented addressing issues of sexuality and violence against women, I was overwhelmed by the number of young women who approached me and shared their stories of shame, pain and struggles to overcome the devastating effects of having been sexually abused during their youth. These women fought every day to re-establish control over their lives and generate feelings of self-worth and positive self-images.

Once I began my clinical work with families I learned that it wasn’t just the survivors who were devastated by their abuse. CSA survivors struggled to connect with partners in a deep and trusting way. Partners who wanted to share loving and supportive relationships with individuals cut deeply by sexual abuse often became victims themselves. Relationships and intimacy were torn apart by desperate loneliness, confusion, and pain as both members of the couple struggled to come to terms with the impact of the abuse on their lives. I have observed the long-term effects of childhood sexual abuse on survivors, their partners, and their extended families and am invested in gaining a better awareness and understanding of conceptualizations, treatments, and interventions that can provide some relief.

Chapter Summary

In this chapter the researcher introduced readers to the long term repercussions childhood sexual abuse can have on survivors and vicariously on their intimate partners. The traditional treatment modalities of individual and group therapy were briefly discussed incorporating both the benefits and potential difficulties presented in these approaches. The primary focus, however, is on conjoint therapy. Authors have suggested
that couples therapy should be included in the treatment process for CSA survivors who are involved in intimate relationships and some have even indicated that it must be included if recovery is to happen. Two theoretical conjoint treatment paradigms based on emotional focused therapy and social learning approaches emphasize that intimate relationships can become healing entities for both the survivors and the partners. Unfortunately, there is little empirical support for or understanding of how couples experience these conjoint treatment processes and several potential hazards including benevolent blame, possible revictimization, and the participants becoming overwhelmed are suggested as reasons as to why further research is needed to fully comprehend the scope of conjoint therapy and its applicability to CSA recovery issues.
The frames constructed by researchers and other professionals are usually informed by the professional literature describing the phenomenon of interest. The vast majority of the literature on childhood sexual abuse either outlines the effects of the abuse on survivors (Alexander, Neimeyer, Follette, Moore, & Harter, 1989; Allers, Benjack, & Allers, 1992; Banyard & Williams, 1996; Brown & Finkelhor, 1986; Canavan, Higgs, & Meyer, 1992; Elam & Kleist, 1999; Fergusson & Mullen, 1999; Turrell & Armsworth, 2000) or is directed towards therapists treating CSA survivors in the traditional modalities of individual and group therapy (Courtois, 1988; Draucker, 1992; Jehu, 1988; Kreidler, 2005; Phelps, Friedlander, & Enns, 1997). It has only been in the last decade that researchers have begun exploring the area of conjoint therapy as a potential treatment modality for childhood sexual abuse recovery (Button & Dietz, 1995; Follette, 1991; Follette & Pistorello, 1995; Johnson, 2002; Maltas, 1996; Millwood, 2003; Reid, 1993; Reid et al., 1995; Reid, Wampler, & Taylor, 1996; Serafin, 1996; Smolover, 1997). As the primary focus of this dissertation relates to understanding the experience of conjoint therapy as an approach to treatment of childhood sexual abuse recovery, the following literature review and critiques will focus on those studies and theories most directly related to couples therapy with this population. Information regarding individual and group therapy are included, however, as conjoint therapy must
be understood in the context of the overarching treatment protocol for childhood sexual abuse recovery.

A review of the literature investigating the phenomenon of childhood sexual abuse reveals multiple themes. In order to facilitate ease of exploration, each of these themes will be explored below and primary research studies will be discussed and critiqued. A general critique of the available literature will be provided and the connection between the existing literature and the current research project will be reviewed. Several critiques will also be included of articles the researcher believes to be foundational to the current research project. The themes to be explored include: (a) benefits to be gained by survivors from individual therapy (b) benefits to be gained by survivors from group therapy (c) impact of individual therapy on relationship and partner (d) impact of group therapy on relationship and partner (e) the impact of childhood sexual abuse on intimate relationships (f) potential benefits of conjoint therapy (g) potential risks involved in conjoint therapy and (h) partner’s and survivor’s “expert” opinions of the process of conjoint therapy.

Benefits of Individual Therapy

Individual and group therapy have been the traditional treatment of choice for addressing the effects of childhood sexual abuse on the adult functioning of survivors (Bacon & Lein, 1996; Bass & Davis, 1988; Harvey & Harney, 1995; Jehu, 1988; Phelps et al., 1997). Even when survivors and partners are advocating for the inclusion of conjoint treatment into the protocol for CSA recovery, they continue to support the fundamental need for survivors to have access to individual treatment (Bacon & Lein, 1996; Reid, 1993; Reid et al., 1995). Most often professionals and participants alike
indicate that individual therapy should be conducted at the outset of the treatment protocol with group and conjoint modalities being added when survivors have had an opportunity to address some of their individual needs (Johnson, 1989; Reid, 1993; Wilson & James, 1992). For many survivors, individual therapy marks the first time they have ever shared their abuse experiences with another person and the availability of a trusted and non-judgmental person is critical to their long term recovery (Jehu, 1988; Phelps, et al., 1997).

Rebuilding Trust

One of the most oft cited effects of childhood sexual abuse is the loss of trust (Allers, et al., 1992; Bacon & Lein, 1996; Browne & Finkelhor, 1996; Courtois, 1988; Johnson, 1989; Johnson, 2002; Phelps, et al., 1997). Perpetrators of sexual abuse upon children steal from them their ability to believe in the love of others and their own worthiness to receive unconditional love. Survivors often learn that it is not safe to trust anyone, even themselves and their own reality (Johnson, 2002). Creating a bond with an individual therapist can be a survivor’s first step in the recovery process (Phelps, et al., 1997). Routinely survivors share that it is difficult for them to trust anyone, even therapists, not to immediately judge them or be repulsed by their revelation of abuse (Canavan et al., 1992). Survivors usually do not seek counseling specifically to address sexual abuse issues, and it can take an extended period of time before the survivor feels secure enough to share his/her experiences (Draucker, 1992).

Phelps, et al. (1997) [see critique] outline at length variables, which contribute to the establishment of a secure therapeutic alliance with survivors. These include the survivors feeling as though they are in control of the pace and focus of the therapy, the
therapist being perceived as physically and emotionally available, the therapist being viewed as non-judgmental and competent and the survivor receiving messages of validation and support. They based their outline on a solid qualitative research study during which they conducted semistructured interviews of 11 women who identified themselves as CSA survivors.

The disclosure of the abuse and the therapist’s reaction are key to establishing a strong therapeutic relationship with CSA survivors. Maltz and Arian (2001) emphasize that therapists should do the opposite of what happened in the abuse. They should provide unconditional support and acceptance and encourage survivors to drive the pace of the session. Individual therapy allows the survivor’s agenda to be the only agenda. The survivor is granted complete control, unlike couples counseling in which the needs of both partners need to be considered.

**Critique: Phelps, Friedlander, and Enns.**

The purpose of Phelps, Friedlander, and Enns’s research (1997) was to assess the fit of therapeutic relationship variables identified in the literature as important to the therapeutic alliance with participants’ own experiences and to better understand ideographically therapist traits which facilitate survivors’ exploration of memories and emotions related to sexual abuse.

The research design of this study incorporated a self-referred sample with the rationale being that researchers did not want to bias the sample by working through therapists. This rationale was sound and supports this sampling approach. A pilot study was conducted at the outset of this research, with changes based on the results of the pilot study being integrated into the design in an iterative fashion. Changes primarily consisted
of rewording questions from the interview protocol into a more open ended format, generating follow-up questions and adding several questions regarding demographic variables. These changes were supported through literature citations and demonstrated sound qualitative research practices.

Throughout the data analysis phase multiple researchers were involved in a layered process of analysis, creating a strong argument for the reliability of the information being presented. Specifically, coders were utilized who were unaware of the literature base and of the intended purposes of the study. The interrater reliability of these coders, as well as their similarity to the themes identified by the primary researchers strongly established reliability. The only caution is that authors merely indicated that raters coded the themes “similarly”, rather than providing more specific delineation of sameness. In addition, at the conclusion of the data analysis phase, participant involvement (member checking) was incorporated into the design as a method of validity establishment. Participants were asked to review the results (in the form of thematic categories) and evaluate the fit of these themes onto their own experiences. No additional codes were identified and the majority of the established codes were accepted or validated with a caveat. The additional step in the research process demonstrates the integrity of the interpretations and increases the believability of conclusions drawn.

Variables identified as important to the creation of a strong therapeutic alliance by participants included: the survivors feeling as though they are in control of the pace and focus of the therapy, the therapist being perceived as physically and emotionally available, the therapist being viewed as non-judgmental and competent and the survivor receiving messages of validation and support. Phelps et al. (1997), through the strategic
use of participant words, accomplished the task of generating credible patterns of experiences that personified the experiences of multiple CSA survivors. Readers can clearly see how themes emerged and how they were understood similarly by participants and researchers alike.

Triangulation was utilized both in obtaining the perspectives of different coders as well as utilizing both a quantitative question with a Likert scale response option (How helpful do you think your therapy was in general), qualitative interviews and subsequent member checks. The detailed design description allows future researchers to duplicate and expand (several suggestions for expansion are provided) the study. The only challenge may be in recreating the interview protocol as authors only provided a small sample of questions utilized.

Only a few concerns exist with regards to this study. Although they indicate that this is a “grounded theory” approach, it is more illustrative of content analysis as no overriding theory is actually generated. Additionally, the title indicates that readers could expect a significant focus on the recovery of memories of childhood sexual abuse and the potential for achieving “false” memory situations. However, the focus of the study and results presented, although having a general relationship to the recovery of memories, are more focused on factors that create a positive therapeutic alliance. The fact that this alliance supports the emergence of memories appears secondary.

The utility of this study to this current research lies in its applicability to the research supporting the positive attributes of individual therapy in CSA recovery. It also provides some guiding concepts for considering the impact of the therapeutic alliance in both individual and couples therapy. If the therapeutic alliance is more powerful than
techniques, how is this alliance different and influential in couples therapy where therapists are challenged to have a strong relationship to two individuals and the interrelationship? In addition, the strong design components generated several ideas regarding ways in which reliability of interpretations can be reinforced and ways in which participant checks can be incorporated into my own design.

*Rebuilding a Sense of Self*

Another benefit of survivors initiating therapy in an individual modality is that they are free to explore, without fear of judgment all the disparate pieces of self (Ferrara, 2002; Harvey & Harney, 1995). Survivors in childhood and into adulthood compartmentalize various aspects of themselves (e.g. the hurt or bad child, the perfectionist, the loving mother) and function as social chameleons only showing the world the image it is safe to portray. Over years survivors can become completely alienated from certain components of self and negate the feelings and experiences characterized by unacceptability (Courtois, 1988). Individual therapy can represent the first time survivors have had the opportunity to explore the forgotten pieces of self without the level of fear or shame that might be experienced when sharing so much of oneself with an intimate partner.

Maintaining a strong connection with a therapist who validates their experiences and emotions in a supportive and consistent manner allows survivors to integrate the compartmentalized parts of self. They can begin to change the working model of self from which they understand who they are (Johnson, 1989). Survivors’ model of self is often based on messages learned in the context of family dysfunction and abusive relationships. According to Sgroi and Bunk (1988), messages internalized by survivors
often generate a self-definition of unworthiness, failure, inadequacy and shamefulness. In the context of a supportive therapeutic environment, survivors can recreate a sense of themselves as “capable, adequate, or worthy of another person’s attention” (Sgroi & Bunk, 1988, p. 184). They can review their construction of self as flawed and unworthy and understand this to be a construction imposed on them by an abusive and destructive other. With their therapist’s support they can begin to construct a new self-identity based on their adult selves and in a context of acceptance and stability (Jehu, 1988).

**Boundary Construction**

Individual therapy facilitates survivors’ construction of healthy personal and emotional boundaries. Being physically, emotionally, psychologically and sexually assaulted as a child leaves many survivors with little or no sense of what rights they have to assert personal boundaries (Elliott & Briere, 1995). Many are not even sure what a healthy boundary feels like, let alone feel powerful enough to enforce these limitations with others. Abused children may feel as though they have little control over their physical, emotional, and psychological boundaries (Ferrara, 2002). As adults, survivors often struggle to assert their own needs and set limitations on the demands of others. Depression, anxiety, sexual promiscuity, sexual aversion, and a dramatically increased likelihood of revictimization in adulthood all generate from survivors’ feeling undeserving of respect and authority over their lives (Browne & Finkelhor, 1986; Serafin, 1996).

Individual therapy allows survivors to redefine parameters around the therapeutic relationship. Effective counselors empower survivors to share as little or as much of their abuse experience as they feel comfortable (Draucker, 1992). Survivors will often “test”
therapists by trying to shock them with the horrors of their abuse or expressing their anger and dislike of certain therapeutic components or even personal components of the therapist (Mayar, 1995). Being able to express their anger and reveal what they perceive to be the very images that will drive others away without alienating or driving away the therapist can be a powerful experience for individuals who have never felt safe enough to make themselves vulnerable (Maltz & Arian, 2001). Taking that type of risk in couples counseling may be too frightening or intimidating for survivors who may be afraid of possible rejection by their partners (Reid, 1993). Experiencing the acceptance of their therapist can increase the survivors’ belief in themselves and pave the way for them to express themselves more fully in their intimate relationships and begin to establish clearer boundaries with others in their lives.

Benefits of Group Therapy

Intensive individual therapy is generally the first step taken by CSA survivors attempting to redefine their lives in more healthy and growth producing ways. The legacy of childhood sexual abuse, however, usually includes a strong component of shame, guilt, and internalized pressure to keep the abuse a secret (Kreidler, 2005). For many survivors, overcoming the stigma of the abuse means learning to share their secret in an atmosphere of warmth and acceptance. Peer group counseling “allows for the breaking of the secrecy, isolation, and stigma resulting from the abuse and fosters exploration and resolution of the trauma and its aftermath” (Courtois, 1988, p. 244). In fact, some strongly advocate for limiting individual therapy to a short period of time (6-12 sessions) and urge survivors to continue their recovery process in the group context (Sgroi & Bunk, 1988). Group therapy has been found to be effective with survivors with varying degrees of mental
health issues (Kreidler, 2005) and provides several advantages including fostering survivors’ ever expanding self-concept, reducing the experience of isolation and stigma, and creating a context in which survivors can explore and experiment with interpersonal processes (Zupancic & Kreidler, 1998).

Expanded Definition of Self

Participation in CSA survivor peer groups enables individuals to continue to recreate themselves in a more positive, authentic, and empowered way (Ferrara, 2002). As presented in the previous section, survivors can struggle to redefine themselves in a positive and self-accepting manner when early childhood experiences reinforced messages of shame, unworthiness, powerlessness, and self-hatred. The ability of individual therapists to help survivors overcome these internalized messages is necessarily limited by the dyadic context, the inherent power differential, the therapist’s position of “helper”, and the survivor’s potential to negate and withdraw from positive messages delivered within such an intimate relationship (Sgroi & Bunk, 1988). The therapeutic milieu is significantly different when shared with peers equally powerful and who through shared experience are uniquely positioned to challenge, support, and empathize with one another.

Van de Kolk (as cited in Courtois, 1988, p. 245) clearly stated the potential groups have for enabling survivors to redefine themselves

In a group patients can start reexperiencing themselves as being useful to other people. Ventilation and sharing of feelings and experiences in groups of people who have gone through similar experiences promotes the experience of being both victim and helper. Even a trusting and secure relationship with a therapist who serves as a parental substitute does not necessarily enable the patient to assess his or her relationship with others accurately.
Interacting with others who have walked a mile in one’s shoes, so to speak, empowers survivors to explore those pieces of themselves that they have feared could never be understood. Distorted beliefs about oneself, one’s family, and the world at large can be shared within the context of the group, challenged, and gradually replaced by new cognitions self-selected and absorbed from positive interpersonal interactions.

*Reduction of Isolation and Stigma*

The interpersonal interactions within peer groups also function to reduce the shame associated with childhood sexual abuse by removing the secrecy (Alexander et al., 1989). Survivors are often isolated and terrified to share their “secret shame” and face the stigma and rejection from others (Bass & Davis, 1988). Group experiences empower survivors with the knowledge that they are not alone in their struggle. Often hearing the stories of others helps survivors to accept the reality of their experiences. This can be novel given the propensity for abuse perpetrators to directly deny their victims even the reality of their own perceptions.

In addition to recognizing that they are not alone, survivors in peer groups are able to interact with other members who have survived similar encounters and in whom they can see strength and resilience (Alexander et al., 1989; Ferrara, 2002; Jehu, 1988; Zupancic & Kreidler, 1998). In accepting and validating the strength in others they vicariously gain a more positive perception and acceptance of themselves (Reid, 1993). They can recognize in themselves aspects of the other survivors, which are valuable and worthy of love and acceptance. Recognition that one is not alone, that others experience shame, guilt, depression, fear, rage, and isolation, can dramatically reduce the power of silence.
Practicing Communication and Social Interactions

As survivors become more sure of themselves and recognize the commonalities they share with other group members they can move into a place of integrating their new perceptions of self into interactions with others. Group members can practice being open and direct with self-expression of needs and honestly sharing themselves while exploring the boundaries of social interaction (Sgroi & Bunk, 1988). Children learn appropriate boundaries, rules for communication, and problem solving within the familial context. Families wherein abuse occurred may have reinforced skewed pictures of these patterns within the survivor. Groups provide a supportive network within which individuals can explore new interactions and even role play familial conversations in a safe environment (Courtois, 1988).

These new lessons in social interaction can provide survivors with the skills of communication and connection that are “the building blocks for successful intimate relationships, such as identifying and communicating emotions, wishes, and requests, giving and receiving help, affection and caring, engaging in limit setting for self and others, and defining and maintaining personal boundaries” (Sgroi, 1988, p. 131). Hence, participation in group therapy can provide survivors with a learning opportunity and practice arena within which to gain the skills and confidence necessary to engage in healthy and satisfying relationships with friends, family, and intimate partners. In addition, the groups can provide an on-going support network to which survivors can return and reinforce newly developed conceptions of self which will almost certainly be challenged by the survivors’ interactions with the nontherapeutic environment (Courtois, 1988).
Impact of Individual Therapy on Relationship and Partner

While the benefits of individual and group therapy are substantiated by almost all survivors and therapists alike, for survivors who are married or involved in committed intimate relationships, individual, and group therapies can have deleterious effects on their relationships (Follette, 1991; Reid, 1993). In fact, Follette, Alexander, and Follette (1991) discovered that married women were less likely to benefit from group therapy than those participants that were not married and survivors themselves indicated that while they found individual therapy to be personally beneficial, it could also be destructive to their marriages (Pistorello & Follette, 1998). The very aspects of individual and group therapies that make them effective for survivor recovery are the ones that can damage intimate relationships.

As survivors create a secure base with their therapist, they may find themselves less reliant on their partner for validation and support. In addition, the rigid boundaries therapists set around confidentiality may further exclude partners from the therapeutic process (Bacon & Lein, 1996; Smolover, 1997). A goal of individual therapy is to assist survivors in redefining their sense of self-worth and creating a new construction of self based on increased strength, value, and resiliency (Jehu, 1988). Partners who are not a part of this process may be confused and angered by the changes in survivors and unable to reconcile their changing place in the relationship (Jehu, 1988; Reid, 1993). Finally, as survivors assert themselves more and create new boundaries around their own needs and desires, partners may feel distressed by the new demands and limitations generated by the survivor (Bacon & Lein, 1996; Barcus, 1997).
Partner Alienation

Survivors report that one of the most distressing components of individual therapy is being unable to share their experiences with their significant others (Reid et al., 1995). Therapists may encourage survivors to focus on themselves and their own healing by setting limits on how much the partners are informed about the survivor’s therapy. It is not uncommon for therapists to advise survivors to completely refrain from sharing any of their therapeutic experiences as a way of reinforcing the security and healing potential within the therapeutic context (Maltz & Arian, 2001). Survivors and partners alike have expressed negative reactions to such directives and have cited those directives as reasons survivors have terminated therapy while partners have either overtly opposed the survivor’s participation in therapy or more covertly undermined the therapeutic process (Reid et al., 1995).

Partners who are completely restrained from all participation in the survivor’s recovery feel alienated by the experience and rejected both by the survivor and the therapist (Bacon & Lein, 1996; Reid et al., 1996). They often resent the secrecy and the distance created in their intimate relationship (Reid, 1993). When they are not part of the process and are ignorant of the amount of time healing takes, they may also resent the time, money and energy the survivor is putting into his/her therapy (Smolover, 1997). On another level, partners are observing their loved one struggling and are usually saddened and frustrated by their inability to help or knowledge of what to do (Smolover, 1997).

Partner/Perpetrator Projection

As survivors begin to explore their abuse history they emotionally relive the emotional upheaval and distress experienced during the abuse (Bass & Davis, 1988).
They may begin to experience intense flashbacks (Courtois, 1988) and even when fully present in the immediate moment their emotional reactions to those around them may be skewed by the intense emotions being generated and explored in therapy. The past and the present can begin to merge and many survivors find themselves intertwining the dual images of their perpetrator and their partner (Hughes, 1994; Reid et al., 1996). Sexual abuse often combines physical intimacy with feelings of pain, shame, guilt, and fear. Therapeutic exploration of the abuse stirs up these emotions for survivors and they can project the residual anger from the abuse onto their current partner (Bacon & Lein, 1996). This is generally most intense immediately following a therapy session, or can result from a certain behavior manifested in the partner that reminds the survivor of the abuser and triggers an emotional reaction (Bass & Davis, 1988; Button & Dietz, 1995; Johnson, 2002).

This unpredictability of the survivor’s moods and reactions can be extremely challenging for partners who are intimately involved in the survivor’s life. Partners indicated that they “could never predict what would ignite anger or when the relationship might deteriorate” (Bacon & Lein, 1996, p. 10) and they “remained cautious and guarded even in regard to “normal” behavior” due to the uncertainty of how long it would last. Partners who are facing the roller coaster ride involved in the survivor’s recovery may not find themselves prepared to endure the emotional toll it takes to remain with the survivor. In many cases relationships crumble under the strain and both members are left to pick up the pieces on their own (Bass & Davis, 1988; Jehu, 1988).

Bacon and Lein (1996) [see critique] presented these and other themes in a qualitative study in which they interviewed six men who were spouses to female
survivors of CSA involved in individual and/or group treatment programs. As part of this study they asked the men to reflect on their experiences throughout their wife’s treatment and to share what the healing journey had been like for them. The men expressed eloquently the anger and alienation that resulted from their perceived rejection by their wives and her therapist. They mourned the loss of “the way it was” in their relationship before the abuse was revealed and they shared the frustration of being unable to experience sexual intimacy with their wives without fear and trepidation. At the same time, expressions such as “I love her. We were friends before marriage and we are still good friends” (p. 11) demonstrate the care these men have for their partners and their desire to play an integral part in the healing process.

_Critique: Bacon and Lein._

Bacon and Lein (1996) completed a qualitative inquiry exploring husbands’ reactions to, concerns about, and stories related to the on-going process of their wives’ recovery from childhood sexual abuse. Both interviews and focus groups were utilized to garner an in-depth understanding of the men’s experiences and capitalize on the synergy produced in the group therapy setting. Results supported the need for inclusion of men in their partner’s treatment and reiterated the need for further research into the partner’s experience during CSA treatment protocols.

The authors provide no information regarding their personal interest or investment in this research area and share little personal information beyond their educational degree and position of employment. This scant information limits our ability to assess bias with regards to the research presented. Ample evidence is provided supporting the idea that individual and group approaches to the treatment for CSA survivors can be damaging to
the couple’s relationship and alienating for the survivor’s partner. Authors fail to explore the available literature, which suggests that conjoint therapy needs to be cautiously managed and in certain situations delayed or avoided pending the survivor’s initial exploration of her abuse experience. This oversight may be indicative of bias in the author’s approach to research.

Given the qualitative nature of this study, additional information regarding research participants should have been provided. Authors provide only age range, duration and duration of dealing with CSA recovery, which tells readers little about the demographics of the group. Information regarding time spent in the group treatment process, additional diagnoses, ethnicity, and the men’s motivation for initially participating in the group process would have provided valuable contextual information. Authors indicate that they utilized “purposive sampling” (p. 5), however, without additional information it is difficult to evaluate the extent to which this sample is a representative of typical partners of CSA survivors. Men who are already attending support groups for partners of CSA survivors are likely more committed to, supportive of and invested in the therapeutic process as a whole and may be qualitatively different from the majority of partners who are not actively involved in treatment.

In addition, little information is provided clarifying which treatment modality quotes and participant statements were reproduced from. Both interviews and focus groups are valid forms of exploratory qualitative research; however, each modality garners a different quality of data and should be evaluated according to relative perspectives. For instance, statements made during a focus group need to be interpreted in the context of a synergistic process, which may obscure or exaggerate individual ideas.
If all of the men mentioned very similar feelings independent of one another during interviews, this may have a different meaning than if the men’s ideas built upon each other in a group setting. Readers also have no information regarding the length of time spent with each man or observing the group process. Authors also briefly mention the influence of a “group therapist”, however they do not explore how the presence of this outside facilitator may have impacted the data generated by the participants. This complicates further our ability to judge the relative import of interview versus focus group data.

Authors do an outstanding job of blanketing the article with extended participant quotes and brief snippets of exchanges between the men during the focus group. These insights provide readers with the beginnings of an in depth understanding of the thoughts and feelings of these men working to support their partners during a difficult period. The exploratory nature of this article combined with the abbreviated presentation in this journal leaves one feeling like he or she has only been given a brief glimpse into the world of these men. Again, the brevity of information regarding research procedures limits our interpretive capabilities. Authors state that “themes and categories emerged” from “repeated examinations and review of the data”, but this brevity again limits our ability to assess the process by which authors allowed the data to direct and shape the research findings.

The issue of most concern in the discussion section is related to recommendations for further involvement of partners in the treatment of CSA recovery with no cautions regarding this approach. Generalizability of findings from this sample is limited given their voluntary involvement in both group therapy and further in the research process.
Authors fail to acknowledge the limitations of generalizing results from this specialized population to partners of CSA survivors who may not be supportive of the recovery process.

Authors do, however, provide an effective integration of the various participant stories and perspectives into a concise, yet compelling argument demonstrating the need to further consider the feelings and needs of male partners whose wives are in recovery. Given the exploratory nature of this article they provide an adequate foundation for future research into this area. This is directly related to the purpose of the present research.

Impact of Group Therapy on Relationship and Partner

A thorough search of the literature base provided no information directly addressing the impact of group therapy for survivors on their partners. However, one could assume similar effects as those seen when a survivor is in individual counseling. As cited in the previous section, Follette (1991) related that married survivors did less well in group therapy than did those individuals who were not involved in an intimate relationship. While numerous reasons could be given for this phenomenon, a possible explanation could lie in the alienation partners experience when survivors are undergoing therapy (Bacon & Lein, 1996; Brack, Brack, & Infante, 1995). This alienation could conceivably influence the survivor’s willingness or ability to engage fully in the therapeutic process.

One could also surmise that the alienation experienced by some partners during survivors’ individual therapy would only be intensified during the group process. Davis (1991), in her guide for partners, explores the loneliness, isolation, and even jealousy that can be experienced by partners who unlike the survivor may not have a built-in network
of supportive and understanding individuals. One partner stated “I feel jealous. She has a support group and books and a whole community of survivors backing her up. I don’t begrudge her any of that. I’m glad she has support. But I wish I did too.” (p. 41-42).

Partners may likely have difficulty understanding and accepting that their intimate partners are able to share all of themselves with a group of strangers, but are unable to share completely within the relationship. This difficulty may lend additional pressure to a relationship that is often already fraught with challenges and obstacles.

Impact of Childhood Sexual Abuse on Intimate Relationship

The long term effect of childhood sexual abuse on the interpersonal functioning of survivors can be devastating. As discussed previously, survivors often find trusting others to be beyond their ability (Alexander, 2003; Allers, et al., 1992; Bacon & Lein, 1996; Browne & Finkelhor, 1986; Courtois, 1988; Johnson, 1989; Johnson, 2002; Phelps, et al., 1997). They approach relationships with a construction of themselves as unworthy and frequently find themselves involved in abusive and destructive relationships (Browne & Finkelhor, 1986; Johnson, 2002). Those survivors who do create loving and supportive matches may always experience fear that the relationship will not last or work excessively at meeting the needs of their partner so as not to lose their love. Survivors often struggle to express their emotions and find it difficult to effectively communicate their wants and needs (Pistorello & Follette, 1998).

Partners of CSA survivors may enjoy the things survivors do in order to keep them happy, but may feel the lack of emotional connection or struggle with the intensity of the survivor’s emotions or emotional reactivity (Bacon & Lein, 1996; Jehu, 1988). Survivors and partners tend to experience significantly more relational distress and
conflict than couples who are not dealing with the effects of childhood sexual abuse and demonstrate less satisfaction with each other and their relationship (Browne & Finkelhor, 1996).

The most common struggles for couples dealing with childhood sexual abuse revolve around communication and sexual intimacy (Johnson, 2002; Pistorello & Follette, 1998). The difficulty survivors tend to have in identifying and effectively communicating their wants and needs is often complemented either by partners who struggle with the same issue or more often by partners who have no trouble at all expressing themselves and balk when survivors begin to set limits on how willing they are to meet those needs (Jehu, 1988). When asked about the experience of being involved in a relationship with CSA survivors, partners often share their feelings of being secondary victims to the sexual abuse experienced by the survivor (Bacon & Lein, 1996; Maltas & Shay, 1995; Reid et al., 1996). They too are impacted by the long term effects of the abuse and as survivors struggle to exorcise the haunting images of the abuse partners are part of that fight. Partners can be invested in the process and joined with the survivor in the battle to reclaim their lives or they can be less directly involved in the healing process, but still deeply affected.

Communication

As indicated above, communication is often extremely poor within couples hampered by the residual effects of CSA. Wiersma, (2003) [see critique] conducted a qualitative study in which she interviewed CSA survivors and their partners investigating the communication processes directly related to the sexual abuse. She found that couples dealing with CSA tended to have very poor communication skills, and although the
sample was small, her results are commiserate with the literature. Survivors tend to have low expectations of getting their needs met and difficulty making themselves vulnerable to rejection by expressing themselves (Bass & Davis, 1988). The “lack of self-efficacy” in communication and “anticipation of an unfavorable response” (Wiersma, 2003, p. 156) are factors which contribute to the couple’s difficulty sharing with each other. Partners in relationships with survivors, who struggle with expressing themselves, are necessarily part of the interaction cycle that maintains poor communication.

Communication problems in relationships can be exacerbated when survivors begin the recovery process (Bacon & Lein, 1996; Brack, Brack, & Infante, 1995). As they shift their focus inwards, concentrate on reconstructing their lives, and begin to assert their own needs, several things can happen. At the outset of recovery, survivors may become more distant as they concentrate on their own needs (Bass & Davis, 1988). Partners may respond by increasing their efforts to gain the survivor’s attention, or they may experience rejection and withdraw into a stance of self-protection (Reid, 1993). Overwhelmingly, couples and therapists agree that the most difficult time in relationships often coincide with survivors’ really beginning to focus on their abuse history in session (Bacon & Lein, 1996; Follette & Pistorello, 1995; Reid, 1993; Reid et al., 1995)

*Critique: Wiersma.*

Wiersma’s (2003) work is a straight-forward study intended to present readers with a picture of the awareness survivors of childhood sexual abuse and their partners have of the effects of the abuse on their communication. This a qualitative study utilizing six couples with a relationship duration ranging from six months to between eight and nine years. The partners were interviewed separately and questions assessed partners’ and
survivors’ perception of the affect of the abuse on themselves and on the other member in the relationship.

The author does not provide personal information, however the tone of the article feels balanced and informed by participant data. The literature review adequately provides a background for the study and demonstrates a clear justification for continuing research. In particular the author cites the lack of information available regarding our awareness as a profession of the interactions between CSA survivors and their partners and the impact of childhood sexual abuse on primary relationships. This gap is directly related to the present research intended to fill in another piece of this puzzle.

The sample parameters in this study are troubling. Survivors were chosen primarily from a university population through the university clinic. Included in the sample were couples who had only been dating for six months or eight months as well as a couple who had been married for eight years. The differences in these couples could be considered a strength as variety can provide richer data, however, one would think that there is a significant difference in awareness of a topic as sensitive as sexual abuse in six month relationships as opposed to eight year marriages. In the presentation of the participant quotes, the author did not indicate from which couples the quotes came, so it is difficult to inform one’s interpretation of the data with an understanding of the impact relationship duration could have on the information.

An additional concern regarding the research methodology includes a significant period of time elapsing between the interviews. Although the researcher asked couples if they had shared information over the duration (which could have lasted up to a week), there is no real way of knowing what impact that time lapse had on the information.
shared. The author indicates that using “multiple couples and multiple perspectives” (p. 154) provides triangulation of data, this is not necessarily appropriate, as only one method of data gathering is utilized. The researcher did utilize an external auditor who reviewed all phases of the research project contributing to the validity of the emergent themes. However, readers were not provided with any personal information about the auditor limiting our awareness of his/her qualifications.

Emergent themes were clearly identified and sufficient participant quotes were provided, however, the appropriateness of the identified categories are questionable given the limitations/concerns discussed previously about the sample. Some of the themes make sense for couples that do not know each other very well (e.g. reliance on non-verbals (as a barrier)) or feel more appropriate for couples who have a more intimate knowledge of each other (e.g. mistaken assumptions about awareness). The author could have provided a frequency table for the themes or some type of breakdown of relationship duration so readers could better assess the fit. The author also mentions that some of the “themes” were only marginally supported, but with only six couples included the theme could have represented the ideas of one or two people.

The conclusions are limited by the same concerns regarding sample and theme appropriateness, however, this study has the beginnings of a strong qualitative work. A future researcher could utilize this same idea and type of sample, but with a larger sample and assess for the presence of the identified themes across relationships of various duration. One could see if new relationships are characterized differently than on-going relationships.
Sex

Second only to difficulty establishing trust, maintaining healthy and enjoyable sexual relationships tends to be difficult for CSA survivors (Bacon & Lein, 1996; Johnson, 2002). This challenge is understandable given the intrinsic connection between trust and sexuality (Pistorello & Follette, 1998) and the bewildering mosaic of sex, betrayal, pain, secrecy, and deceit that is the experience of being sexually molested in childhood. The combination of emotional intimacy, dependency and sexuality that defines adult intimate relationships can be difficult to distinguish from the abusive experiences of the past (Maltas, 1996) Within that relationship lies a predisposition to create situations which could potentially trigger flashbacks of the abuse and survivors may find it extremely painful to allow themselves to be vulnerable.

Pistorello and Follette (1998) [see critique] discovered that survivors in a group therapy setting discussed problems in their intimate relationships more than 50% of the time they were in session. The themes demonstrated in these sessions were dominated by survivors’ anxiety with regards to maintaining emotional communication or a feeling of intimacy in their primary romantic relationship. Within that anxiety minor patterns revealed that survivors fought with avoidance of all sexual activity, retaining a rigid control over the process of sexuality, and/or experiencing guilt related to sexuality and their abuse experiences.

Critique: Pistorello and Follette.

In this fairly complex study with multiple purposes Pistorello and Follette (1998) set out to identify emerging themes/patterns related to relational difficulties in CSA group participants, create an instrument to assess for those patterns, and then explore possible
correlations between their identified themes and severity of the sexual trauma. In this study female survivors of childhood sexual abuse were recruited to participate in twelve week groups to address abuse issues. Videotaped sessions from 12 separate groups were used. From these tapes, researchers used statements made by survivors regarding their relationship difficulties within their intimate relationship to generate themes. These themes were then correlated with specific trauma symptoms identified by survivors through the Sexual Abuse Trauma Index (Briere & Runtz, 1989 as cited in Pistorello & Follette, 1998). Although there are some weaknesses within the study, given the complexity of the design, the authors do an effective job of presenting and supporting their purpose and conclusions.

As a qualitative design one of the weaknesses of the study is that authors provide us with essentially no information about themselves that would enable the reader to assess for bias or undue influence on the interpretations. There are no overt red flags, however, indicating the presence of researcher bias. The information provided in the literature review is balanced, comprehensive and supports the existence of a gap in the literature which this study is appropriately attempting to address.

Authors indicate that they used “intensity sampling” by focusing on group sessions that were “information rich” or defined by survivors as exploring areas of concern within their intimate relationships. They also, however, appeared to be using a form of striated sampling in which they utilized purposive sampling to examine beginning sessions, beginning middle, end middle, and end sessions. This type of sampling gives the authors a broad base from which to explore emerging themes at various times in treatment. We are not given much information regarding how they
decided which sessions to focus on, only that two raters chose sessions based on progress notes. The vagueness could make it difficult to repeat.

The instruments included a sex-history interview, which we are not provided adequate information from which to assess for validity. A second standardized instrument assessing for severity of trauma did demonstrate adequate reliability and validity quotients. Authors also created an instrument as part of this study, which can be used to categorize participants statements regarding relationship issues. One problem arises in the authors’ creation of the instrument. They indicated that participants’ related to “couple relationships or sexual relations in general” (p. 476). The problem is that authors are connecting the categories created in this study to CSA survivor’s experiences within “couples’ relationships” when in fact, participants may have been discussing flirting with a potential partner, interacting with a “one night stand” or discussing hypothetical sexual interactions rather than actual “relationships”. Authors do report adequate triangulation of investigators with several raters being utilized and adequate interrater reliability. This study could be repeated, however, some factors may be difficult to replicate (e. g. similar sample populations and decisions regarding which sessions to sample).

Given the complexity of this study, authors would have been well served by tables outlining some of their initial findings and the process that was undertaken to narrow and refine the categories. Readers are not provided with rich descriptions or any direct participant stories and although the process which researchers utilized to refine the categories is adequately described and appears to be valid for the purpose, readers do not develop relationships with any of the participants. We are instead provided with results that feel similar to quantitative results, although based on qualitative data. An assessment
instrument based on correlations using the trauma scores and emergent categories seems premature. Authors may have provided more compelling support for their instrument and categories by presenting more in depth qualitative stories or participant words, rather than moving on toward a quantitative validation processes.

The conclusions drawn by the authors are adequately supported by the data and the use of multiple raters with interrater reliability provides validity for the results given. A relatively small percentage (more than 25%) of participants had to endorse a specific category before it was included in the instrument, however, authors address this small percentage as one of the limitations. In general authors provide sound rationales based in the literature for the categories that emerged and do a good job of discussing limitations to generalizability. The implications for practice in this article go beyond the information gathered in the study and appear to be theoretical rationales for what could be helpful interventions given the identified relational problem areas.

This article provides a good rationale for the necessity of further study into treatment options, which can address relationship difficulties for couples in which one partner is a CSA survivor. Authors indicate that there is a dearth of research addressing relationship problems in the treatment protocol for CSA survivors. They also present multiple relationship difficulties articulated by CSA survivors in the context of group therapy. Authors in this study also provide support for the importance of incorporating partners into the therapy experience and discuss conjoint treatment approaches that may be beneficial for survivors and their partners. Clearly this has direct relevance to the present study reviewing couples’ experiences with conjoint therapy.
Secondary Victimization

The struggles of survivors to manage difficulties with communication and a myriad of sexual difficulties can lead to partners experiencing their interaction with survivors as unpredictable, confusing, and sometimes painful (Maltas & Shay, 1995; Reid et al., 1996). That is not to say that all partners have exemplary communication skills and are effective at establishing and maintaining intimacy, however, generally the treatment for childhood sexual abuse focuses exclusively on the needs and problems of the survivor and fails to address the pain and frustration being experienced by their partners. Recently, authors have been addressing what some call secondary victimization or trauma contagion that is experienced by partners of CSA survivors (Alexander, 2003; Jehu, 1988; Maltas, 1996; Maltz & Arian, 2001; Reid, 1993).

Repercussions of the trauma of childhood sexual abuse can be experienced by partners as vicarious victimization in that every aspect of their lives is impacted by the “unexpected and overwhelming consequences” (Jehu, 1988, p. 153) of loving someone who is healing from abuse. They often experience difficulty emotionally connecting with the survivor and effectively engaging in a mutually satisfying sexual relationship. Partners may experience a great deal of suffering and psychological strain as they attempt to come to grips with what it means to be in a relationship with a CSA survivor. Maltas and Shay (1995) describe it as “trauma contagion” when partners are “relentlessly exposed to the survivor’s memories and traumatic stress symptoms” (p. 531) leading them to internalize trauma symptoms such as intrusive thoughts, pervasive anxiety, difficulty with trust and sexual dysfunction similar to the survivor, although generally
with less intensity. Given the intensity with which CSA can potentially impact intimate relationships, conjoint therapy may be recognized as important to full recovery.

Potential Benefits of Conjoint Therapy

The potential problems inherent in utilizing only individual and group modalities in the treatment protocol for CSA survivors who are concurrently involved in a committed intimate relationship have been discussed at length. The logical next step is to then look at the potential therapeutic efficacy of utilizing conjoint therapy as an adjunct or as one component of the overall treatment process. It is important to note, however, that the exclusive reliance on conjoint therapy to address the complexities of childhood sexual abuse has not been advocated. The only indication that this would be warranted is confined to the very limited situation in which a couple presents to therapy specifically to address relationship concerns and even in this situation it is likely that the survivor would have already done a significant amount of individual restructuring.

Several qualitative studies substantiate the advocacy by survivors and their partners for the need to include conjoint therapy in the treatment protocol for childhood sexual abuse (Bacon & Lein, 1996; Maltas, 1996; Reid, 1993; Trute et al., 2001). Generally participants indicate that partners’ involvement in therapy would improve communication and connection within the couple and reduce the sense of alienation, blame, and isolation experienced by partners throughout the therapeutic process. The inclusion of partners in treatment is perceived as potentially damaging by survivors, however, if the inclusion is not well-planned and initiated at an appropriate time in the treatment process (Reid et al., 1995).
Effective Communication

Fundamental to all proposals being proffered to address the special needs of couples in which one person is a survivor of childhood sexual abuse is the need to increase the effectiveness and quality of their emotional connection (Alexander, 2003; Bass & Davis, 1988; Button & Dietz, 1995; Follette, 1991; Johnson, 2002; Pistorello & Follette, 1998; Serafin, 1996). Inherent in this need is the ability of each of the partners to identify their personal needs and wants and effectively communicate these to each other. Trute et al. (2001) [see critique] provide a comparative case analysis conducted with six couples dealing with CSA who had received conjoint therapy. The primary benefit of the couple’s approach was their ability to better communicate their emotions and feelings and effectively joint problem solve.

A social learning approach combines communication skills and problem solving skills into a framework of mutual responsibility and ownership in the continuation of relationship difficulties (Follette, 1991). Offered as a potentially suitable schema for addressing CSA recovery issues within survivor’s primary relationships, Follette indicates that the social learning approach is egalitarian and recognizes the needs of both partners without framing one person’s role as to “fix” the other. Given that partners often view the problem as solely residing in the survivor, this approach forces both members of the couple to take responsibility for their own issues that are contributing to the problem. The author emphasizes that individual therapy may be a precursor to this conjoint approach and that general communication and conflict resolution challenges should be resolved before couples attempt to deal with sexual dysfunction issues.
Critique: Trute, Docking, and Hiebert-Murphy.

Trute, Docking, and Hiebert-Murphy (2001) present an outstanding mixed methods study with the stated purpose being to “assess the value of relationship therapy” (p. 100). Researchers used a constant comparative method along with a pre- and post-test empirical design to triangulate information with the intent of providing multiple perspectives around the subject of conjoint therapy for couples in which one partner has experienced sexual abuse in childhood or adolescence and is currently in addictions recovery. Data was combined from client self-report measures, clinician’s observations, and consumer feedback interviews.

Research was completed as part of The Couples Project, which was a pilot program intended to assess the value of relationship therapy. Although not clearly stated, it is possible that funding being provided by this program may have applied pressure to researchers to “discover” that couples counseling was beneficial. Authors do not indicate whether they are affiliated directly with the project, however, without this clarification, it leaves one with questions regarding researcher bias.

Authors provided a reasonably complete literature review supporting the growing perspective in the field that conjoint therapy may be beneficial as an adjunct to individual or group treatment for survivors. However, very little information was provided regarding addiction treatment protocols or offering support for conjoint approaches to addressing this presenting problem. Authors note the dearth of research on “women survivors of child sexual abuse who are in recovery from addictions” (p. 100), however, some information regarding current couples approaches to addictions treatment should be available.
The sampling procedure in this study is somewhat troubling. Of the 20 couples who were deemed “eligible for treatment” and “expressed an interest in couple counseling” (p. 100) twelve were eliminated from the final sample with little or no explanation for their removal. The lack of information regarding the decision making process for sample reduction brings into question the true representative nature of this sample even if we are limiting generalization to couples who are seen as part of this pilot program. Selection bias may have weeded out couples who demonstrated less success in the program.

Data collection procedures in this study also create some question about the validity of the findings. Consumer feedback interviews were completed anywhere between four and 14 months after the termination of therapy. Results from these interviews served as primary data for the constant comparative analysis as well as for the determination of the success of therapy. Significant differences in duration between treatment termination and interviewing, may have dramatically impacted the partners’ perceptions of the value of therapy and particularly influenced their evaluation of the treatment experience and personal changes.

Given the primarily qualitative approach to this investigation and the possibility of researcher bias mentioned above, the authors make efforts to establish the validity of their interpretations. The interviewer who completed the couple’s interviews was not affiliated with the couples program. Additionally, initial data integration, interpretation, and conclusions drawn were cross checked against findings established by a third researcher working independent of the other two. This cross analysis provides additional trust in the findings and conclusions drawn in this study. With regards to reliability, the
triangulation of information provides support for reliability, however, member checks of the integrated information would have been easy to accomplish and beneficial to supporting the hypotheses drawn.

Triangulation, however, was a strength in this study. The provision of both quantitative and qualitative data from both the client and therapist perspective provide readers with a multi-faceted picture of this therapeutic process. The integration of this material throughout the comparative process provides a strong foundation for assertions made, with authors readily modifying their conclusions as divergent themes emerged from the data.

Readers can clearly follow the emergent properties of the assertions and hypotheses created throughout the comparative analysis. The quantitative data, being administered immediately before and after treatment (as opposed to being implemented several months after termination) provide empirical information regarding changes in individual partners and the couple as a whole while the qualitative methods employed provide a rich understanding of the challenges and successes experienced by both the couples and the therapist.

One problem with this study in general and more specifically in the discussion section is the lack of recognition of the impact of the addiction component found in this sample population. Authors report that their findings are dissimilar to those reported in earlier studies focusing on conjoint treatment with abuse survivors, however they fail to acknowledge that these differences may be linked to the substance abuse issues present in their participants. In addition, although authors do limit the generalizability of their findings to a specific heterosexual population, they fail to acknowledge the complete lack
of ethnic diversity in their study population and the distinct limitations this places on the
generalizability of findings to more diverse populations.

_Emotionaional and Physical Reconnection_

Both survivors and partners express feeling isolated and guilt-ridden during
various stages of the recovery process (Bass & Davis, 1988; Button & Dietz, 1995; Maltz & Arian & Arian, 2001). Guilt regarding their sexual abuse history and not sharing their history with partners early on in the relationship can plague survivors while partners may express guilt related to the anger they feel about the abuse experience in general and its impact on their lives. Shame and guilt can be very isolating agents motivating both partners to turn away from each other and remain cut-off from the love and support each could be sharing. As discussed previously, individual and group modalities may reinforce the disconnection between partners and increase the distance in the relationship.

Johnson (2002) proposes that the exact opposite situation should be facilitated by therapists. She asserts that an attachment perspective and emotionally focused therapy can be utilized to reconceptualize survivors’ intimate relationships as potential life-long secure bases from which healing in both members of the couple can be facilitated. In this context, survivors and partners are taught how to reconnect with one another on an emotional level necessarily increasing their emotional communication and diminishing the level of conflict and mutual isolation. Trauma and the history of childhood sexual abuse are framed as negatively impacting the lives of both members of the couple and recovery is believed to occur as partners engage in more adaptive and supportive emotional exchanges. Throughout the process emphasis is placed on increasing trust and validation of worth in both partners.
According to Johnson’s (2002) emotionally focused model of therapy with childhood sexual abuse survivors, when partners are included in the therapeutic process they and the survivors can recreate new realities of being based on their mutual healing experiences. Survivors and partners can forge through loving interactions new and healthier beliefs and models of self. Childhood sexual abuse survivors often experience their reality of self as damaged, worthless and incompetent (Browne & Finkelhor, 1986). Partners may know life with the survivor as unpredictable and frightening, while defining themselves as powerless and isolated (Bacon & Lein, 1996). If trust and connection are reinforced in the couple, the relationship provides a safe place within which definitions of self and the relationship as a whole can be understood as dynamic and changeable (Johnson, 2002). The couple can be encouraged to redefine the reality of their relationship and who they are as individuals. What is important is not how society, therapists, friends or family define a CSA survivor and a CSA survivor’s partner, but how the couple, the experts on their own lives, interpret and understand their relationship and each other. The members of the couple become the expert architects building a new and more satisfying reality together.

In contrast to the emotionally focused model of conjoint treatment, Follette and Pistorello (1995) present the Acceptance and Commitment Therapy (ACT) approach, which integrates a contextual, behavioral, and experiential approach to addressing the needs of CSA survivors and their partners. The model emphasizes acceptance of reactions to internal events, history, self, and others and utilizes metaphors and experiential exercises to facilitate acceptance. The authors propose that the collaborative, experiential, and acceptance approach can be specifically helpful to couples struggling to
overcome shame and guilt associated with their reactions to the abuse. They further indicate that the model facilitates the reduction of hierarchy within the relationship leading to a more balanced acceptance of responsibility for problem maintenance rather than the partner’s perception of self being one defined by their peripheral role as “helper” or support person in the survivors’ healing process (Follette & Pistorello, 1995).

Potential Risks of Conjoint Therapy

Survivors and their partners both suggest that conjoint therapy should be incorporated in the treatment protocol for addressing childhood sexual abuse issues. Therapists and researchers are framing conjoint treatment models and making recommendations for the effective introduction of conjoint therapy. Present within the literature, but not highlighted regularly are the risks that are intrinsic to an approach that requires two individuals to make themselves vulnerable. Revictimization and benevolent blame are two potentially damaging issues of concern when contemplating conjoint therapy.

Revictimization

The literature is rife with evidence that CSA survivors are more likely than non-CSA survivors to be revictimized in adulthood (Alexander, 2003; Browne & Finkelhor, 1986; Malta, 1996; Pistorello & Follette, 1998; Russell, 1986). In addition to a greater likelihood of being raped, CSA survivors are significantly more likely to be emotionally, psychologically, physically, and sexually abused by their partners than non-survivors (Browne & Finkelhor, 1986). Follette et al. (1996) report that 65% of women presenting to domestic violence shelters have also been victims of childhood sexual abuse. Therapists who utilize conjoint treatments must use extreme caution when assessing for
the appropriateness of conjoint treatment with couples who have experienced the effects of childhood sexual abuse. During treatment vigilance is required to ensure that experiences that are shared in session do not result in some form of retaliation from the other partner outside of session.

Benevolent Blame

Revictimization is not always overtly intended by partners, but can result from a common phenomenon that occurs when one person is identified within a couple as the “patient”. Benevolent blame is a passive form of revictimization often maintained unwittingly by partners (Follette, 1991). Partners may view their role, even in conjoint therapy, as that of a supporter in the treatment of the survivor’s problem. Partners often feel they do not have any problems and see no reason to change their interactions or behaviors (Jehu, 1988). Instead, they blame their relationship issues on the survivor while abdicating responsibility for their contribution to relationship difficulties and set out to “fix” the “broken” survivor (Follette, 1991; Follette & Pistorello, 1995). These blaming messages may perpetuate “feelings of shame and stigmatization already experienced by survivors” (Serafin, 1996, p. 4) and negate the positive effects of conjoint treatment.

Suggestions from the “Experts”

Reid (1993) [see Reid critique] incorporated the majority of the information presented above into a qualitative study in which he conducted in-depth interviews with 17 couples where one partner was a survivor of childhood sexual abuse. His results were consistent with those presented throughout this text, however, at the time of his study conjoint therapy was not routinely incorporated in the treatment protocol for CSA survivors and his exploration was limited to the participants’ experiences of the
survivor’s individual and group therapy. The inquiry into the experience of partners focused primarily on their perception of how the survivor’s abuse history and subsequent treatment impacted the relationship. Subsequent articles (Reid et al., 1995 [see critique two]; Reid et al., 1996) expanded the presentation of survivors’ and partners’ stories and outlined suggestions made by participants for future construction of conjoint treatment protocols.

In Reid’s (1993) study, survivors were emphatic that partners need to be involved in the treatment protocol for childhood sexual abuse. As one survivor stated “I don’t think a survivor can heal unless the man, or whoever is in her life, is supportive and caring and wants to know what’s really going on” (Reid, 1993, p. 103). They also provided several suggestions for what might be most effective in involving partners in the process: “(a) psychoeducation about the effects of childhood sexual abuse, (b) more emphasis on the partner/therapist relationship, and (d) supplemental integration of marital and sex therapy with the more traditional modalities of individual and group therapy” (Reid et al., 1995, p. 40). Finally, survivors indicated that conjoint therapy would be most beneficial if it addressed “(a) their current sexual relationship (b) communication skills and (c) how childhood sexual abuse continues to affect their relationship” (Reid et al., 1995, p. 42)

Partners interviewed as part of the above study shared their perceptions regarding the survivor’s participation in individual treatment, the impact of childhood sexual abuse on their marriages, and their advice for the creation of a conjoint treatment framework (Reid et al., 1996). Partners generally supported the benefits of individual therapy for survivors with the most oft cited advantages being the survivor’s opportunity to share her
story and reduce her isolation. Unfortunately they also passionately expressed their alienation from the process of therapy and their perceptions of being unfairly blamed when their wives projected anger related to her abuse onto them. They perceived blame and alienation as reinforced by therapists who actively worked to exclude them from the therapeutic process. Difficulties with communication and sexual intimacy were addressed as most impacted by the effects of childhood sexual abuse. Their advice to therapists included: “(a) the need to educate partner and survivor (b) [increase] therapist-partner contact (c) marital therapy” (Reid et al., 1996). In summary, both survivors and partners expressed a need for conjoint therapy to be included in the overall treatment protocol for childhood sexual abuse, however, they clearly established some parameters around that process.

 Critique: Reid.

Reid’s (1993) dissertation was chosen due to its similarity to the design being undertaken in the current study. Reid utilized a qualitative approach to understanding the subjective perspectives of married couples in which the wife was a survivor of childhood sexual abuse. He primarily focused on their experiences of individual and group therapy as it affected both the survivor and her marital relationship with her husband. He also generated some seminal information regarding the perspectives of partners who were traversing the healing journey alongside the survivor. Finally, he gathered some preliminary data describing the impact of various therapeutic and therapist variables on the experiences of CSA survivors and their husbands.

In general, Reid followed the qualitative format of presenting only the basic components of his research design and theoretical foundation in the first three chapters.
The bulk of his design and data is presented in the last two chapters, which are twice as long as all three initial chapters combined.

The clearest concern regarding this study is the lack of personal information provided by the researcher about either himself or others involved in his study. Given the sensitive content area and the very subjective content analysis design, the lack of defining information creates some challenges for readers attempting to assess the impact of researcher variables on the decision making processes and the interpretive lenses used. Readers are only informed that the primary researcher is male and that he utilizes a female assistant who has a prominent role in the study as she conducts all of the interviews with the survivors. Reid acknowledges that “personal perceptions, values, and assumptions are all an integral part of the data collection and analytical process” (p. 136), but fails to provide even minimal personal information.

The literature review section of this study is very brief. This is in-line with the qualitative concern with the belief that in-depth literature reviews can bias the researcher’s inquiries and subsequent data analysis. He emphasizes the point that there is a very large gap in the literature with regards to information or awareness of the partner’s perception of therapeutic CSA treatments. He does a clear job of connecting the citations that are included or are non-existent in a logical fashion to the research questions grounding his study. An additional comment regarding the literature cited in this project is that there are multiple statements and assumptions presented that clearly could be supported by the literature but are not. There is a tendency to present a string of citations following a general statement but then failure to scatter citations evenly throughout the document.
The sampling procedure utilized for this study is adequate for the purpose of the research. Childhood sexual abuse survivors are often stigmatized and concerns regarding confidentiality are paramount. The design of this study provides several measures designed to protect the confidentiality of clients and strive for anonymity.

One concern regarding the sample utilized in this study, however, is that the partners interviewed are very well educated. In fact, of 17 male participants three have Ph.D.’s, three have graduate degrees and two had completed bachelor’s degrees. In addition, one husband was also a CSA survivor and a convicted perpetrator of CSA against his children. Five others were victims of physical abuse in their own childhood. Although generalizability is not the purpose of qualitative inquiry, the highly educated nature of this sample and the inclusion of a sexual offender may create some questions regarding the commonality of experiences between these husbands and other partners of CSA survivors.

Reid does provide adequate rationales both for his choice of research design and criterion variables utilized to determine the appropriateness of couples for inclusion in the study. He also provides enough information about the design and procedures used in the study (including copies of all forms and documents) to enable future researchers to replicate or expand upon his study.

Reid has a strong results section. The participant quotes appear to be well selected and rich in information. The participants words are emotionally evocative and provide a glimpse into their pain and struggle. However, the presentation format feels jumbled and difficult to follow making it difficult for readers to immerse themselves in the words, meanings, and intensity of the participants. It was only by referring regularly to the title
page that I was able to discern a clear outline of the categories and hierarchy established by the author. In addition, the author includes several categories, which he labels “minor” themes with as few as one survivor identifying the issue as relevant. These sub-themes are clearly labeled in a table in chapter three, however, they are not differentiated clearly in the results section, so one could place too much emphasis on the value of these themes. It would have also been beneficial if the author had made it clear why he felt the identified sub-themes were integral enough to be included when identified as pertinent by so few participants.

The author did not actually generate research hypotheses. This is essentially a descriptive study in which the researcher approached a subject with four very basic questions regarding the effectiveness of therapy in addressing survivor and partner issues. The data generated far surpassed the very general research questions established prior to the data collection, however, the researcher fails to connect his results back to these initial questions.

There is a dearth of researcher conclusions or explanations. The researcher appears to have just organized the data into categories and sub-categories and presented them to readers. The discussion section adds very little to this study and feels more like a reiteration of the results section in a condensed form. Even inconsistencies in the data are not addressed or explored. For instance, participants only identified one factor (a sub-theme) of therapy as having a positive impact on their marital relationship and identified multiple therapeutic factors as being seriously detrimental to their relationship. However, on the respondent questionnaire participants overwhelmingly described their marital
relationship as having vastly improved over the course of therapy. This seems like a glaring inconsistency, but it is not addressed by the author.

The researcher does outline reasonable clinical implications based on the data generated. They are clearly linked to the participants’ perceptions and offer valuable information for practitioners. A concern exists, however, regarding the highly educated nature of the sample and the fact that several of the partners were abused themselves and one was a sexual perpetrator. These characteristics are not cited as limitations to the generalizability of this study although the author cites the standard qualitative perspective that the purpose of qualitative study is not based on generalizability.

In general it feels as though the researcher was confused about his overall orientation to this research. He attempts to create a systemic picture of how therapy impacts the partners, the survivors and how it affects their general relationship functioning. In addressing the partner, however, many of the questions center on how the partner perceives therapy affected the survivor. They are asked “what appeared to be most helpful (for the wife) about your wife’s therapy?” and other questions of this type. This type of questioning creates a feeling of linearity cloaked in circularity.

The value of this study clearly lies in the participant stories that are shared. The researcher had a strong design and obtained a plethora of rich and detailed participant stories. Participants appear to clearly find individual and group treatment for survivors beneficial, although the negative impact on marital relations remains a concern. This concern aligns nicely with the overwhelming expression of partner and survivor desire for the inclusion of marital therapy in the CSA treatment protocol. Throughout the results
section participants clearly expressed their dissatisfaction with the exclusion of partners from treatment and the alienating affect traditional treatment modalities have on partners.

This aspect of Reid’s study has clear implications for my own research. Due to the lack of couples therapy being utilized a decade ago in the treatment of CSA, Reid was unable to assess for the effectiveness of this modality. He was only able to say that participants expressed a need for it and cite it as an implication for practice and research. The opportunity now exists to understand if this treatment modality is experienced as positively by couples dealing with CSA as Reid’s participants would have hoped.

_Critique: Reid, Taylor, and Wampler._

Reid, Taylor, and Wampler (1995) generated a secondary study based on the information gathered by Reid (1993). Their primary findings indicated that CSA survivors would like their partners to be more involved in the recovery process, but the brevity of the article prevented the full, or even partial, understanding of the true depth of this qualitative study. It felt as though the authors presented a tiny bit of information gathered from a huge amount of data leaving the reader feeling as though they are missing the connection between research, results and the discussion.

The authors do an excellent job of presenting their biases towards the support of conjoint therapy in CSA treatment protocols and addressing the fact that the results of their study did not completely turn out the way they had hoped. This lends a sense of believability and validity to the findings that are reported.

The literature review, however, appeared to leave out key information. Authors reveal that they suspected participants would advocate strongly for the incorporation of partners into treatment and this research is one of a small body of research looking at the
value of partners participating in therapy. There was a complete absence of citations or discussion in the introduction of how partner involvement has been addressed in CSA treatment approaches. There is some mention of it in the discussion, however, the lack of information at the beginning of the study leaves readers wondering where the authors are going.

The first information authors present is that this study was part of a larger study, however, no information is given regarding the purpose, participants or process of this larger study. This information would provide readers with a much clearer understanding of where participants were coming from and ways in which their stories were potentially impacted by the agenda of the larger study.

The research design specifics were sketchy enough to make accurate replication very difficult. We do not know for how long participants were interviewed. Who conducted the interviews or in what context. Most importantly, authors indicate that six respondents were excluded from the study because they did not meet criteria, but give no information regarding what that criteria was.

Also disconcerting is that authors use language like “participants indicated the need for a more systematic integration of their partners” (p. 42), however, five of the participants had not had any conjoint therapy at all and of the remaining twelve participants, only two had addressed CSA issues in their marital sessions. How then are we to interpret ideas such as participants want “more” involvement. What does that mean if there has been no involvement at all.
One additional concern involves validity. In this study the researchers independently review four transcripts for emerging themes, however we are given no information about if they arrived at very similar ideas or how they integrated their ideas.

A weakness within this study is the difficulty one has in identifying the core “themes” discovered by the researchers. They are alluded to, however, they are never clearly stated. Readers should have a very clear idea of what the main or most salient findings were in the study. When this doesn’t happen it becomes difficult to follow how conclusions drawn by authors are emergent or supported. That is clearly the case in this article.

The terminology utilized by the authors is also a difficulty. For instance, authors indicate that “inappropriate involvement” of partners was viewed as detrimental to the therapeutic process, yet we have no idea what participants meant by this. It would have been helpful for authors to have provided several examples supporting this statement. Again, the brevity of the article precluded a deep or rich understanding of participants’ experiences.

Authors outline the limitations of the study and discuss the very limited application of the information. The most significant problem in this study is borne out in the discussion. The brevity of this article does not fit with the qualitative process. Authors draw conclusions and make explanations, however, there are not enough data sources or a clear linkage between the participants’ words and the authors’ conclusions for readers to be able to evaluate the appropriateness of those conclusions. Several participant quotes are provided, however several of the conclusions drawn are not supported by the data that is provided. For instance, authors state that participants believe that traditional treatment
modalities (individual and group) should remain the foundation of CSA treatment protocols, yet there is no raw data presented to support this conclusion.

General Literature Critique

Lack of empirical support

The most troubling component of the information garnered from the literature is the prevalence of models framing conjoint treatment and suggestions for practitioners to utilize a couples approach based on theoretical constructions but not supported by empirical studies. Qualitative studies have demonstrated that couples support the idea that couples therapy would be beneficial to the treatment (Bacon & Lein, 1996; Reid, 1993; Reid, et al., 1995) of childhood sexual abuse, however, the only study that interviewed participants who had actually participated in conjoint therapy was focused on substance abuse recovery as well as CSA thereby potentially skewing the results (Trute, et al., 2001). The fact that the results of this study were not consistent with previous findings (Maltas & Shay, 1995) is also difficult to interpret due to the confounding variable of substance abuse.

Perhaps more troubling is the creation of frameworks specifically advocated for use with childhood sexual abuse treatment. Consider the acceptance and commitment therapy (ACT) model (Follette & Pistorello, 1995) or the emotionally focused therapy approach (Johnson, 2002). Although these models may have demonstrated some empirical effectiveness with couples in general, the authors have made adaptations to theoretically address the specific needs of couples dealing with CSA without evidence supporting effectiveness specifically for these models with this population.
Qualitative Inquiry

Throughout the critiques included in this work there is consistently little to no information presented that outlines the individual lenses through which the researchers are gathering and analyzing their data. At the foundation of qualitative inquiry is the awareness that the researcher is the instrument through which the information is analyzed and therefore readers need to be made aware of the specific characteristics that define that research instrument (Patton, 2002). Even in the dissertation presented by Reid (1993) there is a complete dearth of information about either the author or the assistant who conducted all of the survivor interviews. Bearing this in mind, readers are handicapped in their ability to evaluate potential biases in the information that is presented or nuances researchers bring to the study that increased the richness of the data provided.

An additional challenge for readers of the qualitative studies included in this work is the brevity of direct quotes and participant stories. In evaluating the appropriateness of the themes presented by authors and the emergent quality of these themes, readers are reliant upon the authors to provide adequately thick and rich data garnered directly from the expressions of their participants. In several of the resources only a small number of very brief participant quotes were presented as evidence for the conclusions presented by the authors. This brevity makes the validity of those conclusions somewhat suspect and leads readers to remain cautious in their usage.

Future Research

Throughout this literature review the author has presented eight primary areas of study. These included: (a) benefits to be gained by survivors from individual therapy (b) benefits to be gained by survivors from group therapy (c) impact of individual therapy on
relationship and partner (d) impact of group therapy on relationship and partner (e) the impact of childhood sexual abuse on intimate relationships (f) potential benefits of conjoint therapy (g) potential risks involved in conjoint therapy and (h) partner’s and survivor’s “expert” opinions of the process of conjoint therapy. The literature regarding the use of conjoint therapy has clearly expanded since Reid (1993) conducted his dissertation, however, there is still very little information directly garnered from survivors and their partners regarding their perceptions of the effectiveness of conjoint therapy. In the last decade we have come to a time in the profession where conjoint therapy has been incorporated into clinical treatment of CSA on a limited basis, but with enough intensity that research on the process is now possible. The only study to directly assess it to this point was hampered by the confounding variable of substance abuse and questions regarding the sampling and data collection procedures (Trute et al., 2001).

Given that therapists, survivors, and their partners are advocating for the inclusion of conjoint treatments and authors have already started creating frameworks for couples intervention, it is vital that as a profession we begin to assess the effectiveness, benefits, and risks inherent in a conjoint treatment approach to childhood sexual abuse recovery. The purpose of this study is to begin to fulfill that professional gap. Participants involved in this study will be CSA survivors and their partners who have experienced conjoint therapy. Their stories will hopefully help us to understand if conjoint therapy is an effective addition to CSA treatment protocols and give us a better picture of what that treatment should look like if it is to be beneficial.
CHAPTER III

METHODS AND PROCEDURES

Restatement of Purpose

The purpose of this study was to gain conceptual clarity regarding how childhood sexual abuse survivors and their partners experienced conjoint therapy and made meaning within the context of its effectiveness for addressing their needs. As current treatment protocols are being evaluated and new treatment paradigms are being created, theoreticians and clinicians can benefit from rich, detailed, and contextualized data describing what qualities can enhance the therapeutic effectiveness of this treatment modality. Prior research has focused primarily on traditional methods of intervention such as individual and group therapy. This study attempted to fill a gap in the literature by exploring conjoint treatment as a method for addressing CSA recovery issues through an in-depth qualitative analysis of the experiences of couples who had directly focused on CSA issues in the context of conjoint therapy. Practitioners working with the CSA survivor population have had very guidance regarding how survivors and their partners perceive the experience and effectiveness of conjoint therapy. There is even less information available regarding how specific process variables enhance or hinder therapy.

A qualitative research methodology consisting of in-depth conjoint and individual interviews and a demographic questionnaire were utilized to gain a better understanding
of the following research questions: (a) how effective do CSA survivors and their partners perceive conjoint therapy to be as a treatment approach in addressing their individual and relational needs (b) what is the perceived impact of conjoint therapy on the relationship of CSA survivors and their partners (c) what are the risks and benefits of conjoint therapy as perceived by survivors and their partners when utilized in the treatment of CSA recovery (d) what process variables do CSA survivors and their partners identify as most or least effective mechanisms of change, (e) what is the perceived impact of individual and/or group therapy on the relationship of CSA survivors and their partners (if applicable).

The purpose of this research was to add to the fundamental knowledge of the field (Patton, 2002) and emphasis was placed on generating thick, rich data which could inform the profession about the therapeutic experiences of CSA survivors and their partners. Generalizability of these results to a larger population was not the intention, rather the researcher hopes the data gathered will inform theory development as treatment protocols for CSA survivors and their partners are being considered.

Methodological Framework

A phenomenological approach (Moustakas, 1994; Patton, 2002) was utilized throughout this study. The phenomenological approach emphasizes the meaning participants derive from their lived experience and validates the individual and social construction of reality. Patton (2002) provides a concise explanation of phenomenology “capturing and describing” how people experience some phenomenon such as conjoint therapy. The aim is to understand “how they perceive it, describe it, feel about it, judge it, remember it, make sense of it and talk about it with others” (p. 104). This focus on
meaning making may be particularly important with a population such as CSA survivors where their own sense of reality and self-efficacy in meaning making were possibly undermined or denied by their abuser(s) in childhood. Partners as well, may also have experienced denying their own feelings and the reality of their experiences with regard to the impact their partner’s abuse history on their lives. A phenomenological approach highlights the importance of the experiences shared by participants and reinforces the validity of their meaning construction.

Throughout the design, emphasis was placed on collaboration, subjective meanings, and validating the expertise of the participants. The interview process was undertaken in a conversational manner and both conjoint and individual interviews were utilized. Incorporating both types of interviews recognized that these couples have generated interpretations of the conjoint experience within the context of their interactions with each other, but also have an individual construction of reality which may be better understood through a one-to-one interaction with the researcher.

Data analysis was driven by the very specific protocol for understanding phenomenological data outlined by Carl Moustakas (1994) and emphasized the goal of identifying significant statements, grouping them into “meaning units”, and constructing an overall description of the “essence” of the participant experience. Grasping the essence of the shared experience of participants is a hallmark of phenomenology and speaks to identifying an “invariant structure” or an underlying meaning of the experience which is shared by those who have lived it (Creswell, 1998). Extrapolating meaning and interpretation from participant stories was a challenging adventure and the researcher collaborated with colleagues as a way of securing more validity for the analysis. Efforts
were made to incorporate collaboration with the participants in the form of member checking in the middle phase of data analysis. It is the essence of participants’ lived experience, which was the driving force behind this work and the foundation upon which future treatment modalities will hopefully be framed.

Sample

Participant Definitions

A convenience sampling procedure (Patton, 2002) was utilized. Couples recruited for this study had to fit the sample parameters described below.

1. **Childhood Sexual Abuse Survivors:** Individuals who had experienced coerced or forced sexual activity imposed on them as a child, or sexual activity imposed on them as a child by a much older individual regardless of the presence of any clear force or coercion (Browne & Finkelhor, 1986; Millwood, 2003). For the purposes of this study, the sexual abuse must have occurred between the child and a perpetrator who was at least five years older than the survivor.

2. **Partners of Childhood Sexual Abuse Survivors:** Any individual who had maintained a monogamous and committed (self-defined) intimate relationship with a CSA survivor for the duration of at least two years.

4. **Conjoint Therapy:** Treatment of two or more persons in session together (Nichols & Schwartz, 1998). Conjoint treatment was differentiated from survivors’ individual treatment by the distinction of having been conducted by a therapist other than the survivor’s primary individual therapist or by having taken place at a different time than individual counseling alone. Survivors and
their partners who were included in this study must have experienced conjoint therapy within the last five years, during which issues related to the survivors’ childhood sexual abuse history must have been identified as a primary presenting problem. The five-year limit was established based on the acknowledgment of data being retrospective, and therefore, more accessible if experienced in the recent past.

**Participant Recruitment**

Couples were recruited exclusively through therapist intermediaries. Therapists located within a 50 mile radius from the researcher’s home university who treat couples dealing with childhood sexual abuse issues were contacted by mail (Appendix B), telephone, e-mail, or personally by the researcher and asked if they would be willing to recruit previous clients for participation in the study. Therapists who were interested in participating in the study were sent participant packets which contained consent forms (Appendix A) and fliers (Appendix C) introducing the researcher and outlining the research project. Therapists then sent or gave these packets to previous clients who contacted the primary researcher either by phone or by returning the consent forms. The couples were supplied with self-addressed, postage-paid envelopes for the consent forms.

Those couples who agreed to participate were contacted via telephone by the researcher, and were provided with a more detailed description of the study. The initial phone interview guide (Appendix D) was then used to assess the couple’s fit with the sampling criteria and the conjoint interview was scheduled. This telephone contact provided participants an opportunity to decline participation. Two survivors contacted the primary researcher and indicated they were interested in participating, but their partners
were unwilling to complete the research process. Approximately 45 participant packets were sent to therapists who indicated their willingness to recruit previous clients. No additional consent forms were returned beyond those of participants who completed the study. As a gratuity for their willingness to participate in the research, each couple was given a gift certificate for $30.00 good at a national restaurant chain of their choice.

**Participant Demographics**

Participants were asked to complete a basic demographic questionnaire (Appendix H) at the end of the initial conjoint interview. Information regarding this data and a brief description of each couple is provided below.

**Couple One.**

Claire (34) is an intrafamily childhood sexual abuse survivor. She and her husband James (31) are a heterosexual, Caucasian couple who have been married for eight years. Both work full time professional jobs and Claire has a master’s degree. James is currently in law school. They have two young children and earn a combined income of more than $50,000 annually. Both members of the couple were eager to participate in the research and they agreed at the end of the conjoint interview that they had forgotten how beneficial the therapeutic experience had been. This couple’s interview was characterized by frequent laughter and a fluid conversational pattern in which they finished each other’s sentences.

**Couple Two.**

Jamie (42) also experienced childhood sexual abuse within the context of her family of origin. Chris (49) and Jamie are Caucasian and have been married for 18 years. Both members of the couple have attained bachelor’s degrees, work in full time
professional positions, and fall in the $25,001 - $50,000 annual salary range. They have two pre-adolescent children. Jamie and Chris are both active in educating the public regarding the impact of childhood sexual abuse and also used a great deal of humor during their interviews.

Couple Three.

Barb (56) and Charles (56) are a Caucasian heterosexual couple who have been married for 26 years and have three children in their early 20’s. Charles has his bachelor’s degree, while Barb has completed a professional degree. They indicated that they are make above $50,000 annually. Barb was talkative and lively during the interview process while Charles was more stoic and reserved. They were, however, both supportive and attentive towards each other. Charles expressed feeling a personal lack of respect for their couples counselor, but stated that he had continued with that particular counselor because Barb found him to be helpful.

Couple Four.

Stacy (24) and Nicole (21) are a Caucasian lesbian couple who have been living together in a committed and monogamous relationship for over three years. Both have completed some college courses, are working full time and make less than a combined annual income of $25,000. Stacy is a survivor of intrafamily childhood sexual abuse and was more quiet than her partner during the interview process. Although Nicole initially encouraged Stacy, who was hesitant, to seek counseling, both agreed that their conjoint couples counseling experience was very helpful. The sentiments expressed by this couple were very congruent with the first three interviews. Both members of the couple were very aware of and responsive to nonverbal emotional cues and would often provide a
comforting touch or look. At the conclusion of the interview process this couple indicated that they hope to return to couples counseling to “refresh” their communication skills.

Data Management

Data Collection

Semi-structured interview guides were utilized for both the conjoint interview (Appendix E) and the secondary individual interviews (Appendix F and G). The interview guides outlined the primary areas of inquiry that the researcher was interested in exploring while allowing the interview to be framed as a conversation (Patton, 2002). Maintaining a conversational approach to interviewing allowed participants to collaboratively explore with the researcher the topic of their experience with conjoint therapy in a relaxed manner. The emergent stories of participants were given voice and allowed to direct the focus of the communication with the researcher. The phenomenological focus encouraged more in-depth exploration of how participants made sense of their experience with conjoint therapy and how their meaning construction was framed individually and within the context of their relationship.

Given the limited time the researcher had with participants the interview guides were utilized to provide a framework which the researcher used throughout the actual interview process to confirm that all potential research areas of interest were being sufficiently explored (Patton, 2002). The interview guides for this study focused on several central concepts including the conjoint therapy experience, the impact of process variables on therapy, and the impact of various therapeutic modalities on the couples’ relationship status.
The conjoint interview included exploration of the experiences of couples who were involved in the process of conjoint therapy during which the issue of childhood sexual abuse was a primary presenting concern. They were asked to reflect on their perception of its effectiveness and how they defined the concept of therapeutic effectiveness. Both members of the couple were asked to discuss how they felt conjoint therapy impacted their individual and relationship needs, what they considered to be some of the risks and benefits of conjoint therapy, and what specific interventions or factors were most and least effective in generating change. Finally, partners and survivors were asked to reflect on their experience with other modes of treatment (individual and group therapy), if applicable, and explore their perceptions of how it impacted them individually and relationally. This last exploration of experience provided better understanding of the contextual positioning of conjoint therapy within an overarching treatment protocol.

The couples were interviewed initially conjointly as a means of understanding the participants’ joint experience with couples therapy. At the conclusion of the conjoint interview each member of the couple was asked to complete a demographic questionnaire (Appendix H). Completion of the questionnaire at this point, insured that participants had already established a measure of trust and alliance with the researcher. Once the demographic questionnaires were completed the researcher answered any remaining questions expressed by the participants. A time and location was then arranged for the individual interviews.

The researcher met with participants individually approximately one to three weeks following the conjoint interview. The individual interviews were intended to
provide participants with an opportunity to elaborate on or modify information shared during the conjoint interview and also provide each individual participant an opportunity to share reflections on their experience with therapy that they may not have felt comfortable discussing in front of their partner.

The researcher asked participants during the initial conjoint interview if they were willing to engage in the data analysis phase of the research study. During the data analysis portion of the research process, once the initial analysis of transcripts was completed, themes were generated and organized into the participant reflection form (Appendix I). Couples who agreed to participate in this stage of the study were mailed a copy of this form and asked to provide written feedback regarding the fit between their experiences and the meaning structures extrapolated from the data by the researcher. Six of the eight participant reflection forms were returned.

*Data Analysis*

Transcripts of participant interviews were completed throughout the interview process. Initial interview transcripts were reviewed by the primary researcher and her dissertation chair to assess for completeness and appropriateness of the interview guides. It was agreed that the interview guides were appropriate and that no additions or substitutions were needed.

Once the interview transcripts were completed, the researcher began a process of inductive analysis. Data analysis was completed following the format outlined by Moustakas (1994) for phenomenological studies. The first step in this process was horizontalization of the data in which transcripts were carefully reviewed and statements that expressed participants’ lived experience with the phenomenon, in this case conjoint
therapy, were identified and listed in a non-hierarchical manner with each statement being regarded as equally important. These statements were then organized into meaningful clusters or groups and repetitive or irrelevant information was eliminated. During the third step in the data analysis process the researcher reflected on these “meaningful clusters”. The intention was to consider a variety of perspectives on the data or ways of understanding conceptualizations or themes which organized the potential structure of the meaning participants assign to the phenomenon of conjoint therapy.

The meaningful clusters were then summarized, put into a chart format (Appendix I) and mailed (using certified and registered mail to ensure confidentiality) to participants for their reflection. Once themes were extrapolated from the clusters of information an overall description and integration of the constructs identified were generated conveying the “essence” of the lived experience shared by CSA survivors and their partners. In making decisions regarding the creation of codes or themes, each code must have been demonstrated by at least a 55% majority of the participants in order to be considered a theme. The caveat to this is that a particular concept may have been present in only 55% of the survivors or 55% of the partners if the concept was limited to one or the other demographic. The results of this data analysis will be described in detail in chapters four of this dissertation and the implications of the data will be discussed in chapter five.

Presentation of Data

Throughout this text quotes and excerpts from participant narratives were provided. In order to increase the efficiency of locating each excerpt, references to participant transcripts have been included. Each reference begins with a number indicating the order in which the participant was interviewed. A letter then identifies
whether the narrative was generated during the conjoint interview (J), the survivor only interview (S), or the partner only interview (P). Finally, a page number refers readers to the specific page in the participant transcript where the quotation can be found.

Validity Measures

Lincoln and Guba (1985) outlined the importance of qualitative researchers providing evidence that their studies are trustworthy. The core components of trustworthiness (i.e. credibility, transferability, dependability, and confirmability) are intended to provide readers with some measure for evaluating the truthfulness and congruence of the data provided and the conclusions offered. Within this study several elements were incorporated that were intended to demonstrate trustworthiness in the results.

Triangulation

In addition to the in-depth interviews a participant demographic questionnaire was utilized to supplement the interview data and provide a texture that will enable others to assess the applicability of this information to their own context. Triangulation of researchers was incorporated by having the primary researcher’s dissertation chair and the methods specialist review the raw data and the identified themes for appropriateness and thoroughness.

Member Checks

Once initial themes were identified and reviewed by committee members for appropriateness, these themes were organized into the participant reflections form (Appendix H). The reflection form was then mailed to participants who were asked to review the initial themes and provide feedback regarding the quality of fit with their
experiences. In accordance with the phenomenological assumption that meaning is subjective, soliciting feedback from the “experts” regarding the appropriateness of the meanings made from their words was integral to providing authenticity and credibility.

*Peer Debriefing*

The sensitivity and emotional intensity inherent in any study examining childhood sexual abuse calls for particular attention to be paid to the empathic neutrality (Patton, 2002) of the researcher. Empathic neutrality suggests maintaining a middle ground between becoming too involved in the data and being engulfed or moving too far away from the data and losing touch with the meaning (Patton, 2002). Debriefing sessions with the committee chair were used to assist the researcher in maintaining a solid connection with the data without becoming overwhelmed.

*Risks, Benefits, and Ethics*

*Risks to Participants*

Childhood sexual abuse carries with it a stigma. Survivors and their partners are often concerned about how they will be perceived by others who find out about their struggles with CSA (Jehu, 1988). Given the very sensitive nature of the childhood sexual abuse and its impact on both survivors and their partners, participants may have been concerned that they could be identified by their stories. In order to address this concern, therapist intermediaries were used to ensure that only willing participants who responded to the information in the participant packets were directly contacted by the researcher. In addition, participants were assured that all references to specific individual names would be excluded from the interview transcripts and that all voice recording would be erased at the conclusion of the study.
The intent of qualitative inquiry is to gather rich, detailed accounts of the participants’ experiences with as much thick description as possible. Although the focus of this study was on the therapeutic experience and not the actual abuse experienced by survivors, there was a risk that the intense nature of the subject may have created retraumatization for some survivors, partners, or to the relationship. The recovery process was likely challenging and at times painful, scary, and traumatic for both members of the couple. Although none of the participants reacted negatively to the interview process, being asked to reflect on their therapeutic journey could have raised old and emotionally wrenching memories for the participants creating emotional distress. In order to address this possibility, participants were provided with referral information at the time of the conjoint interview. They were given a list of therapists and phone numbers that they could have utilized in order to reinitiate therapy if necessary. None of the participants experienced active or distressing thoughts of self harm or harm to another person during the research process and none of the participants requested to stop the interviews.

The last potential risk to participants was inherent to the design being utilized in this study. As both partners were commenting on their perceptions of their relationship experiences, it was possible that disagreements and even conflict may have erupted between the couple. This did not happen during the interview process, but participants were encouraged to utilize the referral information in order to locate a therapist if they needed to in the future.

Benefits to Participants

One of the long-term consequences of surviving CSA are the feelings of being unable to control one’s self and environment (Trepper & Barrett, 1989). Survivors who
participate in recovery groups, advocacy programs, and other proactive experiences often feel like they are finally in control and are empowered (Courtois, 1988). Instead of blindly reacting to the emotional trauma of abuse, they are able to use their experiences in order to help others who have experienced similar realities. Over the course of this research, the researcher emphasized the value of this study to providing better services to CSA survivors and their partners. Participants were viewed as collaborators throughout the process and some expressed feeling empowered by being given an opportunity to share their expertise and contributing to the improved efficacy of CSA treatment efforts.

Another consequence for both CSA survivors and their partners involves feelings of isolation and of being “the only one” (Bass & Davis, 1988) who has experienced such a devastating event. Occasionally when survivors share their experience with an outsider they are met with disbelief and questioning (Davis, 1991). Partners who are struggling to deal with the traumatic impact of CSA on the survivor and on their relationship are often reluctant to share their pain and appear weak or somehow dysfunctional (Davis, 1991). By participating in a qualitative inquiry process, participants were able to tell their stories in depth and have the impact and importance of those stories validated and reinforced. Therefore, one benefit was the potential for healing created through participants sharing their healing experiences and having those experiences valued by the researcher.

Finally, participant couples expressed that reexperiencing their therapeutic journey reinforced their bond and strengthened their connection. Couples who work through difficult tasks can experience a emotional high that comes from relying on one another and learning to trust in the support and acceptance of their partner (Johnson,
2002). As participants told their stories, the love and trust that developed through their healing was hopefully relived and thereby fortified.

*Ethical Issues*

One of the risks identified in the previous section centered on the sensitivity of the subject matter being investigated in this study. Individuals and their partners who suffer the ramifications of surviving childhood sexual abuse may find that reliving their therapeutic experiences is traumatic (Johnson, 2002). In this instance, the researcher is also a counselor. This combination created a potentially challenging ethical dilemma. The very process of sharing their stories was hopefully therapeutic for the participants. However, a clear boundary needed to be drawn around the researcher so that participants were clearly aware from the outset of the study that the researcher was not able to provide therapeutic intervention. In order to compensate for this potential difficulty, the researcher directly discussed the limitations of her involvement with the participants as part of the informed consent procedure that took place prior to the interviews. The referral list was also cited as the resource for participants if they felt they need to receive services beyond the scope of the researcher.

The fact that this was qualitative study dealing with an emotionally and politically sensitive topic, created an on-going ethical challenge. Necessarily, the researcher made subjective decisions throughout the study. Several steps were included in this study in order to create as reliable and valid a study as possible. The committee chairperson was involved in every step of the decision making process and agreement was obtained between the chairperson and the researcher prior to proceeding through each phase of the study. Finally, participants were asked to review and assess themes for appropriateness
and fit. Inclusion of these safeguards into the research design help to create adequate validity and trustworthiness.
CHAPTER IV

RESULTS

In phenomenological research the purpose is to understand the fundamental essence of a particular lived experience. Moustakas (1994) frames it as “a complete description is given of its essential constituents, variations of perceptions, thoughts, feelings, sounds, colors, and shapes” (p. 34). In this study, the experience of interest encompasses childhood sexual abuse (CSA) survivor’s and their partner’s involvement in various forms of therapy intended to address abuse recovery and relationship issues. Participants have all engaged in a shared experience, but the texture of the phenomenon is defined by the individual differences inherent in the therapeutic journey and the couples themselves. Analysis of the in-depth interviews conducted with the four participant couples revealed similarities which testify to broad strokes of shared meaning being generated throughout the participants’ therapeutic journey. In this chapter three transformative dimensions of experience (a) trust, (b) communication, and (c) boundary setting, and one facilitative dimension of experience (d) therapeutic fit will be discussed as the primary essences of the lived experiences of participants.

Transformative dimensions classify the ways in which participants experienced intrapsychic and interpersonal change. Upon reflection, survivors and partners conveyed portraits of change rich with both internal and external developmental shifts. These shifts changed their experience of self and other. Barb eloquently and emotionally described
this shift. “When all of this really comes out. What am I going to be like. You know, because…because, the whole thing is you’re going to change. And you’re going to be a different person” (3, J, p. 2). Clearly conveyed throughout survivor and partner narratives was the idea that therapeutic experiences changed the ways in which they perceived every aspect of themselves, their partners, and their world. The process was challenging and setbacks were common, however, each participant identified pieces of themselves and their relationships, which were irreversibly transformed.

The transformative dimension of trust is multilayered. Difficulty with trust has long been recognized as one of the primary long-term repercussions for survivors of childhood sexual abuse (Bacon & Lein, 1996; Johnson, 1989; Serafin, 1996). The issue of trust is also much more complex than a simple struggle to have faith or confidence in others. For CSA survivors, trust encompasses the fundamental belief in the worth or value of oneself and having faith in one’s ability and right to have and express needs, desires, and limits. Participant survivors expressed not trusting their own bodies and emotional reactions and questioned whether their partner would find them worthwhile enough to endure the challenging behaviors sometimes manifested as a response to early trauma. In addition, survivors questioned their value as partners in the relationship and their general worth as people. The difficulty in trusting themselves only exacerbated the problem many survivors had with trusting those around them.

Survivors experienced transformation in their understanding of themselves as worthy human beings capable of trusting in their own intrinsic value and ability to successfully traverse the challenges of life. For participant survivors, this transformation did not take place in a vacuum, but rather was incubated in a loving and supportive
environment shared with caring partners. Participant partners expressed having their own self-doubts as they attempted to understand survivors and their changing relationships. They questioned their ability to provide for the survivors’ needs in appropriate ways and to not inflict further pain. As reflected in participant narratives, partners experienced an increase in self-confidence over the course of therapy. They developed a new sense of self in their own right and within the context of their intimate relationships.

The transformative dimension of trust incorporates intrapsychic change in the self-perceptions of both survivors and partners as well as significant change in interpersonal trust and understanding. Participant couples described interacting in new and more satisfying ways following their involvement in couples therapy. They created a picture of themselves as teams working together to make their relationships fulfilling and enjoyable for each other. Not that the couples did not experience challenging times and obstacles, however, the trusting bond forged over the course of therapy reinforced their belief in themselves, in the genuine allegiance of their partner, and in their joint ability to work through challenges and emerge still united in trust.

The transformation in trust experienced by individual participants and each couple as a unit was facilitated by nurturing therapists. A core construct conveyed by participants was the need to establish a trusting relationship with a therapist perceived as effective, caring, invested, supportive, and ultimately trustworthy. This was consistently echoed in participant narratives as both survivors and partners alike urged other survivors and partners to continue searching for a counseling professional until they find one that feels like a good “fit”.

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The transformative dimension of communication soundly rests on the foundation of trust. The exchange of beliefs, feelings, and expressions of connection are necessarily influenced and correlated with the fluidity of trust between partners. Most participants, particularly survivors, expressed sharing a long history of poor communication patterns stemming back to their family of origin. As substantiated in the literature (Alexander, 2003; Bass & Davis, 1988; Follette, 1991; Wiersma, 2003) poor communication skills utilized by CSA survivors often become significant obstacles in newly formed, and even more established intimate relationships. Survivors experience difficulty validating and therefore expressing their own wants and needs and partners often struggle with their own ineffective communication skills further hampering the connective process of interaction within the couple.

Participant couples consistently conveyed the perception that poor communication was a core issue in their relationship and multiple couples sought therapy initially to address this concern. Each of the couples shared the belief that the transformation in their communication was key to the recovery of the survivor and vital to the health of their relationship. They spoke of actually becoming role models who positively influenced the interactional patterns within both the survivor’s and partner’s family of origin. Participant couples identified changes within their own communicative behaviors and within their shared exchanges as profoundly beneficial.

According to participant narratives, therapists played a key role in facilitating improved patterns of connection and information exchange between the partners. In session, therapists often acted as “mediators” or “filters” who initially translated for the partners and elucidated maladaptive patterns of interaction which supported symptoms,
hindered effective problem solving, and prevented emotional connection. As participants traversed the healing process therapists provided scaffolding by which the couples gradually tested out and came to trust their emergent skills.

Boundary setting is the third transformative dimension and integrates dimensions of trust and communication. Survivors, more so than their partners, described difficulty in identifying and asserting their needs, consistently denying their own desires in order to care for those around them or fulfill the often unrealistic expectations of others. These survivor narratives substantiated previous research which found that sexually abused children were denied the opportunity to set boundaries (Elliott & Briere, 1995) and were not afforded protection and safety within their family (Nadelson & Polansky, 1991). This leads to adult survivors who feel insecure in setting limits and who are hypervigilant about the needs of others to the exclusion of their own (Hughes, 1994). Partners, however, were also challenged by the survivor’s difficulty in setting limits. Similar to the partners studied by Bacon and Lein (1996) partners in the current study expressed fear that they would somehow unknowingly cross survivors’ boundary of comfort and then experience guilt and shame for behaving in ways they perceived as mirroring that of the perpetrator. Developing the ability to effectively set boundaries was a transformative experience for both survivors and partners. Partners also described significant positive affect related to their ability to better understand the limits of survivors and their ability to be supportive as survivors established effective boundaries within their family of origin.

Participants consistently described therapeutic contexts in which therapists role modeled effective boundary setting and empowered participants to establish their own
limits even within the therapeutic relationship. Having their feelings respected with regard to the structure and pace of therapy was meaningful to survivors who may have experienced limited power and control over their lives in the past. Partners expressed strongly the importance of being “invited” into the therapeutic process as opposed to being “required” to attend. Additionally, the maintenance of equality between therapist and clients was cited as critical to the success of treatment. Each of these therapeutic structures was experienced as instrumental in reinforcing participants’ ability and right to identify their own needs, express those needs, and expect others to respect their boundaries.

Clearly each of the transformative dimensions was generated from multiple interactions and contextual variables. Given that therapy often took place over the course of years, participants experienced a variety of different therapeutic milieus and multiple developmental and psychosocial changes. Analysis of participant narratives revealed, however, that one of the most pertinent and meaningful change mechanisms centered on the “fit” between the therapist and the participant couples. Multiple factors related to therapist interactions have already been introduced, but in addition, participants described the power of working with a therapist with whom each of the partners could generate trust, share similar communication styles, and feel “comfortable”. Participants described both positive and negative therapeutic experiences and asserted strongly that a good fit with a therapist was one of the strongest predictors of treatment success.

Although many therapist characteristics and process structures were identified as potentially influential to this therapist-client fit, several meaningful clusters of ideas were identified. Participants expressed feeling a positive emotional connection with their
therapists. This was strongly connected with the therapist acting as an advocate for the couple and providing a consistently supportive stance regarding the individual’s and couple’s capacity for change and successful healing. In addition, therapists with whom participants experienced a strong connection treated each individual couple as a unique entity. These therapists remained open to trying out new ideas and encouraged participants to try interventions without forcing their own belief structure or trying to make participant couples fit some preconceived model of treatment. It is clear that participant transformation, both intrapsychic and interpersonal, was strongly influenced by the therapist-client connection.

Dimensions

One of the fundamental truths shared by all participants in this study was the awareness that they were transformed in a meaningful way by the experience of dealing therapeutically with childhood sexual abuse issues in the context of a monogamous relationship. Each participant acknowledged in some way that they as an individual had changed and that their relationship with their partner was also different. For survivors, their relationships with their family of origin underwent a significant modification by the conclusion of the therapeutic experience. Most expressed the belief that these transformations either could not have taken place without the couples counseling experience or at the very least would have been incomplete. The three transformative dimensions of experience (a) trust, (b) communication, (c) boundary setting, and one facilitative dimension of experience (d) therapeutic fit will be further explored.
Transformative Dimension: Trust

“Individual counseling was a must...”.

The transformative dimension of trust was the most fundamental, if somewhat intangible structure within participant narratives. Some participants directly expressed how difficult it was for them to consider talking about their abuse. When asked about initially considering entering into therapy, Barb stated “I was afraid to talk about it. It was very frightening” (3, J, p. 2). Furthermore, she reflected the multitude of fears and questions that can overwhelm survivors considering therapy.

Barb - I was behaving like I had never behaved before. Sad. Depressed. Probably yelled at Charles in front of the kids. And I have never…Never, ever done anything like that before. We were just lucky that way, you know. And I was…I was frightened. Well, I thought, you know, what in the world is going to happen? I mean…in the end is he really still going to love me? You know, when all of this really comes out. What am I going to be like?

(3, J, p. 2)

As Jehu (1988) discussed, survivors often feel intense fear and worry that they may be shamed by others who hear their stories or be judged and rejected. Overcoming the fear of being shamed and reestablishing trust in oneself and one’s self-worth can be particularly difficult for CSA survivors who have learned to distrust themselves and everyone around them (Bass & Davis 1988; Zupancic & Kreidler, 1998). Though participant couples indicated that establishing trust within the relationship was important, most agreed that as a survivor you need “your own listening and your own time” (Jamie, 2, J, p. 10) within individual counseling in order to work through your “personal issues”. Participant survivors strongly asserted that there were benefits to establishing a trusting relationship with an individual therapist who was trained to understand their experiences and who could provide a “practice arena” within which to try out conversations they
wanted to have with their spouses. When asked about her experience with individual
counseling, Jamie reported

Jaime - Well, individual counseling was a must. So, I would never see couples
counseling only. I think that’s a must. And I liked the fact that we worked on
personal issues that… not necessarily you wanted to share with your spouse, but
your counselor would help you work out issues with your spouse. And then if
came into something that you both needed to work on it …it made sense to do the
couples counseling.

(2, S, p. 1)

In a further exchange with Jamie and her husband Chris, they discussed the potential
need for individual counseling to be included throughout the therapeutic process even if
couples counseling is on-going.

Chris – And I think also in couples therapy … you reach a point where it’s
something very sensitive and something that’s hard to get out. And if it’s the first
time … you may not mention it because your spouse is there. You might need
some individual coaxing to get that out. And I feel as though there were things she
might have never have brought out if the two of us had been sitting there together
and you for the first time started to talk about this and you hadn’t talked about it,
ever before. I think you would have been more reserved.
Jaime – Ahh, I don’t…
Chris – There were times when you went individually and then like you
said…ahhh, he said, “have Chris come back in”.
Jaime – Mm hmm. Right
Chris – Now you were ready to talk about it. Because you’d made sense of it and
got it straightened out.
Jaime – Mm hmm.
Chris – And I found that helpful.
Jaime – And sometimes I even had a practiced….pre-written script so I made sure
I covered certain things.
Chris – Mm hmm
Jaime – But then when I said it or whatever I didn’t miss anything and didn’t feel
like I had my little school teacher mom saying “line two don’t forget”.

(2, J, p. 10)

“Group counseling really solidified...”.

In addition to supporting the need for individual therapy, several of the
participants advocated for survivors to participate in group therapy. As mentioned earlier,
a pervasive long-term consequence of childhood sexual abuse is an internalized and toxic shame (Zupancic & Kreidler, 1998). Shame and trust are intrinsically intertwined as survivors cannot experience trust in themselves and in their self-worth if they are defining themselves as shameful and somehow deserving of punishment or rejection. Although individual counseling provides survivors with one unconditionally accepting relationship, it is significantly more empowering if one learns to trust peers enough to risk becoming vulnerable (Courtois, 1988; Sgroi, 1988). As can be seen in the following excerpts, participants agreed with the power of group therapy to rebuild their sense of normalcy and self-acceptance.

Researcher – What impact do you feel your individual and your group experiences had on your relationship?
Claire – Uhm, I’m not sure I could have had a good marriage if I hadn’t gone through that…
Researcher – The individual and group?
Claire – Individual especially. I could have gone without the group, but it was very beneficial. To see what other women looked like. And, how did they handle it. How did they hide their secret. And it made me feel so much more normal and connected. Oh yeah, I can’t imagine trying to communicate with James having to hide this big secret that I haven’t dealt with. I can’t even imagine.

(1, S, p. 1)

Jamie - The group therapy was … (sighs) …really great for triggering things that even you and your counselor never got to. So, even though I probably went through all the recovery stages and the whole…that…that book for sexual abuse…
Researcher – The Courage to Heal?
Jamie – Thank you, thank you…Even though I went through the Courage to Heal in individual counseling and really felt kind of whole about all levels and trying different things. The group counseling really solidified that stuff. And I think it really took away the huge shame piece.
Researcher – Hmmm
Jamie - I don’t think without the…meeting other women that the shame element would have just disappeared.

(2, S, p. 1)

Barb – And less and less as I went to group. And I think the one thing…an advantage to both was that…umm… Charles didn’t want to hear about it all the
time. It’s something like… you know…he was very good, but it’s not like …how can I say it…it’s like not…let’s not make this …the whole…our whole existence. Barb – Okay, It’s just a part of it. And group helped. Don’t you think? Charles – Absolutely. I preferred you go. I think she connected with a number of the people there and I think it helped. It helped to have…other people who had been there….who had had similar experiences to her. They could talk about things... there with each other. And from my standpoint, that was fine by me….that … there….frankly there were things that I didn’t want to hear. I was very angry about things …the whole … everything that happened… she didn’t need that. They could understand her. I could feel for her, but I couldn’t completely understand. Barb – I think that was a very good thing. I think it was a good thing that I could say certain things and he didn’t have to be a part of that.

“I think there would have been a little bit of a trust problem...”.

Each of the survivors who had experienced group counseling advocated for its inclusion in the treatment protocol for childhood sexual abuse recovery (Stacy did not have a group experience), however, several participants expressed concern that only participating in individual and/or group could potentially create trust concerns within their marriage or primary relationship. The concept of “keeping secrets” from their partner and its potentially destructive power was expressed by several survivors.

Jaime - I would worry that they (partners) would start feeling excluded too much. From what’s going on in the woman’s life with the counselor. And still another set of secrets going on. I mean they already have this person who kept this huge horrible secret or whatever. So now we add therapy and all that’s going on there to a whole new pot of brew. I think it would create dissension in the marriage rather quickly.

(2, J, p. 10)

Stacy – And I think there would have been a little bit of a trust problem. Like problems with us keeping secrets from one another. Nicole – Right. Like probably…not that I’m a very untrusting person…like I trust Stacy with my life. But at that point in time there were a lot of issues we had with trust with each other. And…so yeah…I may have thought… “why is she not wanting me to be there” Or… Stacy – What is she saying she’s not talking to me about
Nicole – Right. What am I doing wrong that’s probably all they’re talking about kind of thing. So, I think that in her particular situation that individual counseling might not have been the best.

Nicole – Individual might help the survivor herself, but it won’t help the partner and it might cause a strain on the relationship.
Researcher – Okay. And again you think it may cause a strain because they’d be wondering about secrets or what?
Stacy – They’d be wondering about secrets, they don’t know what the other person is going through… I know sometimes I came back from counseling and I was crying. And she was there so she knows why I’m crying and she can give me my time and understand and I think if I was in individual and I came home crying, she’d start freaking out and “I don’t want you to go back. I don’t want you coming home crying all the time.” “What’s going on”. Wondering what’s going on in my head.

Claire and James more subtly expressed a concern that many partners may have if he or she was not involved in the therapeutic process.

Claire – James used to joke, I mean, I’d come home from therapy and he’d say… “did she tell you to leave me? Are you divorcing me?” And we’d joke about it and I’d be like “yeah, pack your bags”.

The words of these survivors and partners illustrated and substantiated the concept of “partner alienation” as it is discussed in the literature (Bacon & Lein, 1996; Reid et al., 1996). As demonstrated in participant narratives, partners and CSA survivors worried about the impact of partners perceiving that “secrets” were being kept from them when they were not included in the therapeutic process. Jamie’s expression directly supported concerns from the literature suggesting that CSA survivors’ realities are built upon shame and secrets. It also supported the assertion and individual and group counseling, which completely excludes partners, could reinforce the maintenance of secrets, the atmosphere of distrust, and ultimately undermine therapeutic efforts to reduce shame (Follette, 1991; Maltas, 1996; Reid, 1993).
“I couldn’t have asked for more supportive partner...”.

Though participant survivors consistently expressed that having their partners involved in the therapeutic process was helpful in reducing secrecy and increasing trust, they also shared concerns that their partners may leave or abandon them. Inherent in the transformative dimension of trust is survivors changing from fearing their partner will abandon them, like so many others have in the past, to feeling secure and safe in their relationship. Claire discussed her fear that her then fiancée would leave her while she was dealing with her abuse.

James – But I ...I do feel as though I was there though. I remember you going through it, you know, I wanted to at least know how you were doing.
Claire – yeah, I couldn’t have asked for more supportive partner at that time. Really. I kept waiting for you to bolt and you didn’t. And I had major abandonment issues. And I was right in the middle of all this therapy and pissed because my parents wouldn’t do anything to stop it. [Break] James – Yeah, I remember listening to it on the way back. And I got back...called you to say “Hey, I’m back” and say “hey, whatever” and that’s when you told me how mad you were at me.
Claire – Yeah, I was totally on the abandonment train. “You’re just like everybody else in my life.” So, that’s why I was so pissed. You know, looking back. (1, J, p. 15)

The feelings expressed by Claire directly support the findings of Follette (1991) who discusses the hypervigilance of survivors to potential abandonment, particularly by intimate partners. Follette proposed that incorporating conjoint therapy into CSA treatment protocols can enable survivors to overcome fears, learn to communicate effectively, and improve emotional connections. This proposal was supported by Claire as she went on to discuss her fear of trusting James in more detail and explored how James worked to increase her trust in him and support her throughout the process.
Claire – I’m like “you don’t need to know about this, get away, why are you interested? He pursued it. “I want to be there for you. I want to be supportive. I want to be helpful.” If anything…I was just…I was so afraid to trust him.

Because, I didn’t know we were going to get married and have kids. I mean, this is just some guy I was dating. …Uhhh, I had revealed to a boyfriend in college what my brother did to me. So James was the second guy I was with who I told. But, no, I discouraged it at first. I was just like “this is awful, I’m nauseated, I have insomnia, I have all these irrational fears that my brother is going to get in his truck and drive to Cincinnati. I didn’t want him to be part of it, but he he made it his business to be supportive and to be there. I think if I had been with someone else. Another guy who was like, you know, “you’re gonna have to deal with it on your own”. I would almost have expected that. And instead I got “no I’m not going away. I’m here. And this is important and I’m …ahh, let me help you. Yeah, he’s a good egg.

Claire’s narrative revealed how survivors may initially push their partners away when contemplating therapy covertly expressing their fear of being rejected or abandoned. When partners, like James, who are supportive are able to reassure survivors of their investment and concern the mutual healing process can be significantly helpful. It should be noted here, however, that all of the participant survivors were involved in relationships where their partners were supportive and understanding. As a profession we need to recognize that many childhood sexual abuse survivors are less likely to be involved with supportive partners (Follette et al., 1996). Clearly, when survivors are involved in abusive relationships, or relationships with non-supportive partners, conjoint therapy is inappropriate.

In loving relationships shared by couples similar to participants, however, partner involvement can be very powerful. Barb shared the personal transformational process that occurred when she and her husband discussed how he could become more involved in her therapy.

Barb - And because I was sort of frightened on how it would all end up I thought “wow, I don’t want to change so much that he’s not going to like me or want me
to be around. Or maybe the same thing. What if I change and I’m not interested in him anymore”. And by him showing a little interest in going...that was just ...like “oh, I don’t need to worry or think about that anymore”. Because whatever it is, we will deal with it and be fine. And that helped. When I didn’t have to worry about going to counseling anymore to think that it would interfere with home...then I could go and make progress on my own. That was a real nice thing. It was like you could set that aside. That’s not ...that was not any part of that

Researcher – Because he was part of that experience.

Barb – Because he was part of it. He knew what was going on. And realized that it was for the betterment. And then...then you’re not afraid of anything and you really can let it go. And it never...ever came up again. It really never...ever did I think about it again...after I settled it in my mind.

(3, J, p. 2)

As demonstrated in Barb’s narrative, and shared by other participant survivors, partner involvement enabled survivors to engage more fully in the therapeutic process with the security of knowing that their partner was supportive and involved. This result bears out the beliefs shared by survivors in Reid’s (1993) study. His participants, who had not experienced conjoint therapy, suggested that incorporating partners more fully into the recovery process would have greatly promoted the healing process and helped them improve their marital relationships. Husbands in Reid’s study passionately expressed feeling alienated from the survivor’s treatment, expressed feeling unfairly blamed, and felt some resentment for having the role of perpetrator projected on them throughout the therapeutic process. They vehemently expressed their need to be more a part of their wife’s therapy and learn how to improve communication and connection in their marital relationship. Partner’s in the current study experienced a different reality.

“The partner...has to be willing to be very patient...”.

The desire to be supportive of their spouse or partner was one of the strongest emotions expressed by all of the participant survivors in this current study. Particularly when asked about their advice for other partners, participants expressed their belief that
partners must find ways to be supportive of both the survivors and the therapeutic process.

James – Yeah right, A little bit. If you want…if you want a successful marriage, this is what needs to be done…and if…she says “don’t do this”, “Don’t wear this cologne”. Don’t…you know, you’ve gotta be able to say “Okay”.
Claire – And not take it personally

Claire – Yeah…you’d better hash it out
James – The guy, the man, the partner…has to be willing to be very patient. And do whatever it takes to work through.

James - But, to be supportive and know when to listen. Know when to… leave her be.

Chris – I guess, first and most would be to just believe ‘em. And secondly get involved to understand where they are coming from. Because, you …I’m talking to a male partner…you somehow are going to run into things that are gonna come left of center, hit you upside the head, and you’re not gonna know…you’re gonna be clueless to what just happened. And the more you participate, the more you are gonna understand what happened. And think it will literally…it can bring a couple closer together. Because couples go through things that no one else in the world knows about. And they have to have some kind of dynamic of believability between the two of them to face the rest of the world. And I think the more the partner can get involved the stronger it makes the relationship and even at times try your best to believe it, but if at times there are things that just seem unbelievable because you’re in counseling, because you’re communicating, you’re freer to admit that. And then, find some wisdom…how you do start to say “Oh God, I guess it really did happen”. Instead of just saying “I …I…I… don’t understand”.

Charles - And maybe you’ll size up…probably immediately whether or not their spouse or whatever wants them to be there…and thinks it’s beneficial for them as well…then they could support them and help them stick.

Nicole – As the partner of a survivor I would say to be very open and understanding. You have to feel and hear and know the needs of the survivor. Because that plays a very big role. You know. You have to show them that they can trust you and that you’re there to support them.
Researcher – Mm hmm
Nicole - Especially with counseling, you know, depending on how the person wants you to be involved. Because if they want you to be involved actively like Stacy and I were then you should do that. If they want you to just kind of be there to support them.

(4, J, p. 10)

Nicole – I saw that by me supporting Stacy and really giving my honest opinions in our counseling sessions that it helped Stacy to be more confident in herself. You know, by saying things that were true…you know like…she needs to be more comfortable with her body…things like that helped her to open up a little bit and to become more comfortable with herself. So, by seeing me just telling the truth and supporting Stacy and seeing the positive effect that had on her helped in so many ways. And just to know that by supporting somebody that that could change so much just made me feel great.

(4, P, p. 3)

Partners placed value on the power of their support, as expressed in these narratives. James commented on the importance of partner support to the health of his marriage, Chris highlighted that if partners are supportive then survivors are more likely to “stick” with therapy, and Nicole focused on the empowerment she provided Stacy as Stacy struggled to overcome her struggles with self-esteem. At the same time, Nicole illustrated the emotional reward that can be reaped by partners as they see changes in survivors.

“It wasn’t about me. It was about her…”

Follette (1991) discussed at length the concept of “benevolent blame” and cautioned therapists that partners may see themselves as rescuers whose only job it is to attend sessions and place the blame on the survivors for all of the relationship issues. This concern was not borne out in the majority of participant couples. Although, as illustrated in the above narratives, all of the partners felt it was their place to support the survivor’s recovery, they also expressed having changed themselves for the betterment of their relationship. Most also acknowledged their own participation in and responsibility for patterns of miscommunication and relationship conflict or turmoil. Only one participant,
Charles, strongly asserted that he did not have any “issues” or need to change, but simply participated in therapy at the request of his wife so that she could work on her issues.

Charles – My speaking with (therapist) was very limited. We did talk about the pressure I felt…briefly
Barb – Very briefly
Charles – And that helped Barb see a little bit…a bit about me…but I…it wasn’t about me. It was about her.
Barb – I don’t know that we talked much about Charles. I don’t know that they connected. I think it was pretty much geared towards me and Charles was there as my life support.

(3, J, p.3)

Barb – Can I ask you a question
Charles – Sure
Barb – Counselor number two…what was your first impression of that person? Do you remember?
Charles – It wasn’t positive.
Barb – It wasn’t?
Charles – No.
Barb – Did you tell me that at the time? When I was seeing him. That you did not like him.
Charles – No. It wasn’t a big deal. I didn’t feel like it had to do with me.

(3, J, p. 11)

Even with Charles’s reluctance to acknowledge having any need for therapy personally, he expressed feeling there were benefits to couples counseling for both of them

Barb - And I think that may have been a real transition problem. And I credit that to learning how to talk and share with each other. To share control and responsibility. So, is that…what do you think?
Charles – That matches with my sense of reality. I would agree that we had to learn how to share to some extent and … we always talked…some more than others (laughs)

(3, J, p. 8)

Charles - You know you are going to have communication problems. So maybe do the couples thing to smooth the edges off those issues that need to get resolved. Get those resolved. Maybe you need a professional to key in on some of those things that are still gnawing at you. Things that maybe never really came out in discussions between the two of you. Maybe you need some polishing.

(3, J, p. 9)
Charles was a relatively stoic individual and one of the most difficult participants to draw into conversation, however, as he created a conflicted portrait of his experiences with couples counseling, the emotional pain he felt was clear.

Researcher - Barb you had talked about growing and changing and becoming a different person. Do you [Charles] feel that you were able to sort of follow along with her and understand all these changes as she became a different person?
Charles – I had to. After the initial disclosure…which is actually a little fuzzy. Those are one of those things that are really hard to hear. It’s more the feeling that I have left about finding out. Feeling numb, then anger. It was like getting kicked in the groin.
Barb – Desperate.
Charles - I had a feel for the fact that …at that point…things were…she…things were going to change. It was a full stop. A reality check. She withdrew for awhile. Became really quiet. She had always been a go getter…high energy…fast paced, but things slowed down for awhile. Got quiet. Someone had to take care of the kids. Things definitely changed for awhile. We stopped talking...
Barb – Did you change?
Charles - Probably
Barb – Was it a burden? Probably…
Charles – It was a total reality check. Yeah, I changed. I’m sure I’m harder. Emotionally hardened…harsher…(inaudible). Although I guess you could argue that I was already hard (laughs)
Barb – No…no…you are still pretty soft. It was a hard time. Desperate time for both of us I would say. And as Charles said a reality check.

(3, J, p. 7)

Charles worked hard to support his wife, but he also worked hard at insulating himself from the pain of exploring the impact of CSA on his own sense of self. He did not directly blame his wife for the pain he experienced, however, he did not fully engage in the therapeutic process beyond what she asked of him. As long as his involvement was framed solely as him supporting her recovery and change, he could accept it. It was only in indirect ways that he acknowledged personal change in how he reacted emotionally or behaviorally.
Charles’s reaction richly illustrated the concept of trauma contagion (Maltas & Shay, 1995) that can occur when partners are vicariously exposed to the traumatic events of childhood sexual abuse. Partners often experience challenges to their prior assumptions about the survivor, their relationship, and the world around him; b) high levels of stress, activated by the survivor’s own chronic states of hyperarousal and reactivity, which can lead to various stress-related symptoms in the partner; and c) the partner’s (usually unconscious) role in the repetition and reenactment of traumatic aspects of the original abusive relationship. (p. 532)

In this case, Charles found it easier to disconnect from his own pain and focus on his wife’s recovery throughout the treatment process. He was willing to acknowledge the benefits of learning some basic communication techniques, which was relatively non-painful, but when asked to reflect on the emotional components of his wife’s recovery he generally expressed that “it wasn’t about me” and turned control of the conversation over to his wife. Though his pain was clearly expressed above, he focused almost entirely on how his wife’s emotional state was the issue of concern rather than any affective interaction between the couple.

The lengthy excerpts, incorporated above, illustrate the complex interactions that took place within participant couples. Partner support and benevolent blame are shades of the same color, however, even as Charles attempted to distance from the process he remained clearly focused on the love he felt for his wife and his dedication to supporting her. The other participant partners were more direct in acknowledging their own pain and need to embrace personal change as part of their relationship issues, but they remained focused on their role of that as supporter.
A theme which ran throughout the participant narratives expanded on the concept of partner support. As partners focused on supporting survivors and survivors experienced increasing levels of trust in the partners, a general context of teamwork and connection was generated within the couple. Johnson (2002) described this process as the creation of a “safe haven” or a “secure base” from within which both members of the couple can experience healing and generate new and more fulfilling models of self. Achieved by increasing the emotional connection of couples and diminishing the conflict and mutual isolation, this atmosphere of safety and trust was clearly reflected in the stories shared by participants.

Claire – I’m not sure if I’ve ever told you this, but it means so much that you’ve never made fun of me. Or you’ve never said. All I have to do is say “look, my brother used to do that to me”… and James is just like
James – I’m half sick with guilt…
Claire – He drops it.
James – I think “My God why…”
Claire - It’s not like “get over it. It’s been all these years.
James – Not like that, no.
Claire - I’m your husband. You know I wouldn’t hurt you. There’s a whole bunch of things he could say, but he doesn’t and I appreciate that. And it doesn’t happen very often. I mean…I don’t think it does.
James – Mm uhn (negative…agrees)
Claire – But when I say “Whoa, that’s something that (brother) used to do, James is like “whoa, gotcha, done”. And it’s done and I appreciate that.
James – So his reaction is very powerful and meaningful for you.
Claire – Right. I know…I’m like…immediately back in a safe place with him.
Researcher – And you said something interesting too. You said “I’m half sick with guilt”.
James – Yeah, I mean I wish I hadn’t…although there’s no way for me to know, but I wish I hadn’t made her feel that way.

(1, J, p. 12)

Jamie - There would have to be couples counseling for her too. I mean… I can’t even imagine getting through the communication of that horrible secret thing. If you don’t have that spouse there to take those risks with. I can’t even…I wouldn’t feel comfortable checking off done. I would feel like you would have to always
check off about a five. Because there’s a huge gap between really feeling safe. And I don’t know that you could do that without couples counseling.

(2, J, p. 9)

Charles - I mean, we talked about it. It was like a huge burden was lifted. It was like we had been married for years and .... It was like she had become someone else...not her. There were a lot...lots of emotions. It could have taken years. The fact that she had her therapist and that she had her ...the group...the other women was good. The fact that we talked about it was good. We were able to work through it and work through the emotions and get to where you want to be. I think her being...feeling comfortable talking to me helped ... communicating...it didn’t take years. We could just talk and .... She was making progress. The fact that she could identify the steps that she was taking and actively pursuing them. And I helped that.

(3, J, p. 4)

Stacy – But definitely take an inventory of everything that’s happened that’s painful because it’s something that needs to happen. Especially with me because I kept everything locked in. I didn’t want anyone to know what happened. I didn’t want to talk about it.

Nicole – That’s where the partner’s support comes in. Because for her to say “okay, I want to tell you all this stuff”...I went “okay”... “wow”...That was big to me. I mean it made me feel good in the fact that she was ready to open up and talk to me, but at the same time it was like “wow”.

(4, J, p. 11)

Reflected in the words of these participants’ were embedded feelings of pain and shame as well as intense feelings of connection, love, and nurturance. Survivors expressed their gratitude to partners for their support and love while partners expressed their love as well as their pride in being able to help the survivor. These eloquent words portray in rich detail the intensity of emotion shared by these couples and express the power inherent within the couple bond. Over the course of therapy participants each experienced a transformation in how they understood their partner and how they defined themselves within the context of that relationship.
“There’s the three of us out here in this dingy...”.

This transformation did not take place by happenstance. Participants consistently highlighted the importance of establishing trust not only with each other, but also with a supportive and nurturing therapist. Although a variety of therapist and therapeutic variables were identified as meaningful by participants, there was a more ambiguous overall expression of needing a good “fit” between the therapist and clients. Uniformly participant couples echoed Stacy’s feelings who said “I knew within the first five or ten minutes that I definitely wanted to stick with this one” (4, J, p. 13). An initial impression of feeling a connection and comfort with the therapist resounded throughout the participant narratives.

Jamie – I would say in that sense never. I would say truly we connected with our therapist though, as a person.
Chris – Mm hmm.
Jamie – Too, that helped.
Researcher – Good personality match.
Chris – Yeah
Jamie – Yeah
Researcher – Style at least.
Chris – Oh, very much so.
Jamie – Oh, tons
Chris – Yeah.

(2, J, p. 12)

Nicole - So, you kind of understand that everyone deals with things in their own way. And...but I think that ... you know, if you can find the right counselor to fit the needs of both people involved it’s a huge help.
Stacy - Or even if the survivor in the couple is comfortable with the person but the partner prefers someone else, they should go with who the survivor feels comfortable with. Because they have such issues with trust.
Researcher – Okay
Stacy – It matters that both people feel comfortable, but definitely if the survivor feels comfortable, just suck it up and go, because it is very hard for someone to feel really comfortable with a person.

(4, J, p. 10)
Throughout the remainder of this text the underlying structure of this connection will be explored further, however, with specific regards to establishing trust between the clients and therapists, participants clearly verbalized the need for therapists to be non-judgmental, supportive of clients and their relationships, and to act as advocates for clients. Claire and James were particularly focused on the comfort they felt in light of their therapist’s stance.

Claire – Okay, yeah, so it was like a parental figure who was rooting for us. “like you can do this, get through your first, these early years of marriage and…”
James – I hate to think where we would be if we had not…

(1, J, p. 4)

Researcher – I just want to clarify one of the other things I seem to hear is that there was really a proactive support for the marriage “You’ll get through this.” Really encouraging the marriage and strengthening the relationship
Claire – Yes
James – Yes
Claire – And similar to that. I don’t think I realized it at the time, but I sensed that and that gave me confidence that we’re going to be okay
James – Mm Hmm. Especially with her
Claire – She was like you two are going to be fine
James – Yeah

(1, J, p. 4)

Chris – Well, and I …I …what I liked about it…and I don’t know if there had been more information it would have been handled differently or not…but I always felt like … our therapist…he’d come across and I’d almost feel like…okay, there’s the three of us out here in this dingy and somehow we’ve got to find a way to get to shore…now how do you paddle with three people in a boat.

(2, J, p. 8)

The connections and relationships shared in these narratives illustrated that the establishment of comfort and trust between clients and therapists can be just if not more important than specific interventions in addressing the therapeutic needs of participants. Phelps, Friedlander, and Enns (1997) suggested that the “nonspecific aspects of the therapeutic relationship may be more important than is the therapist’s use of specific
techniques” (p. 328) and this was borne out in participant narratives. As Chris drew the picture for us, of him and his wife sharing a boat as fellow travelers with their therapist, we clearly saw the texture of their therapeutic relationship which inspired trust, teamwork, and compassion. Effective therapists were portrayed as individuals willing to advocate for, and connect with clients, in a way that inspired trust. Barb revealed a therapeutic intervention which built on the trusting bond between therapist and client. She described a group session during which an outside therapist came in and introduced the intervention of massage therapy.

**Barb** - But, it was odd at first with her touch. And... she brought in a massage table. She didn’t start out with massages because it was like “I don’t think it’s a good idea to start out like that with these women”. So you would just kind of be laying there relaxing and she would just ...she really just maybe initially just touched. You know “are you okay” and how much further should she go ...and some of them were like “that’s enough...that’s enough” and she was just barely touching. And then progressed to almost a full massage. Which was fine. **Researcher** – So she’d just start out touching your hand...

**Barb** – Yeah, and just talking. Yeah, just kind of talking. And faces. I remember faces and hands and heads I think initially just to try to get you to relax. Part of it also was to be able to relax more and then maybe you would open up more. The reactions were amazing. I learned as much from watching other women’s reactions. There was one woman who almost literally just jumped off the table and in the corner. And if there had been a door in that corner she would have been gone. **Researcher** –Mm Hmm

**Barb** - She would just kind of go over like she was getting rid of the bad spirits or... I don’t know. I don’t know what that was...But...things like that were very good. And the ones that had a difficult time...then one on one without the group they worked on touch therapy in his office.

(3, S, p. 2)

Inherent in this excerpt was the understanding that touch was an intervention through which survivors could learn to relax and develop trust by allowing a therapist to touch them. But it is also clear that for some this intervention was more successful when they were able to meet with their individual therapist with whom they had already established
a trusting bond. They returned to the safety of the familiar where they could allow themselves to be more vulnerable.

In addition to touch or massage therapy being used as an in-session intervention, it was also cited as an intervention used to increase the trust between participant couples.

Chris – Massage therapy.
Jamie – Yes, some of our assignments were to seek out pleasurable things we wanted to do. (laughs)
Chris – Yeah, but also you know, just … you know, I would rub your back or something.
Jamie – Oh yeah, we did do the massage therapy tapes.
Chris – Yeah, but not every … the way I interpreted it is so that not every touch was threatening. This was something that I wasn’t expecting anything in return. So there was all … all the different kind of senses played a part in it. He was very good at making that very well rounded.
Jamie – Oh yeah, and our weekend getaways. Away from our children…because it was homework. It wasn’t that you wanted to go. (laughs)

“What I did find helpful was the homework...”.

Homework, such as massage therapy and a multitude of other specific interventions, were commonly discussed as one of the primary factors that contributed to increasing the connection between the couple and facilitating the healing process.

Chris - What I did find helpful was the homework. If I had to list everything, I think doing the homework was the most impacting and it was the most positive thing. And then it would be the couples therapy, I think. But the homework. Because it made us sit down as a couple, and you didn’t have this middle man.

(2, P, p. 3)

Chris - I liked the homework. Sometimes it was books. Sometimes it was like. Just massage therapy you know. Other times it was just taking a walk. It was, you know, it was so varied. That I just found it all very good.

(2, P, p. 4)

Barb - The touch therapy was excellent. And… let’s see, what else did we do? We did … like studies ahead of time and we would all sit around… we knew what we had to discuss… Homework. Like homework. That worked well.

(3, S, p. 1)
Researcher – Do you think the counselor encouraged your partner to become more involved?
Stacy – Definitely. She’d have little … little things for the two of us to do.
Researcher – Okay.
Stacy – Like whether it was just go somewhere for a couples hours by ourselves no one else. Or talking…like setting aside time for the two of us to just talk. And even things like that now we do.
Researcher – Hmm.
Stacy – Like we make it a point to at least a couple times a week to go to the metro parks just the two of us or…you know…watch a movie together with no one else. Because we were taking in everyone else’s problems and it didn’t leave time for us. We were getting burned out on everything.
Stacy – Basically it was.

Participants were asked to engage in a variety of different activities between sessions, and encouraged to understand the therapeutic process as fluid rather than compartmentalized into weekly segments. Participants were encouraged to deepen trust in each other by spending time together, talking, touching, shutting out the world, and communicating. Each of these activities supported the continued growth and transformation of participants by decreasing their isolation and reinforcing their emotional connection.

Across participant narratives all of the survivors and partners portrayed themselves as different at the end of the therapeutic journey. Survivors of childhood sexual abuse often have their core sense of self destroyed or distorted and carry that misconstruction of self into their adult intimate relationships (Courtois, 1988; Johnson, 2002). They often lack a fundamental level of trust in themselves and in potential partners. As participants shared their experiences with counseling they clearly demonstrated a transformation in which they reestablished or strengthened their sense of self-worth and created an emotionally connected bond with their partners. This bond,
which was facilitated by nurturing and supportive therapists, allowed survivors to accept their emergent qualities of self and enabled partners to feel as though they were intimately involved as both the survivor and their relationship transformed into a new way of being.

*Transformative Dimension: Communication*

The involvement of survivors and partners in the transformation process was solidly rooted in the need to be able to relate to one another in an authentic and effective way. Communication problems were consistently identified as the primary factor undermining the trust and connection shared by participant couples. Most couples sought therapy not specifically to address childhood sexual abuse issues, but for similar reasons to Jamie who said “the whole thing started because I wasn’t being heard and you (partner – Chris) were misinterpreting things I was saying” (2, J, p. 3). Initially therapists tended to focus on helping couples identify their patterns of miscommunication and then helping them to identify individual and conjoint patterns which could be improved. As exchanges within the couples became more effective, participants described feeling better able to both express themselves and better able to understand the physical, emotional, and psychological reactions of their partners. In the following section, the transformative dimension of communication will be explored and the context of this change within the therapeutic process discussed.

“It’s not so much the sexual violation as it is a communication violation...”.

Communication difficulties have long been recognized as a pervasive problem for individuals who have experienced childhood sexual abuse (Johnson, 2002; Pistorello & Follette, 1998; Wiersma, 2003). Survivors often learn that to communicate their true
emotions or to discuss what is happening in their lives is to risk significant harm to themselves or to people they love. They learn to deny their own sense of reality and ignore personal needs rather than developing effective skills to convey their feelings, thoughts, and beliefs. Within intimate relationships survivors and partners often struggle to understand each other, share an authentic emotional connection, and joint problem solve (Follette, 1991). Jaime and Chris eloquently discussed how childhood sexual abuse affected the communication in their relationship.

Jaime – It’s not so much the sexual violation as it is a communication violation and you cannot learn to communicate with other human beings that you ultimately distrusted. If part of the healing process isn’t ultimately communicating with those same human beings. Chances are the closest person to you is going to be your spouse. So, if you weren't communicating with them before you remembered there is no way you are going to improve that communication if they’re not part of the process. I just…

Chris – Well…and the opposite is true to…in…maybe not the opposite… from the spouses point of view you could literally go from someone who doesn’t communicate their feelings or shares them like a trickle to all of the sudden the damn breaks. All of the sudden you’ve got this person who just is sharing everything, where they didn’t share anything before. And that’s just as much a shock or something you have to get used to. And I think it’s…As long as the therapist approaches it with that kind of attitude…that it affects both persons…

(2, J, pp. 12-13)

Communication is a fundamental issue in all couples. But, as Jamie and Chris discussed, for couples dealing with the effects of childhood sexual abuse, communication is fraught with difficult challenges that involve both the survivor and the partner (Wiersma, 2003). Particular to the couple dealing with CSA is the phenomenon discussed by Jamie, whereby survivors initially express very little of their feelings and beliefs, but during the course of therapy begin to exponentially increase their level of expression. This substantiates previous research indicating that the most challenging period in survivors’ relationships coincides with survivors beginning to explore their abuse history.
and assert their wants and needs more strongly (Bacon & Lein, 1996; Reid, 1993). Partners who are not involved in the therapeutic process will most likely have difficulty understanding the dramatic changes survivors undergo and find the experience alienating and disconcerting. When partners are involved they can actively engage in the change process and remain invested in the relationship (Follette, 1991; Johnson, 2002).

“But to hear it from her he would accept it...”.

Engaging both members of the couple in the change process often starts by facilitating insight into the currently ineffective patterns of communication. Participant couples consistently painted a picture of communication problems that ranged from simply not being able to effectively hear each other to intense fear of expressing personal needs. Claire and James shared how humor helped them to identify behaviors that were preventing them from being able to hear one another.

Claire - Yeah. It was fun to hear her nail James. It was very fun because she would say things and I’m like “Yes! I’ve been saying this.” But to hear it from her he would accept it. And I am sure she nailed me too. I’m sure she did. That wasn’t as fun (laughter).
Researcher - When you say that she nailed him, what do you mean by that?
Claire - An insight into him like patterns of behavior...and, you know, responses to things that might be ...
James – Not in a bad way
Claire – No, no, no, not in a bad way

(1, J, p. 3)

Claire - You know, she would say something, and then James would say something, and then she would come back. It was like chess because she would come back with a move and just kind of look at him. And then... she read both of us very well.
James – Yeah, I think we were just both very open and she probably got a very good read as to who we were.
Researcher - But it seems like to she challenged you on some things, on patterns
James – Yeah, she didn’t let us answer with a simple yes or no.
Claire - That’s a better word than nailed. She challenged
Researcher – When you mentioned insight too you said that she may have highlighted a pattern of behavior and it was like “oh, yeah, we do that” kind of insight. That “Aha” moment
Claire – Definitely. Yeah
James – Mm hmmm (agrees)
Claire - And it was done in such a way that it was very palatable. You know she
James – No she never …there were never hurt feelings. She was able to make each of us laugh at ourselves, by realizing “Gosh, I do that”
Claire – Yeah (agrees). And maybe things would be better if I did it in another way
James – Yeah
Claire – Yeah, she was real good with that.

(1, J, p. 3)

On the other hand, learning to communicate with Chris was extremely painful for Jaime.

Jamie - There was a period where I literally had so much difficulty expressing my own personal desires. I was in such fear of doing that. For fear it would destroy or upset the relationship. That literally we had sessions for me to just practice saying what I wanted to do with my life. That was so complicated for me. And some of it was the fact that the counselor knew darn well that I wasn’t married to this mean ogre who wouldn’t …hurt me. It was to really support me to realize this person’s not going to pounce on me. Emotionally or otherwise. And just. I must have felt like a little child or something. That was below or not equal to him that I was so fearful of saying things. So, it was more about … giving me that support. And I couldn’t obviously do it at home on my own. And I think that part was helpful.

(2, S, p. 5)

Most partners experienced basic patterns of miscommunication, which therapists helped dismantle, or the couple had difficulty learning to talk to one another in a way that they could be heard.

Stacy – Just basically saying…you know…wake up kind of thing. That was really really helpful to both of us. .
Nicole – And I think for me too was that I wasn’t always able to get my point or my feelings across to Stacy in a good way. And it was able to help so that she didn’t always just hear it from me. She heard it from the counselor too.
Stacy – Our counselor was our filter. We would both say something, but neither of us could hear what the other was saying because we were so passionate about what we felt. And talking to someone else like okay this is what she just said and this is what she just said. And a lot of times it came up that we were saying the same things just in different ways.

(4, J, p. 1)
Barb - And I think that may have been a real transition problem. And I credit that to learning how to talk and share with each other. To share control and responsibility. So, is that…what do you think?  
Charles – That matches with my sense of reality. I would agree that we had to learn how to share to some extent and … we always talked…some more than others (laughs)  
Barb – (laughs)  
Charles – But we learned to talk and Barb let go of some of the reigns.  

(3, J, p. 8)

As participant narratives illustrated, couples shared the challenge of learning to express themselves effectively with each other. With varying degrees of difficulty participants slowly began to transform how they engaged with one another. In Jamie’s narrative we see that trust and communication were intimately intertwined and dependent upon one another. Communication facilitated increasing trust and as survivors learned to place more trust in their partners they felt comfortable with increased vulnerability. Trust was not automatically granted to the partners, but rather partners garnered increased trust by better understanding the survivor’s perspective and validating their feelings.

This pattern of increasing trust, vulnerability, validation, and affective interaction are at the core of the emotionally focused model of conjoint trauma treatment proposed by Johnson (2002). All the narratives revealed the gradual process by which couples softened and learned to trust and validate each another. The trust and validation form the basis of a relationship characterized as being a “safe haven”. It is from the safety of this intimate relationship that survivors can heal and recreate a new sense of self. Johnson specifically stated “success in helping the survivor recast his or her intrapsychic world depends on the creation of new interpersonal connections” (p. 31). Partners can be more securely connected with the survivor and experience a new, and hopefully more enjoyable and fulfilling, relationship. That was certainly the case with the participants in
this study. Participants clearly portrayed the benefits of conjoint therapy proposed by Johnson.

“It freed me up to say to him don’t do that...”.

Participants’ shared experience often required them to deal with facets of the survivor’s abuse which were still very much a part of the couple’s relationship. Participant survivors described having posttraumatic reactions to benign partner behaviors and through counseling learned to directly share what was happening. In the following exchange Claire and James illustrated the freedom and empowerment that were discovered when they were able to openly and directly discuss Claire’s reaction to James.

Claire – I started having flashbacks and dreams and all this stuff was coming up. And boy, all these memories were coming back that I’d never had before. And I knew they were real, but I just couldn’t understand, you know, well, where have they been all this time. Why didn’t I have them yesterday? Why are they here today? And that was hard and it did affect us. I’d get right in the middle of sex. I would get just waves of nausea. I’d be like “I gotta stop, I’m gonna vomit”. James – (Laughing) Wow, what the Hell did I do? Claire - (Laughing) I’m just like, No, I gotta stop I’m sick. I am physically sick. I can’t do this anymore. And, I didn’t know why. I didn’t know what was going on. You were very patient and very understanding. But Yeah. Before we go into the couples therapy and started addressing it. It was definitely affecting us.

Claire – It freed me up to say to him don’t do that, my brother did that and it really pisses me off. Because once it was all out in the open I could say to him “look, I know that in any other woman, in any other situation, this would be a completely benign kind of gesture…but to me… James – Mm hmm Claire – It just lights me up. It pisses me off. James – And if you didn’t. If I wasn’t aware...of what... why you felt that way...or aware of what had happened in the past. My God I think Claire – You’d go nuts. James - But now I know you’re free to say to me. Don’t do that...because...you know... Claire – It brings up all that old stuff and I immediately am …you know James - Yeah. I still Claire – I still feel seven years old…powerless James – I still do things that I don’t realize
Claire – How could you…How can you know unless I tell you? And I do and you stop…and

(1, J, pp. 9-10)

Jaime echoed the importance of survivors being able to directly communicate with their partners, particularly with regards to sexuality in the context of physical and psychological traumatic reactions.

Jamie – I don’t know how you recover somebody whose been sexually abused whose sexual awareness was destroyed probably from early childhood. And reform that in any healthy manner without involving the partner or spouse. Because it isn’t a normal view. It’s not a healthy way of looking at it. It’s a very detached way of intimacy that the person’s done on their own anyway. They’re almost living in this alone world by themselves. And I would not have been able to as a survivor, fight flashbacks and replayed dreams that would truly, really happen during a sexual encounter without my spouse knowing that these bizarre things were in our bedroom. And not to be there. And why weren’t they there before I remembered. That would have been an extremely difficult process to go through alone. And I think it would have fed into my ability to detach. Totally. Without my spouse knowing. I might say no were stopping now because I can’t stop the flashbacks.

(2, S, p. 7)

Participants all portrayed their experience as one in which, over time, their communication advanced to the point where, although they were comfortable directly discussing survivors’ traumatic reactions, partners actually got to the point of recognizing the survivors’ nonverbal communications and responding appropriately.

Stacy – I am more able to…when something does trigger me I can either turn it off or just go through the …you know the memory and move on. Try not to let it affect me. Which is really hard, but…like I’ll tell her like… “okay, you’ve gotta wait a minute” because of what’s going on. What you just said or what you just did reminded me of someone. Or we’ll talk about my memory. Nicole - Sometimes it doesn’t even have to be now that she says anything. Like sometimes now I can just see it in her face and know “okay, well I did something wrong” or something came up that reminded her of something else. Stacy – And depending on my expression or what my body style is she’ll come and hug me or she’ll just leave me alone. And wait for me to come to her.

(4, J, p. 7)
“She was the middle person that helped make sense of...”.

The previous participant narratives illustrated the powerful communication changes experienced by these couples. The skills and insight necessary to accomplish the transformation were generated both within therapeutic sessions and through the use of homework completed between sessions. Participants such as Claire and James described an initial focus in session on identifying and modifying basic miscommunication patterns with therapists “nailing” or “challenging” participants to take responsibility for changing their style of communication. Often participants struggled to understand how their expressions were being misconstrued and a common therapist characterization was that of “filter”, “mediator”, or “translator”.

Chris – I don’t think from a spouse’s point of view… I could have ever really understood what you went through without having gone through therapy. Because it opened up some doors that I think normally weren’t there. And with the therapist almost being like a third party there was some clarification that came out of there …that otherwise wasn’t necessarily there. Sometimes. I compare it to…a little boy, a little girl comes up and says something to you. You don’t understand and so you ask them again and ask them again you ask them again you ask them again after the third or fourth time you just agree and they look at you like “I said the same thing I did the third or fourth time, why did you understand it now?” Where he was the middle person or she was the middle person that helped make sense of that at the time. So…

Jamie – I think for me I would have created you as an enemy very early on. And at times I did anyway. So, if it wasn’t for the couples counseling and piecing apart…dissecting our actual sentences…what I heard versus what was said…or maybe how Chris said it be really may not have meant it. I would have never…I would probably have been a prime candidate for divorce.

Chris – Yeah, sometimes I think that. Some things I think that you might have heard came off much more serious or severe than what I actually intended it to be because I hadn’t gone through what you did…so I was looking at it instead of having my foot run over by a truck…as just somebody stepping on my toe. Where, with therapy, it helped me understand the impact of what I just said and how you might have interpreted it. It just clarified a lot of things.

Jamie – I would agree.

Researcher – It sounds like he was a translator for the two of you in some respects.

Jamie – (Laughs) Oh yeah,
Chris – Yeah, pretty much so.

Nicole – And like she said, the whole filter. You know, we were able to figure things out. And afterwards, we would always talk for a good I’d say hour
Stacy – Maybe hour and a half
Nicole – Hour and a half about just everything and it was like sincere. We wouldn’t argue, it would just be a conversation.
Researcher – Mm hmm.
Stacy – About everything we had just talked through and then it would be like “oh, next week this is what we have to talk about”.
Nicole – Yeah, so I think that we’re … you know, the whole filter helped, but it allowed us to step back from our own lives and look at it from an outsiders perspective, which I think helped a lot.

Nicole - But I think because it was such a big help to…like I said have that mediator in the room…so that it’s not a fight, it’s a conversation of our feelings…and it was such a big help that I think that will carry out through the years. Sometimes now when we fight and we don’t necessarily have a mediator there for us …so we kind of just back off from each other…go our separate ways and come back later when… instead of it’s all emotions we can actually sit down and talk about things and I think the couples counseling helped that a lot. I think it did anyway.
Researcher – What did you find was the most helpful with regards to the …your entire therapeutic journey together and in individual?
Nicole – I would have to think back to that communication. It was a lot easier to have someone there to be a sounding board for us to get our feelings out and then kind of explained it a little bit better. Like we both kind of understood what was going on, but to have somebody there who was an outsider just explain… you know … the feelings

Therapists engaged with participants as a “sounding board” or “mediator” in session, provided participants with objective feedback, and enabled them to gain a new perspective. The success of this component of participant experiencing supports the social learning model of conjoint therapy discussed by Follette (1991). In this model couples are taught communication and problem solving skills with a special emphasis placed on the collaboration of the couple rather than an unbalanced focused on survivor problems and needs. In the previous narratives a balance is maintained within the couples
as both members became aware their strengths and areas of challenge regarding communicating with their partner. The social learning model structures improved communication, but Follette pointed out that one of the primary purposes of the improvement is “enhancing emotional intimacy” and enabling “intimacy and vulnerability”. Throughout this analysis the intertwining of trust, intimacy, communication, and connection are evident and powerful. Couples counseling provided participants with a context in which they were able to explore and share their emotions with each other while under the guidance and protection of a counselor who was invested in their progress and able to redirect their interactions in a more effective and healthy way.

“Try using your conversation and I statements...”

In couples where childhood sexual abuse has been an influencing factor, the layers of emotional reaction can be difficult to separate and even more difficult to express in a nuanced and accurate way. Chris described the common challenge for CSA couples whereby the emotional atmosphere becomes highly charged and communication becomes derailed. Participant couples were able to transform their destructive and highly reactive emotional communication patterns. They developed skills which enabled them to take a step back from their reactive positions and reengage differently by effectively verbalizing their affect and validating each other’s feelings. Nicole clearly expressed this construct when she stated “I learned to listen to her before I reacted. And I learned to better articulate myself to her and not get upset right off the bat” (4, J, p. 1). Therapists facilitated the establishment of these skills by working on communication both in session
and between sessions. In the following narratives two couples discussed interventions that they felt helped improve their communication.

Chris – They [homework assignments] weren’t always like “just go off and enjoy the evening”. There were some that were really tough. That we didn’t look forward to…
Jamie – Conversation ones. Try using your conversation and I statements. And don’t go off on tangents.
Chris – And don’t use the word “but”. I remember that. (both laugh)
Jamie – But
Chris - And no I…
Jamie – And no what if’s…ohhh…no but’s, what if’s…just the facts
Chris – Yeah
Jamie – We really deviated when we argued
Chris – But we always walked out of there. I feel like we walked out of there with the idea that there was a purpose to it.
Jamie – yeah, well, we role played arguments
Chris – Yeah
Jamie – And we were then kind of…we had to role play back how we could have done that argument much better.
Chris – Right. Right.
Jamie - Yeah, so how would people get through that all by themselves without therapy.
Chris – Good question.
Jamie - Because, you would miss half the point of the therapy. Because the point of the therapy is to come out as a whole…more whole person than you were before you came out with the abuse. How do you do that if part of the communication gap is this secrecy.

(2, J, p. 11)

Researcher – When you mentioned insight too you said that she may have highlighted a pattern of behavior and it was like “oh, yeah, we do that” kind of insight. That “Aha” moment
Claire – Definitely. Yeah
James – Mm hmmm (agrees)
Claire - And it was done in such a way that it was very palatable. You know she…
James – No she never …there were never hurt feelings. She was able to make each of us laugh at ourselves, by realizing “Gosh, I do do that”
Claire – Yeah (agrees).
Claire – And maybe things would be better if I did it in another way
James – Yeah

(1, J, p.3)
Participants clearly benefited from having their therapists act as mediators and teachers, but participant couples also substantiated the importance of engaging with one another in new communicative ways outside of therapy.

Researcher – Were there any specific interventions that you did as a couple over the course of your time together that you thought were helpful that maybe (therapist) suggested or anything like that?
Barb – Most of the suggestions would have come through me and it would have been…you know, exercises or topics to talk about. He would give us specific topics and then we would discuss them.

Nicole - And afterwards [after session], we would always talk for a good I’d say hour
Stacy – Maybe hour and a half
Nicole – Hour and a half about just everything and it was like sincere. We wouldn’t argue, it would just be a conversation.
Researcher – Mm hmm.
Stacy – About everything we had just talked through and then it would be like “oh, next week this is what we have to talk about”.

“My family dynamic changed dramatically...”.

The transformative dimensions of communication and trust were two powerful dimensions that made the counseling experience meaningful to both childhood sexual abuse survivors and their partners. In learning to communicate with each other, participant couples changed the landscape of their lives. Participants, directly or indirectly, conveyed that had they not learned to communicate in a different way, and trust one another, their relationship would have failed. Participant transformations also had a ripple effect in that family dynamics were changed as a result of the couple transformations. Jaime became quiet and contemplative when she shared how her changing relationship impacted her family of origin.

Jamie – Right, but I can’t imagine how …my family dynamic changed dramatically through therapy… dramatically… I do not at all have the same
existing family members. There are some that I will not choose to probably ever have a relationship with.

Chris – Right
Jamie – But a huge, vast majority changed. As part of the whole process. I can’t believe that that same male change would have happened if he wasn’t part of my supporting team. My father would have never changed had I not been married. I can bank on that baby…never. So… how… he ended up being my father’s role model for me.

Chris – Hmmmm.
Jamie - So, if you weren’t part of that process how would my … my brother gonna support me no matter what. I knew that going into that probably. But my father never would have. Had you not been a strong male role model in my life. He would have opted out.
Chris – Yeah, I could see that. Your brother would have forged separate relationships. One with your father and one with you. He would have been able to keep those separate. The difference with me was …is…I was on your side of the tracks.

Throughout her narrative Jaime revealed how crucial Chris’s support and trust were. In this previous excerpt the powerful emotional bond and unquestioning support of her partner were evident. Embedded in Jaime’s reflection was the understanding that her interactions with her family of origin changed. She disconnected from some members of her family and communicated with others in a very different way. Chris was a part of that and together they learned to trust and share with each other in ways that felt safe and powerful. The couple as a unit developed a strongly integrated and mutually rewarding sense of ego.

Transformative Dimension: Boundary Setting

The transformative dimensions of trust and communication were elemental and powerful within participant narratives. In the last excerpt from Jamie and Chris, the power of their relationship bond was conveyed by Chris’s unwavering loyalty and Jaime’s new relationship with her father. Throughout the interviews, survivors discussed the difficulty they shared in creating a limit on the degree to which they would sacrifice
their own wants and needs both within their intimate relationships and within the
relationships with their family of origin. The process of learning to express their own
needs necessarily impacted their partner relationships and most participants described a
process by which the couple used their strengthening ego as a dyad to support one
another in creating boundaries both within and around their relationship.

“I certainly did take charge and control in a lot of ways...”.

Each of the participant survivors expressed difficulties involving their ability to
establish healthy boundaries and effectively express their wants and needs. Research
shows that the struggle described by study participants is pervasive across childhood
sexual abuse survivors (Courtios, 1988; Elliot & Briere, 1995; Hughes, 1994). Survivors
also described allowing the needs of others to drive their actions, though their response
could either be to frantically work to please the desire of the other or on the contrary to
exert an iron control. In either case survivors found it extremely difficult to share a
balance of power and communication with their partners and maintained a limited sense
and need for control to shame and the drive to keep their trauma hidden. As participants
describe, once they began the healing process a more balanced atmosphere of shared
power and responsibility manifested. The balance within Barb and Charles’ relationship
was initially skewed much more towards Barb taking control and running the children,
the household, and making most of the decisions. As she learned to trust Charles, and talk
to him about how she was feeling, she was able to let go of some of that control.

Barb - I was not an over-controlling person, but I certainly did take charge and
take control in a lot of ways...and I let some of that go. That was good for me. To not
feel that it was my responsibility to do the whole lot, but then I think that made it
a whole lot easier. And probably, I don’t know if you noticed a big change, but
then Charles probably did… for example, when you planned that first vacation. We wanted to get away and Charles planned the whole vacation. A whole week away. At the time I remember thinking “what makes you think that you can do that”. And it was wonderful. And thereafter it just was all the time. Now had I not been going through that would I put up more of a fight? Who knows, but probably a lot of that is …we’d not had problems. And my thought is that if we hadn’t gone to counseling maybe down the road we would have…And I think that may have been a real transition problem. And I credit that to learning how to talk and share with each other. To share control and responsibility. So, is that…what do you think?

Charles – That matches with my sense of reality. I would agree that we had to learn how to share to some extent and … we always talked…some more than others (laughs)

Barb was able to silence her own internalized voice of shame and trust herself and Charles. Charles was therefore able to take more of a role in the family. Barb found that it was mutually enjoyable and transformed their relationship into one with more of a balance of power and control. Although in individual ways, survivors who participated in this study shared a similar experience.

Though neither she nor her partner described her as controlling, Jamie manifested her difficulty setting boundaries and asserting her own needs in a way similar to Barb. She created a picture of her life prior to therapy as running around almost frantically trying to care for her family with little consideration of her own needs. She described an intervention that changed her perspective on setting limits regarding how much she will sacrifice of herself.

Jamie – And then my… my one assignment I still laugh about it today was… your job when your kids take their nap…because I had two toddlers…right after I remembered my abuse…a newborn and a toddler…17 months a part…and one of my assignments once I got them…it took nine months to a year until they would actually nap together…that was my big momentous…and why are you cleaning the house and doing all this stuff? I want you to just drink a glass of tea. That was to me to this day the wildest assignment.

Researcher – And did you attempt it?
Jamie – Oh, I did it. And there are times now when even at work… “I feel tired…I’m gonna go have a glass of tea”. I have learned in life to treat myself to that time out. I would have never learned that if it wasn’t for therapy.

(2, J, p. 5)

Her framing of this intervention as her “wildest assignment” illustrates what we know from the literature regarding how natural it is for CSA survivors to ignore their own needs, even for physical rest (Courtois, 1988; Dolan, 1991). As Jaime continued therapy, she, along with other members of her support group, “really learned from each other how to take our time back …somehow… and give ourselves those rewards. Because it was not always our husband or our children who weren’t letting us take that time it was us” (2, S, p. 2). She learned to set boundaries and limits in her life, which enabled her to feel more heard and free to express her needs.

Claire also struggled to assert herself, but her traumatic reactions to physical interactions were powerful and forced her and James to address communication and boundary setting within their sexual relationship.

Claire - I’d get right in the middle of sex. I would get just waves of nausea. I’d be like “I gotta stop, I’m gonna vomit”.

James – (Laughing) Wow, what the Hell did I do?

Claire - (Laughing) I’m just like, No, I gotta stop I’m sick. I am physically sick. I can’t do this anymore. And, I didn’t know why. I didn’t know what was going on. You were very patient and very understanding. But Yeah. Before we got into the couples therapy and started addressing it. It was definitely affecting us.

(1, J, p. 11)

“It’s okay to be sexy and be a sexual being…”

This exchange barely tapped into the challenge that childhood sexual abuse can create within the sex lives of survivors and their partners. Sexual difficulties are usually second only to loss of trust when it comes to residual symptoms of childhood sexual abuse. Maltz (2001) wrote at length about the difficulty survivors can have in separating
healthy adult sexual expression from the destructive and painful experiences of childhood. She emphasized in her treatment manual the need for couples to learn to communicate effectively and develop a trust level, which supports survivors’ ability to assert their needs and set healthy boundaries. Although no questions in this study directly addressed participants’ sex lives, it is clear that the creation of a more enjoyable and fulfilling sex life resulted from improved emotional connections, trust, and direct communication regarding needs and limits. When she discussed learning to set limits with her partner, Claire stated “It freed me up to say to him don’t do that, my brother did that and it really pisses me off” and James responded “but now I know you’re free to say to me. Don’t do that”. James was able to relax and not feel constant anxiety around Claire because he trusted her ability to assert herself. Claire went on to describe how therapy enabled her to set healthy boundaries in her sex life.

Claire - It helped me learn the difference between…it’s okay to be sexy and be a sexual being and have control over yourself and enjoy it versus being exploited. It’s okay to have relations. It’s okay to express yourself and whatever. And it’s okay to do these things with your husband that you were made to do. I learned how to separate the two. And I can’t imagine how difficult that would be if I had never addressed it in therapy. I definitely think it would have affected our married life and our sex life. If I couldn’t separate it.

(1, J, pp. 12-13)

Together Claire and James expressed how enjoyable their sex life could be in the context of a relationship characterized by solid trust, good communication, and healthy boundary setting.

Claire – So, two kids later I do enjoy sex and I never…almost never ever do things creep in. I can’t think of the last time. I mean it’s been a couple years since I ever…But it was dealt with and hashed out. It was extremely painful at the time. And now …I’m glad I did the work then.
James – I remember it being very difficult at first. I mean from my standpoint…and wondering…I mean…my gosh. I want to marry you. Are we
going to be able to have a normal relationship. I remember that being a concern and wondering that. I’m glad…I’m glad things worked out the way they have.

(1, J, p. 17)

“Sometimes now I can just see it in her face and know...”.

All four participant survivors shared the challenge of expressing personal needs in their intimate relationships. These expressions often revolved around a partner’s need for emotional and even physical space. Childhood sexual abuse survivors often struggle to convey to partners how they would most like to be supported. Partners are then left to guess how to best respond. In the following narratives, participants describe the delicate communication and boundary setting process involved in creating a supportive and safe relationship.

Stacy - Which is really hard, but…like I’ll tell her like…“okay, you’ve gotta wait a minute” because of what’s going on. What you just said or what you just did reminded me of someone. Or we’ll talk about my memory.

Nicole - Sometimes it doesn’t even have to be now that she says anything. Like sometimes now I can just see it in her face and know “okay, well I didn’t something wrong” or something came up that reminded her of something else.

Stacy – And depending on my expression or what my body style is she’ll come and hug me or she’ll just leave me alone…and wait for me to come to her.

Researcher – Okay. Are some of those skills things you picked up by coming here?

Nicole – Yeah. I think so, especially because by being able to be there while Stacy was getting some of her feelings out and to see what was what. Because I am a big person about watching emotion, especially when somebody’s talking. So to see her talk about certain things and to see the emotion that came along with it. And then her expressing her feelings even more helped me to understand where things lie. You know.

Researcher – Okay.

Nicole – And help me understand her body expressions. So that helped me kind of …like she said, come and give her a hug or back up and just get out of the way. So I think that helped a lot.

(4, J, p. 7)

Researcher – Any advice you would give to partners who are considering becoming part of the survivor’s process?

Claire – Don’t, don’t push to get too close, you know, stay at a good distance …let the…let the survivor say “Okay, you can come in now.” You know, you’re
there, you’re available to come in. But don’t push your way in. Don’t revictimize the person by insisting, you know “you have to tell me every detail of what happened, and who did it and where and blah, blah, blah, blah, blah (fast speech). You know, that just totally revictimizes the person unless, unless they are wanting to spill all of that out. So, just be there…be patient…and…I there’s really weird manifestations, you know, like nausea during intercourse. I’m like “oh my God, I’m gonna vomit…Stop” You know, and … and the partner needs to understand that it’s not them. It’s going on in here (points to head) and in here (points to stomach).

Researcher – It sounds like there’s a balance. You said you were discouraging your husband from getting involved, and he kind of pursued it, and yet not pursuing too hard. Not wanting all the details. It sounds like a balance. Your advice to partners is there’s a balance. Be interested …

Claire – Right. And it’s a fluid balance. Sometimes it’s okay…sometimes I need to be left alone. Sometimes it’s okay to hold me in bed, sometimes when I say “get off of me, I don’t want to be touched” don’t take it personally. Back … you know…just back off, just let me sleep. It’s, it’s a dance and I’m not sure a lot of guys would…I could just see guys, you know, like pounding their head against the wall…like what do I do. I don’t understand her. First she said this, then this, I mean, I could see how it would be frustrating for a partner. Very, very frustrating. Not knowing what to do and feeling helpless.

(1, S, p. 3)

In each of the previous narratives participants described the essence of a survivor’s experience with traumatic reactions and one can easily understand how difficult it would be for partners to either not take the reaction personally, or to identify and respond in appropriately supportive ways. Over the course of therapy, participant survivors learned to express how they were feeling and provide guidance to their partners as to how to respond. This is one of the key components of Follette’s (1991) problem solving within the social learning approach. Nicole’s response showed how partners can progress to the point of being able to read subtle non-verbal cues. This powerful silent communication can strengthen the couples’ bond and continue to promote a healing relationship.
“She made it okay for you to hate my brother…”.

Though this study focused on survivors and their intimate relationships, an interesting finding within the participant narratives was the common theme of survivors and partners jointly learning to set boundaries and change interactions with the survivor’s family of origin. This intergenerational transformation was generally viewed as the natural “next step” for participant couples who grew more comfortable in their own relationships. Support was clearly portrayed as integral to the success of survivors’ abilities to assert their boundaries and rights. Jaime shared in her narrative how difficult it would have been to talk with her family regarding her abuse if Chris had not been there.

Jaime – Well, and just imagine this…Imagine you and I and no couples counseling. I remember my abuse. One of my assignments at the next family reunion was to hoard all the women together and have an open discussion about how this happened. And now that we weren’t going to be a part of this secret anymore and if anyone else wanted to come forward. Now, imagine (laughs) this wonderful family get together that he has to go to with his in-laws as this carousing is happening. I can’t imagine…. That being your homework assignment was scary enough…
Researcher – Mm hmm
Jaime – But to think if I had a spouse who had no clue what was going on. Or could have cared less… or … he was included in that process and we had an escape plan if it didn’t go well.

(2, J, p. 13)

Jaime went on to say “it was a wonderful experience” because Chris was involved and they were able to share in the experience together. Jaime was able to reorganize her family relationships in a way that was satisfying and comfortable for her.

Unlike Jaime, Claire and Stacy both shared the challenge of continuing to interact in a peripheral way with their abuser. It was not easy for either woman to overcome her socialized politeness in order to assert her own boundaries. Claire described how the process began in couples therapy.
Claire – I found it helpful, it must have been the first one that we did this with, that she had us set up boundaries because I... the main abuser in my childhood was my older brother and so she ... you know ... we’d go in there and I’d say “oh God, the holidays are coming and he’ll be around”.

James – Yeah,
Claire – And she’s say “Don’t let him in the house”.
James – Yeah
Claire – “Why would you invite him over?” And I’d be like “well I have too, my mother will get mad”. And she would say “no, this is how it is. Do not invite him into your home.” And he... We lived in an apartment. He’d show up. He would just like show up at the door. And I would feel like I had to let him in. And she’d be like “that’s bullshit”. “Either don’t answer the door. Or say through the door “I’m sick, go away””. She helped set up boundaries for our marriage.

Abusers often manipulate survivors by playing on their feelings of politeness and fear of offending someone or disappointing their parents. In Claire’s narrative, remnants of this psychological manipulation were still evident. In addition, James and Claire both had to come to terms with their feelings about the abuser in order to address the situation.

Claire – The whole boundaries thing. I think she (therapist) made it okay for you to hate my brother.
James – Mm hmm
Claire – I mean she was just like “Yeah, he’s an asshole” and she made it okay ... because James had all this, you know, hate your brother for what he did. And she was like “that’s okay, that’s normal, that’s healthy, that’s okay”. And, you know, why didn’t I hate him as much as he did? So, she helped specifically with that. I can remember making decisions of how, when we would go visit, how long were going to stay somewhere

Claire and James went on to describe “the seven minute good-bye” (1, J, p. 7) in which they would agree on a specific time to leave a gathering where the perpetrator was present and would have a contingency plan should Claire feel threatened in any way. During the interview Claire and James were jovial and excited about how “great” they felt being able to set their boundaries. James described his rationale for why it was so empowering for the two of them. He stated “it gives you power over what feels so out of
control” (1, J, p. 7), which concisely illustrated the empowerment that can come from the transformative dimensions described by these participants.

In a similarly dramatic way, Stacy and Nicole described modifying their relationship with Stacy’s father. In the following excerpt Nicole described her attempts to support Stacy as she was learning to set boundaries with her father.

Nicole – I think it just kind of started happening. Once Stacy started telling me what went on…any time her dad was in the house I always made sure that I was really close. Either next to her or at least in the same room. So if I saw that tension building in her face I could just slide right in and be like …because he doesn’t know…

Stacy – He knows

Nicole – He probably thinks I’m none the wiser…well, he might, but at the same time what is he going to say to me? It’s different. He might say something to his child, but what’s he going to say to me? So I can kind of get in between them and be like “well, we have to go or I need to go to the store to get cigarettes and I’m not sober so will you drive”. Just to get her out of the scenario. I also remember…one thing that helped…she would have problems in her room…so I was like “well, it might help if you put a lock on the door”. That way when you’re in your room you can lock it and nobody can get in.

Researcher – Mm hmm

Nicole – So it was kind of understanding where she felt comfortable…where she felt uncomfortable and just helping her out with that sort of thing. But I think that helped a lot in a lot of different scenarios. I don’t know. I would hope … and I feel like I played a big part in helping her come to terms with things and helping her become more comfortable with things.

(4, J, p. 15)

In this narrative Nicole shared with us her feelings of ownership in helping Stacy become more comfortable and feel safer in a threatening situation. Stacy continued the conversation and expressed her own empowerment as she learned to set boundaries with her father on her own.

Stacy – And I would say…like the next day I was put in a situation just like that with my father being at the house and I left. And it felt…it was really hard, and so I just left.

Researcher – Okay. At the end how was that experience for you to get up and leave?
Stacy – It was great. I had always wanted to leave and sometimes I’ll just leave the room, but he follows me into the other room where I can still hear him. But actually, I left the house and it was wonderful.

(4, J, p. 3)

Stacy and the other participants created a tapestry in which trusting in themselves and trusting in their partner empowered them to take charge of their lives. This empowerment was shared within the couple as they negotiated the therapeutic process.

“I wanted certain things to be looked at…”

Participant couples clearly expressed their need to have some control over the pace and direction of therapy. Johnson (2002) highlighted the importance of allowing survivors to control the pace and direction of therapy in order to promote a sense of safety while other researchers emphasize this control as establishing a collaborative and supportive therapeutic alliance. Stacy and Nicole discussed at length their need to clearly communicate their desired structure for therapy. They discussed bad counseling experiences from the past in which multiple therapists had entered session with their own agendas and had ignored or overridden the clients’ voices. They approached their couples counselor from a different perspective and found the experience significantly more satisfying. Stacy emphasized the importance of “laying the groundwork. Like for us, we needed to say “okay, we want to look at the past”’” (4, J, p. 5), which was echoed in the following excerpt from Nicole

I wanted certain things to be looked at…But I think that that helped a lot. All of us just saying what we wanted initially. And just saying here’s what we feel and here’s where we think we should be going.

(4, J, p. 5)
Both of these women continued to work on consistently setting firm boundaries and asserting their personal needs. Their success may have been supported by the power they felt in influencing the content and process of therapy.

“Don’t jam a form of therapy down somebody’s throat….”

In addition to having input into the process and content generated in session, participants also expressed a desire to have control over the mode of therapeutic interaction. Partners in particular were consistently vocal regarding their desire to have control over their level of involvement in the therapeutic process. The following excerpt illustrated the interactions shared by Jaime and Chris as they discussed Chris’s involvement.

Chris – I think it would be to have an open mind. And what I mean by an open mind is don’t be extremely rigid in your outline of therapy. Always be open. Everybody’s an individual. Ahhh, classic textbook isn’t always going to work with everyone. And be…always be out there looking for new ways of connecting so that the partner feels more a part of the process instead of feeling pushed aside or just that …quit…don’t jam a form of therapy down somebody’s throat. Always be open that maybe that person doesn’t fit the scenario. And find other avenues. And that’s why I think our therapist worked so well. He did have all these varied ways of doing things. That …somehow…somewhere along the line my mind was going to connect with something that he made us do. And I think that’s the primary. Make sure you have enough variety that you can connect with that person.

Researcher – If one thing doesn’t work have a back up…and a back up…and a back up.

Chris – Yeah, and always try new things. Because, sometimes I think there were things I hadn’t even thought of or I had just let go of… “oh, that doesn’t make any sense, I’ll never get it”. And then he’d have us do something new and “bingo”. I’d be back on the road. And it would be like “wow, okay, this really helps”.

Echoing similar sentiments, both Barb and Charles expressed the importance of partners having an “invitation” to attend sessions, but not being “forced” to arbitrarily attend.

Researcher – Okay. How did you…how did you sort of get invited into that experience? How did that come about that you started in that process?
Charles – I don’t really remember. The main thing was the revelation of Barb remembering. Hearing about what was going on in group. Having an open invitation… to come on down and see what goes on. To be involved in as much or as little. Or, if I needed it.

(3, J, p. 1)

Researcher – What advice would you give to couples who are considering attending couples therapy?
Barb – That it’s very valuable. That it’s a cooperative. And don’t get hung up on if one partner does or does not want to go all the time. You know…give them time…and maybe they will never go, but don’t…don’t hold that against them in that respect.

(3, J, p. 8)

As described earlier in this text, much is made in the literature of the concept of “benevolent blame” (Follette, 1991). One could hypothesize that partners having flexibility over their level of involvement in therapy may have contributed to the lack of blame. If partners were forced to attend sessions they did not feel pertained to them, they would likely feel resentment and perhaps project that resentment onto their partners through the guise of benevolent blame. Participants, however, felt empowered to attend when they chose and were provided rationales for how the session content pertained to them. The trust and communication dimensions were again called into play as the partners were reassured that they would not be “attacked” or “ganged up on” in session and had a clear idea as to what to expect.

Boundary setting is a complex construct that requires a strong sense of self-esteem, effective communication skills, and a significant amount of support. In the previous narratives the progression of this transformative dimension clearly illustrated the process childhood sexual abuse survivors and their partners experienced throughout the therapeutic journey. In a very reciprocal manner, survivors learned to assert themselves while partners learned to trust and respect that survivors were honestly conveying their
needs and desires. As trust and communication improved within the couple, boundaries were reinforced between the couple and outside contextual stressors such as the survivor’s family of origin. Finally, we can see that boundary setting was a critical component within the therapeutic relationship. Clients and their therapists must forge a strong relationship based on mutual respect and create a structure within which clients voices are heard, understood and respected.

Facilitative Dimension: Therapeutic Fit

As evidenced by the literature and participant narratives, a large part of successful therapy clearly rests on the clients being able to trust and feel comfortable with the therapist (Jehu, 1988; Phelps et al., 1997). Trute et al. (2001) asserted that “it is essential to join strongly with each partner and build trust as a prelude to any relationship change” (p. 108). At the culmination of therapy participants had clearly demonstrated change and growth in each of the three transformative dimensions. Survivors and partners both experienced an increase in trust in themselves and in each other. Communication within the couple had improved to the point where often partners could read, interpret accurately, and respond appropriately to both verbal and nonverbal messages. Additionally, couples had developed the ability to set healthy boundaries both within the couple and between the couple and environmental stressors. Throughout the narratives shared by participants the influence of the therapeutic relationship is clearly illustrated. Woven throughout the tapestry of experience created by participants, was the colorful thread that was the therapist.

Participant survivors learned to trust in themselves with the support of positive therapists who unceasingly provided non-judgmental support and created a safe haven
within the therapeutic environment. As couples generated increased trust in their relationship, therapists provided advocacy for the couple and reassured both partners that they would be able to safely traverse the difficult road to recovery. Therapists were often described as “filters, mediators, and translators” who facilitated effective communication. They were called upon to challenge ineffective communication patterns and use creative interventions both in and out of session to improve participants skills and ability to be emotionally connected. From the outset of therapy, therapists were called upon to respect the rights of participants to guide the structure and process of therapy while simultaneously pushing them to take appropriate risks and expand their realities. As is clear from participant narratives, the influence of the therapeutic fit is powerful and needs to be taken seriously as professionals continue to expand their work with this client population.

The “therapeutic fit” is a relatively ambiguous label that takes into account a multitude of therapist and client characteristics interacting in a unique way in every individual therapeutic context. There were, however, some specific therapist variables which were consistently expressed by participants as helpful in creating a positive and healthy therapeutic fit. These variables included therapists acting as an advocate not only for individual clients, but for the couples’ relationship as well. Part of acting as an advocate for the relationship entailed keeping the focus on the health of the relationship even as individual issues were addressed or when only one member of the couple was being seen in session. Participants also emphasized the importance of therapists recognizing the uniqueness of each couple and the importance of not trying to impose rigid interventions on a couple for whom the approach was not a good fit. In conjunction
with recognizing the unique personality of each couple, participants highlighted the value of therapists keeping an open mind and not being afraid to try out new ideas and interventions. Finally, one of the most prevalent and powerful ideas shared by participants was the belief that if a therapist is not a good fit with the couple, then the couple needs to try other professionals until they find one with whom they are both comfortable.

“She didn’t make us feel that she was superior to us…”

Therapist as advocate was discussed briefly with regards to trust being generated within the therapeutic relationship. Chris gave us the powerful image of him, his wife and therapist out “in this dingy” trying to find their way across the ocean. This textured image helps us to understand the level of trust, equality, and shared mission experienced by the participants. Survivors and their partners emphasized the importance of therapists engaging with them as equals, experts on their own lives, who were welcome to express their needs. Stacy and Nicole stated that the therapist’s willingness to create an equal playing ground and adapt her style to fit the needs of the couple was the deciding factor in their remaining in therapy. As can be seen in the following excerpt, therapist attitude and flexibility were very powerful therapeutic factors.

Stacy – That and it’s like the counselor sits down with the person and she can say “okay, this is my style”, like our counselor did. This is the kind of person I am. This is how I do it. You know…if you don’t like my style I can refer you to another person. That and laying the groundwork. Like for us, we needed to say “okay, we want to look at the past”.
Researcher - Mm hmmm.
Stacy – Instead of the future all the time. And initially for counselors saying “okay, would you like to work totally in the present and maybe work…just figuring out how they want their counseling. Because I know coming in I had a certain way that I wanted
Researcher – okay
Stacy – And for her to come out and say “okay, this is how I am” and our styles kind of matched and I wasn’t expecting that.
Nicole – You know, our first session. That’s what it was about. It was like “well, this is who I am as a counselor now tell me about who you are and…”
Stacy – And what’s going on.
Nicole – Right. And that helped a lot.
Researcher - Okay.
Nicole - Oh yeah, definitely.
Researcher – Sounds like it created an equal playing ground between you and the counselor.
Nicole – Right.
Researcher - Equals.
Nicole – And I think that she might have changed things around a little bit. I mean, still using her style and what she felt was right, but made it fit the three of us so that it matched well. Which I think is a really hard thing to do. Because, like Stacy said, Stacy and her felt the same way about things and I was all like…I had a certain way that…and it wasn’t far from what Stacy wanted, but I wanted certain things to be looked at…so
Researcher – Mm hmm
Nicole – But I think that that helped a lot. All of us just saying what we wanted initially. And just saying here’s what we feel and here’s where we think we should be going.
Stacy – And I think something else that helped is she didn’t make us feel that she was superior to us or something.
Nicole – Right
Stacy - She did it more like she was a friend coming in. So that was definitely helpful. She never talked down to us, she never … seemed like she was trying to belittle us or anything. It was just here I am.
Nicole – And she would get the whole like “you gotta do this” attitude, but she still seemed friendly in a sense. She was like a friend coming up to you and punching you on the shoulder and saying “shut up and take a look at things” instead of saying… “well you’re wrong” type of thing. Which I had encountered with counselors in the past and I was like “okay…bye”.
Researcher – Yeah.
Nicole – And it’s annoying. And she never handled it like that at all.
Stacy – Mm mmm (negative agreement)
Researcher – Okay. So that…that equal footing and almost a friend type of a person was big for you?
Stacy – Yeah. Even though she wasn’t like a friend we would have on the outside, but just to feel like we could open up to her.
Researcher – Right.
Stacy – I felt like I could open up to her which was a tremendous thing. You know, so that definitely helped.
Stacy and Nicole entered therapy with a clear understanding of what they wanted and a somewhat negative history of therapeutic experiences. Their therapist facilitated the healing process by supporting the couple as equal partners and adapting her style to meet the needs being expressed. The therapist also communicated directly with these participants both regarding her therapeutic style initially and throughout the therapeutic process. The participants described her style as similar to a friend who could push them toward change and growth. This therapist used the power inherently given her by her position to advocate for the needs of her clients, but she also respected their boundaries and had the flexibility to adapt to their needs.

“They are rooting for us in the long run...”.

In addition to advocating for the needs of their clients in session, participants described positive experiences with therapists who strongly advocated for the couple’s marriage. Excerpts from Claire and James evidencing this were presented at the beginning of this chapter, but in the following brief exchange they shared with high energy and positive affect the experience of their therapist “rooting” for them.

Claire – I think she reinforced it. Her and then W. The other one. And G. I felt reinforced as a couple
James – Yeah,
Claire – And the marriage
James – As though they were all rooting for us.
Claire – Yeah, they are rooting for us in the long run.
James – Yeah.
Claire – I felt that way
James – Well, sure
James - Very supportive. Very interested. As much in our progress as we are.
Researcher – Okay

(1, J, p. 3)

Claire and James discussed their therapists directly advocating for the marriage, but other participant couples described a more indirect advocacy.
“*This individual session is also benefiting the couple...*”.

A common theme running throughout the narratives addressed the focus therapists retained on the relationship whether or not both partners were in the room. Claire and James, again, directly expressed the support their felt for their marriage.

*James* – We sought …We started seeing her as a couple. We saw her occasionally individually. Probably half and half. We saw her as much individually

*Claire* – But she made the marriage

*James* - Right

*Claire* - the focus.

*James* – Right

*Claire* – Instead of either one of us.

*James* – Right, so even when we were seeing her individually I think she had it in her mind that “this individual session is also benefiting the couple”.

*Claire* – Mm hmm, yeah, right.

(1, J, p. 6)

Other couples expressed the same idea, but in a slightly less direct manner.

*Jamie* – I would say with my counseling it contributed to at least half. Or a part of my personal counseling involved my marital relationship. So, even if you weren’t in the room and it was not always together, a lot of it referred back to times and sessions we did have together. So, I would say it was 50% of the process. For me…as a person who was sexually abused.

(2, J, p. 1)

*Jamie* – No, there were different times when we didn’t have couples counseling, I would have homework that related and one of those was to bring the Myer’s-Brigg’s home.

*Chris* – Oh, all right

*Jamie* – Even though, at times, we weren’t in couples counseling, we were.

*Researcher* – So even during your individual sessions he brought a lot of couples issues into the session?

*Jamie* – Correct

*Jamie* – Mm hmmm (agrees)

(2, J, pp. 1-2)

*Barb* – But it was all geared…even when it was me alone or the…with the exercises…topics…whatever…discussions…you know…even when they weren’t…when the spouses were not there, it was all now. A big part of it was geared not just toward you, but toward them. Husbands.

*Researcher* – mm hmmm
Barb – You know and the importance of them dealing with it and it would come up often. In the things that we would talk about with our therapists. We didn’t…and it wasn’t so much what was the husband’s response per say…because we were real careful not to say to much about them…but none of them…none of them liked that. And I think had they thought we were all sitting around talking about them it would have made it…bad. But it was about how we reacted to their reactions.

(3, J, p. 4)

The essence of the therapeutic experience for each of the couples involved a focus on the couple regardless of who was in the room. This was a powerful intervention which reinforced the survivor as part of a larger context. As survivors redefined themselves, they were empowered by their identity as one member of a dyad characterized by love, support, and nurturance. The focus on survivors as a member of a couple reduced the likelihood of partner alienation and freed survivors to focus own their own issues without being concerned that their partner would be left out or somehow become resentful. Partners, meanwhile, were reassured that the needs of the couple would not be completely sacrificed to meet the personal needs of the survivor.

The focus on the couple may also have facilitated trust, communication, and boundary setting by changing the cognitive structure of participants. Childhood sexual abuse survivors often feel isolated, stigmatized, and as though they have to hide their shame from others (Courtois, 1988; Zupancic & Kreidler, 1998). As evidenced in earlier excerpts, survivors feared that their partners would “abandon” them (Claire) or that they would personally become “different people” (Barb) who their partner would not love. Survivors were struggling with their own insecurities and as Jaime discussed, she was afraid that to simply express how she felt would “destroy or upset the relationship”. She went on to say that she felt like “a little child that was below or not equal to him and so fearful of saying things” (2, S, p. 5). Each of these statements reinforced the isolation felt
by survivors. A focus on the couples even during individual sessions reinforced the
cognition that each survivor’s partner was invested in the process and supportive of
recovery. Survivors felt reassured that they could bring their partner in when they wanted
and felt confident that the partner was not going to spontaneously reject them because
they were involved in the process. Given the consistency of participant comments, the
focus on the couple even during individual sessions was clearly important to the healing
journey.

“Don’t put… a round peg in a square hole...”.

Focusing on the couple in general may have helped survivors modify their
cognitive structure, but just as important was the therapist’s ability to accept the
uniqueness of each individual couple. Barb and Charles carried on a conversation during
the interview process discussing their frustration with a particular therapist trying to push
onto them interventions which “should” work because they “almost always work”. This
couple was very discontent with this approach and switched to a therapist who was able
to recognize their uniqueness and tentatively present multiple interventions. In the
following excerpt Barb discussed their discontent.

Barb – And it was sometimes really bizarre things and then it was early on and it
was like you should to this or he should do that. But that’s not right. That is not at
all right. And yet all the sudden you’re feeling although…because he’s not doing
what the counselor said then…you know…then there’s no support and on and on
and I didn’t stay with him very long. And then when we went on to (therapist) it
was not like that at all…as much….as much. When it would come up I would
realize I know our limits…or…our boundaries or whatever I’d guess you call it.

(3, J, p. 4)

Stacy and Nicole echoed the feelings of Barb and Charles. They placed a heavy emphasis
on the importance of their counselor adapting her style to meet their unique needs. Nicole
stated “I think that she might have changed things around a little bit. I mean, still using
her style and what she felt was right, but made it fit the three of us so that it matched well.” This match enabled Stacy and Nicole to connect with their therapist and heal within that therapeutic context.

When asked to provide advice to therapists working with CSA survivors and their partners, each of the partners immediately focused on the importance of treating every client and couple as a unique entity. It is interesting that it was the first thought of the partner, though not of the survivors. It may be that just as partners did not want to be forced into a particular therapeutic modality such as couples counseling, they also did not want to be forced to adhere to a particular theory or style of therapy. James stated

Researcher – The last one is ... Any additional advice you would give to therapists who are working with partners?
P – I don’t think so. Just...maybe...give suggestions of how they can be helpful in the recovery process. You know. It’s tough...I’m sure everyone is different. Every situation is different. But, maybe some people want to talk about their problems and their therapy session, or their group session and some people don’t want to talk about it...at least for awhile. Just …
Researcher – Play it by ear depending on the person?
P – Right...sure...

(1, P, p. 2-3)

Chris reiterated this belief in a more direct way.

Researcher – My last question is what advice would you give to therapists who are conducting or considering conducting couples therapy with CSA survivors and their partners?
Chris – Don’t put... a round peg in a square hole. I think that’s what I learned. He approached every situation individually in that he never tried to label, peg us with you know having to fit a certain ... you know...it’s just like. Think outside the box. That’s how I would do it. Yeah, to counselors, that would be my advice.

(2, J, p. 12)

And finally, Charles said

Researcher – Okay. Given your experience through all of this through different counselors and your wife’s experiences...what advice do you have for counselors who are working with survivors and their partners?
Charles – Start with an open mind. Gather the facts. Sort it out...get a feel for the individuals involved and make your decisions accordingly on how to proceed.

(3, P, pp. 3-4)

Perhaps the dearth of information regarding the treatment of adult CSA survivors within a conjoint context was actually a blessing for participants and their therapists. The extreme limitation on available treatment modalities forced these successful therapists to be creative in their treatment approaches. Each participant couple felt valued and respected by their therapist due to the individualized treatment and sense of all three working together to address the needs of the couple. The importance participant couples placed on being treated as a unique entity needs to be heeded by therapists as models of therapy are generated for working with this population. Even if evidence supports that a particular approach is effective in general, the power of adapting style and structure to each individual couple is invaluable.

"Try another therapist...”.

Participants strongly advised therapists to value the integrity and individuality of each couple above all else. When asked to advise other survivors and partners who were considering therapy, the overwhelming sentiment conveyed was “if you don’t feel like you are getting anything out of it…try another therapist” (Claire, 1, J, p. 17). In literally every interview, participants expressed the importance of finding a comfortable and healthy therapeutic “fit”. Trust and communication difficulties have repeatedly been cited in the literature and throughout participant narratives as the most difficult obstacle to overcome in the healing process. Participants emphasized the importance of certain therapist characteristics and therapeutic processes to the strength of the therapeutic alliance, however, it was clear that for all of the couples it was a process of trying
multiple therapists until they found one with whom they “clicked”. Claire and James equated the process of finding that “perfect therapist” to the process of dating.

James – Maybe try different therapists. If one is not …
Claire – Yeah,
James – If the first therapist is …you don’t feel like you are getting anything out of it…try another therapist.
Claire – Don’t give up.
James – It’s a …
Claire – It’s like dating.
James – It’s like dating.
Claire - If you don’t click with the therapist go find another one.
James – Yeah, you’ve got to. Because everyone…everyone’s different. Every personality is different.

Even partner three, Charles, who was less than enthusiastic about participating in therapy suggested that finding the right therapist was very important to the outcome of the treatment process.

Researcher – How about advice for partners who’s wives or spouses or husbands or whatever are considering going through counseling?
Charles – Individual choice.
Researcher – Okay.
Charles – I’d encourage them to hear different folks out and see if they think it’s for them.
Researcher – Okay.
Charles – Or perhaps go to a couple …check it out…see if it does help them. It was great.
Researcher - So when you say figure it out or check it out are you saying for some people couples counseling may be helpful give it a try or other options
Charles - Yeah. I’m saying probably for most folks…and most folks in my mind have ever even been exposed to psychologists…they may not have any idea of what it’s like. And for them I say absolutely go…and see. And if you have a good therapist and get along and like him and all the rest…then maybe you’ll definitely get some good out of it. And maybe you’ll size up.

Both Jamie and Stacy reinforced that survivors have to be comfortable with the therapist in order to make the healing process work.
Researcher – Sounds like good advice though. If the counselor does not fit with you…it’s not a connection…try someone else.
Jamie – Right. It’s no different than somebody you meet in college or somebody you…call a friend. I don’t think a counselor has to be…somebody…you’re gonna call a friend, but you have to feel at ease. And if you don’t like Dr. Ruth’s squeaky voice and her approach don’t go with it. You know. Some people find Dr. Phil offensive and can’t find the humor in him. You need to find…some people want more direct and they want more assignments and they want…structure.
Researcher – Right
Jamie - Give…find somebody that really is that.

(2, J, p. 15)

Researcher – Only a couple more questions. What advice would you give to survivors who are considering participating in therapy?
Stacy – They definitely need to do it. And if you’re not comfortable with the first person keep going. It’s going to be hard but they really need to keep going back. It is very much worth it.
Researcher – Okay.
Stacy – Not stopping.
R – Not stopping. Okay. How about what advice would you give for partners?
Stacy – Like I said last time. It is about the survivor. And if they feel comfortable with someone even if you don’t…sucks to be you, but just keep going even for the survivor because it’s … very hard to trust somebody … after you’ve been through this experience.

(4, S, p. 3)

In each of the narratives the importance of comfort, connection, and solid communication between the clients and therapists was reinforced. Every participant attributed a successful outcome, at least in part, to the power of the therapeutic alliance.

Survivors trusted their therapists, allowed themselves to be vulnerable, and began to rebuild their trust in the world around them. Sharing a connection with the therapist meant that partners tried new ways of being and supported the healing work of survivors without fear of alienation or rejection. Most of the participants tried numerous therapists before finding a connection with their primary couples counselor. In each case, once this fit was established, participants were able to traverse a very difficult pathway towards recovery.
CHAPTER V
DISCUSSION

The purpose of this study was to gain a better understanding of conjoint therapy as a treatment component addressing the needs of childhood sexual abuse (CSA) survivors and their partners. The emotional and passionate stories shared by participants not only broadens our understanding of conjoint therapy, but also provides a glimpse at the dramatic and life altering changes survivors and their partners experience as they undertake the difficult journey towards recovery. Participants in this study invited us into their lives and shared emotionally saturated details of the devastating impact childhood sexual abuse had on their lives and relationships. Their stories, however, did not end there. Participants recounted with vibrant texture and vitality the challenge and joy of shedding the trauma of their past and transforming their lives into a shared experience of trust, mutual understanding, and emotional connectedness.

Research questions posed at the outset of this research sought to gain insight into the perceived effectiveness of conjoint therapy and expand our professional awareness of the impact of conjoint therapy on the relationships of childhood sexual abuse survivors and their partners. Exploration of these questions with the experts, the survivors and partners themselves, generated a cohesive and nuanced portrait of healthy transformation. The essence of the experience of conjoint therapy focused on one concept…change!
Participant couples shared the experience of transformation. The process of recovery necessarily altered participants’ perception of themselves and their relationships. Couples discussed the dramatic shift in the equilibrium of the relationship throughout the therapeutic process and reported that it brought them to a place wholly different from where they started. Charles and Barb reported that they were able to “work through it and work through the emotions and get to where we want[ed] to be” (3, J, p. 4). Jamie reflected on her experience with change in the following narrative.

I didn’t emerge the same person… and I can’t even imagine the poor husband who just sent their wife to counseling and said “when it’s all over it’s all over”. Because there is no way they have the same woman as the end result. And I don’t know how a marriage survives that (2, J, p. 2)

The relationships shared by participant couples were characterized by reciprocal adaptation to change as the transformations took place within the context of a mutually shared experience. Jaime alluded to the inherent difficulties that would likely be experienced by couples in which the survivor was “sent off” to counseling while the partner remained excluded from the process. The inclusion of conjoint therapy for participant couples clearly provided a more effective and satisfying therapeutic experience in which transformation deepened and strengthened participants’ relationships rather than alienating them from one another. The four dimensions explored in the results section structure the developmental shifts experienced by couples both intrapsychically and interpersonally. Rather than simply providing us with a numeric barometer of the perceived effectiveness of conjoint therapy, these dimensions provide an integrated illustration of how powerful and beneficial participants perceived conjoint therapy to be.

The transformative dimensions of trust, communication, and boundary setting provide structure and meaning to the change experienced by participants. Childhood
sexual abuse survivors and their partners perceived a significant difference in each of these constructs as a result of having undergone the therapeutic journey. It would be erroneous to say that conjoint therapy alone facilitated the transformation. Participants all agreed that individual and group therapy were integral components of their treatment. However, each of the participants also echoed Jaime’s statement that she would not be completely healed without the conjoint experience.

Jaime - I wouldn’t feel comfortable checking off done. I would feel like you would have to always check off about a five. Because there’s a huge gap between really feeling safe. And I don’t know that you could do that without couples counseling.

(2, J, p. 9)

Conjoint therapy provided survivors with an avenue for incorporating their strongest supporter into the healing process and enabled partners to be intimately involved in the evolutionary process of growth and recovery.

The significant emphasis on the transformative dimension of trust in participant narratives is not surprising given our awareness of the detrimental impact of childhood sexual abuse on survivors’ ability to trust themselves and create trustworthy intimate relationships. The effectiveness of conjoint therapy was clearly illustrated by the passion with which survivors and partners discussed their increased trust in themselves and each other at the conclusion of therapy. Previous research supported the utility of conjoint therapy in increasing physical and emotional reconnection within survivors’ intimate relationships (Johnson, 2002). Participant narratives clearly demonstrated continued support for this construct, but increased our awareness of the multilayered texture of the increased connection.
Survivors expressed initially fearing that their partners would abandon them either as they dealt with the trauma symptoms or as they changed into different people during the therapeutic process. Having their partners involved relieved this fear and enabled survivors as Barb stated to “set that aside” (3, J, p. 2). The therapeutic focus on strengthening survivors’ intimate relationships helped participant couples establish the “safe haven” proposed by Johnson (2002). Survivors were able to become “different people” or redefine their core belief structure about themselves within the safety of a supportive and loving relationship. Participants emphasized the importance of focusing on the couple even when only one member of the couple was in session. This orientation empowered survivors to see themselves not as isolated, abandoned, and rejected, but rather as part of a strong dyad in which they were valued, nurtured, and loved. Given our professional awareness of the importance of attachment to the development of a secure sense of self, one can easily recognize the power of fostering a strong intimate relationship in promoting the healing process for childhood sexual abuse survivors.

An additional layer illustrated in participant narratives broadened our understanding of the partners’ role in the therapeutic process. Little information existed prior to this study regarding the partner’s perspective on the treatment protocol for CSA survivors. Previous researchers explored the alienation, anger, sadness, confusion, and rejection experienced by partners who were excluded from the therapy process (Bacon & Lein, 1996; Reid et al., 1996). Participants in this study generally agreed with previous research findings with more than 50% of those responding to the participant reflection form acknowledging that they would worry about partners feeling excluded from the process if conjoint therapy was not included. Prior to this current study, however, little
was known about the experience of partners who had actually participated in conjoint treatment. Partners expressed not only feeling more informed about the recovery process, but also experienced significant personal change and fulfillment. Partners related how being involved in the process facilitated the ability to express their own feelings, understand the emotional and physical reactions of the survivor, feel effective in their ability to provide support, and enjoy a sense of emotional closeness with the survivor. Nicole summed it up best when she stated “And just to know that by supporting somebody that that could change so much just made me feel great” (4, P, p. 3).

Given the positive reaction of partners involved in this study, it is not surprising that two constructs proposed in the literature were not borne out with current participants. Revictimization and benevolent blame have been proposed as potential concerns for therapists who choose to include partners in the recovery process for childhood sexual abuse survivors. Survivor revictimization is a significant concern given its increased likelihood with the CSA survivor population. In order to gauge this issue, participants were specifically asked if they had ever regretted talking about something in session. Uniformly, participants denied ever being afraid of having their words used against them or feeling as though they regretted allowing themselves to be vulnerable in front of their partner. Participant narratives also failed to convey a sense that survivors felt blamed or completely responsible for relationship concerns while partners filled the role of rescuer. With the exception of Charles, who made it clear that he did not have any therapeutic issues and participated both in therapy and the research study at the behest of his wife, partners consistently highlighted their own responsibility in communication problems and experience of personal growth throughout the healing process. None of the survivors
indicated that their partners had made them feel guilty or blamed them for their relationship concerns or traumatic symptoms. All of the couples expressed feeling like they were a team addressing the needs of the couple even if the need was simply providing support for the survivor as he/she traversed recovery.

A team focus was most notably reinforced in the context of communication issues. Even Charles acknowledged that he benefited from improved communication with his wife and experienced personal change in how he engaged with her. It is well established that childhood sexual abuse is correlated with significant communication barriers and therapy is often sought to address communication problems. For participant couples, the framework of sexual abuse recovery was utilized to facilitate insight into the origins of communication challenges, however, the actions and reactions of both members of the couple were targets for change. Miscommunication patterns were initially identified and interventions which support the efficacy of Follette’s (1991) social learning model of therapy were used to revise the patterns of interaction utilized by the couple. Participants not only learned skills which enabled them to better understand one another and joint problem solve, but also learned skills which supported emotional reconnection. The relationship founded on a secure base as described by Johnson (2002) cannot be fostered without clear communication. Survivors described a significant change in their ability to express their thoughts and emotions while partners developed the capacity to effectively validate the survivor’s messages both verbal and nonverbal.

While all couples can experience communication difficulties, the couple dealing with trauma face unique challenges. Many participant survivors experienced physical and mental flashbacks to their abuse and struggled with extreme reactions to these powerful
triggers. In her emotionally evocative narrative Claire shared how she would often become nauseous during sexual interactions with her husband. She and James then revealed the empowerment they felt when she learned to directly share what was happening with her and he was able to respond in an appropriate way. One can only imagine how destructive Claire’s posttraumatic reaction to James’ lovemaking could be if they had never learned to talk about it. A key element in the transformative dimension of communication was the mutual change in both the survivor and the partner. Research has almost exclusively focused on the survivor’s change with the partner merely acting as a support structure, but the development experienced by partners cannot be ignored.

The integrated change in trust and communication was also reflected in the effectiveness and frequency with which participants established and maintained healthy boundaries. Previous research focused on the power of individual therapy to support boundary construction with survivors. Partners, however, were excluded from this process fostering alienation and an experience of the survivor’s new boundaries as confusing and often anger provoking (Jehu, 1988; Reid, 1993). Current participants described a very different process. Most of the survivors did start out in individual therapy and would occasionally use individual sessions to “try out” ideas or skills before sharing them with their partners. However, partners were intimately involved in the therapeutic process making them aware of why survivors might struggle with certain boundary issues and helping them learn to support and respect the new skills being used.

Boundaries were created on many levels. Survivors learned to effectively assert themselves, directly express their wants and needs, and empower partners by helping them understand how to be meaningfully supportive. Survivors learned to either take
more control or allow their partner more control of decisions and family functioning as the couple found a balance of shared power. The transformative power of boundary setting was also emphasized with regards to the sexual relationships shared by participant couples. Claire stated “it helped me learn the difference between…it’s okay to be sexy and be a sexual being and have control over yourself and enjoy it versus being exploited” (1, J, p. 12). She, and other survivors, expressed learning to feel more comfortable being sexual with their partners and being able to state when they were uncomfortable. Partners then expressed feeling less guilt as they were reassured that they would not be confused with the perpetrator and somehow unknowingly violate the survivors. This supports the assertion that improved communication within conjoint therapy can reduce the likelihood of survivors confusing their partner and perpetrator and experiencing projected trauma reactions.

A second layer of transformation took place between the couple and the survivors’ families of origin. This is a finding unique to the current research and adds an interesting texture to our understanding of the recovery process for childhood sexual abuse survivors and their partners. Changing interactional patterns with the survivors’ families of origin was seen as the “next step” in recovery as the couple experienced increased trust and confidence in their intimate relationship. Particularly interesting was the transformation experienced by partners as they dealt with their in-laws. James expressed learning to accept his hatred of Claire’s brother, while Nicole felt empowered as she supported Stacy’s efforts to set boundaries with her father. Couples approached their interactions with the survivor’s family as a team united in strength and purpose;
further reinforcing the recovery process for the survivor and validating the transformed intimacy within the couple.

Research participants did not address the effectiveness of conjoint therapy or the impact of couples therapy on their relationship by providing us with a quantitative statistic. Instead they described the essence of transformation through vibrant and emotionally evocative portraits of experience and change. It is through understanding this essence of transformation that we are able to interpret the effectiveness of this therapeutic approach. Participant survivors expressed feeling like “different people” at the conclusion of therapy. They experienced dramatic intrapsychic and interpersonal change in their understanding of themselves as valuable individuals defined within the context of a loving and supportive relationship. They learned to trust themselves, their partner, and in their ability to effectively assert their own needs and desires. Partners experienced their own growth and transformation as individuals and as supportive and loving mates. They learned to trust the survivors and their own reactions while effectively sharing their own feelings and providing appropriate and meaningful support. The effectiveness of conjoint therapy and its impact on survivors’ relationships can be effectively summed up by participants who expressed the following sentiments.

Nicole: So, for her to say “yes, I want you to be part of something that is this intimate in my life and that I would prefer you to be there to a family member …that just made me feel incredible. So, I couldn’t say that I was ever discouraged. Because…just seeing that gave me the strength to get up every day and make it a point to help Stacy out.

(4, P, p. 4)

Our focus thus far has been on the transformative dimensions and how they addressed the effectiveness of therapy and it’s impact on the survivors’ relationships. However, one of the key findings of this study explores not an outcome dimension, but a
process dimension. One of the questions posed at the beginning of this research aimed for increased understanding of the process variables which participants identified as the greatest mechanisms of change. As can be seen by the pervasive inclusion of therapist characteristics throughout the narratives, the most powerful mechanism of change was found in the therapeutic relationship itself. The emphasis on the importance of therapist-client fit, particularly for couples work with this population has not been reflected in previous research. It is a key finding within the current study.

Every participant couple discussed the importance of finding the right “fit” with a therapist and advised future couples to “move on” if the therapist they were with did not feel right. Establishing trust and a shared understanding regarding goals and therapeutic style were conveyed as fundamental to successful treatment. Multiple variables were also identified as valuable to the creation of this therapeutic bond. Advocacy for the couple and their relationship was a quality that was meaningful to participants’ understanding effective treatment with CSA survivors involved in intimate relationships. Chris experienced empowerment and comfort from the image of him, his wife, and their therapist guiding the boat of their recovery as a team across the water. Claire and James experienced the same sense of comfort and advocacy as they recounted how their therapists were “rooting” for them. All of the couples experienced as meaningful the focus on the couple even if only one member of the dyad was in session. They again drew power and comfort from knowing that they were not isolated, but were undertaking this journey with the support and trust of a loving partner and a professional; invested not only in one person’s growth, but also in preserving the strength and integrity of the survivor’s primary intimate relationship. This investment in the couple ensured that the
lives survivors’ built were not destroyed by their transformation, but were rather protected and framed as resources for growth.

In addition to highlighting the value of advocacy and trust within the therapeutic relationship, participants emphasized the value of therapists as communication mediators or filters. The ramification of childhood sexual abuse on the communication skills of survivors has already been discussed at length and it is not a surprise that a therapeutic emphasis on improving communication skills was important to participants. The consistency and intensity with which couples focused on the need for a translator was meaningful in that therapists not only dissected sentences and facilitated improved listening skills, but they also interpreted and mediated intense emotionally reactive interactions. Survivors and partners had difficulty understanding their own physical and emotional reactions, so effectively communicating these feelings to their partner was extremely difficult. Therapists working with participant couples were skilled at translating many layers of emotional expression while reinforcing basic communication. The power of this therapeutic intervention was concisely conveyed by Jaime’s words.

Jaime – I think for me I would have created you as an enemy very early on. And at times I did anyone. So, if it wasn’t for the couples counseling and piecing apart…dissecting our actual sentences…what I heard versus what was said…or maybe how Chris said it be really may not have meant it. I would have never…I would probably have been a prime candidate for divorce.

(2, J, p. 1)

The intensity and focus on the facilitative dimension of therapeutic fit was one of the key research findings in this study. With little deviation and with repetitive emphasis, participants discussed the importance of a strong “fit” between themselves and their therapist. Factors described by participants that contribute to a good fit included therapists (a) being non-judgmental, (b) acting as advocates for the relationship,
(c) functioning as mediators, (d) treating couples as equals, (e) matching their therapeutic style to the needs of the couple, (f) focusing on the couple even with only one person in session, and (g) treating each couple as unique. Additionally, participants highlighted the importance of feeling as though they had a voice in guiding the pace and structure of therapy. Partners in particular emphasized the meaningfulness of their being able to decide how and when they wanted to be involved in the therapeutic process. It was suggested in chapter four that partners having this level of control over the therapeutic process might explain the lack of support for benevolent blame found in this research study. Partners are likely less inclined to feel resentment when empowered to make their own choices and may be more willingly engaged in the therapeutic process and open to exploring their own change.

One final research question explored the perceived impact of individual and group therapy on the recovery process and the couples’ relationships. Participants consistently upheld findings from previous research. Participants all agreed that individual therapy can be helpful in providing survivors with a safe place to begin to explore their abuse experiences and practice sharing information that may be difficult to discuss with their partners. Those survivors who had participated in a group therapy experience all emphasized the value of this context to the reduction of internalized shame and increased feelings of normalcy. Additionally, the support component of group therapy was highlighted as a valuable adjunct to survivors’ participation in other modes of therapy.

Although participants emphasized the value of both individual and group therapies to the recovery process, they also consistently reiterated Jaime’s statement that therapy would be incomplete without the conjoint component. One assertion made by
participants accented the destructive power of keeping secrets. Partners expressed feeling may fear that the survivor would be counseled to leave the relationship or that they could become concerned about what was being said about them in the survivor’s individual sessions. The construct of partner alienation (Follette, 1991) was also supported by participant couples as they shared that partners not being involved in the recovery process may lead to them feeling excluded, distrustful, and could lead to the destruction of either their relationship, their healing process, or both.

The findings of this current research support much of the existing research and offer new insight into the constructs of conjoint therapy that are meaningful to survivors and their partners. The transformative dimensions of trust and communication are congruent with previous research and validate the assumptions made by participants in previous research who asserted that couples counseling would increase emotional connection and the ability to converse with one another. The boundary setting dimension expands on existing research and increases our awareness of the importance of therapists addressing this issue with survivors and their partners. Previous research focused on boundary setting education in individual therapy. Survivors, however, indicated that this intervention could have negative effects on their relationships. Participant narratives in the current study support the value of framing boundary setting as a process in which survivors and partners learn to integrate changing patterns of boundary setting both within their relationship and between their relationship and outside entities such as the survivor’s family of origin. Participant survivors found the support of their partners to be an invaluable asset in their learning to be assertive with their families and experienced the increased strength of the couple as fundamental to their redefinition of self.
Little previous research addressing the needs of survivors and their partners focused on the relationship between clients and their therapists. Work has been done indicating that the relationship between survivors and their individual therapists is key to recovery, but the current study is the first to explore the interaction between therapeutic relationships in conjoint therapy and transformation within the couple. Participant narratives consistently illustrated the value survivors and partners placed on therapist characteristics and the fit between those characteristics and the needs of the couple. The therapeutic fit facilitated participant change by reinforcing the strength of the couple and framing their intimate relationship as a resource for recovery. Participants were able to explore alternative ways of being within the safe confines of a supportive and nurturing therapeutic environment. According to participants, change cannot take place without this safe haven being established and they suggested future couples “move on” if they do not experience a healthy and comfortable fit with their therapists. These four dimensions, and the overall subjective experience of change, define the essence of the experience of conjoint therapy for the four couples involved in this study.

Member Checking

Member checking was incorporated into this research as a way of increasing validity of the results. Participants were asked at the conclusion of the first interview if they would be willing to complete the follow-up questionnaire as a way of validating themes identified by the primary researcher. Six of the eight forms were completed and returned (See appendix I ). Several limitations will be discussed later regarding this participant reflection form, however, it is important to acknowledge the responses given by participants. Readers should be aware that although all participants agreed to complete
the reflection form, one participant checked either disagree or not applicable to all but eight of the 43 items on the form. Additionally, this individual wrote “I don’t like surveys” and “This is an unwelcome reminder of the past” in the comment section of the form. Given the limitation on information gained from the form, it is impossible to identify this individual either as a particular participant or even as a survivor or partner.

The strongest consensus of agreement focused on the items related to communication. Each of the seven items were agreed with by either five or six of the respondents. Respondents also supported the themes of positives of individual therapy, positives of group therapy, boundary setting, partner support, therapist characteristics, types of therapy, and therapeutic style with agreeable responses from at least four or more participants. Items on the reflection form which addressed the negatives of individual and group therapy contradicted stories shared by participants during the interviews. One reason for the discrepancy may lie in the fact that during the interviews participants were expressing concerns regarding ONLY having individual or group therapies to the exclusion of conjoint. The items (five and seven) that explicitly stated “if couples therapy is not included” still maintained a 66.6% agreement, while, the other two items (six and eight) did not indicate the exclusion of conjoint treatment. This difference may have influenced how participants interpreted these questions leading to a 50% agreement that with group therapy only couples may experience reduced trust and a 33% agreement that individual therapy only may create reduced trust. Fifty percent of respondents indicated that a positive of couples counseling lies in the fact that it may increase trust in their relationship, however, this was a primary theme expressed by all participants during the interviewing process. It has been acknowledged throughout this
research that individual, group, and conjoint therapy were all identified as vital to the recovery process by survivors and their partners. It may be that couples were reluctant to specifically attribute their change in trust as directly reflective of only the conjoint process, this is only a hypothesis, however, as further interviewing was not completed to clarify the interpretation made by participants. Overall participants agreed with the initial themes identified by the researcher.

Implications for Clinical Practice

As professionals continue to work with childhood sexual abuse survivors, certain well-established practices are supported as effective by the current research. Individual and group therapies were described as both meaningful and powerful by participant survivors. These modes of therapy are currently best practice approaches to treatment and should be maintained. However, therapists should keep in mind the concerns expressed by participants regarding the destructive power of secrets and the alienation that could potentially be felt by partners who are excluded from the therapeutic process. If survivors in treatment are involved in loving and supportive intimate relationships, the partners involved in this relationship should, at the minimum, be incorporated into the treatment process even if it is only in the context of learning about the recovery process and being educated regarding the best ways to support the survivor.

Ideally, according to participant couples, conjoint therapy should be undertaken as a standard approach to CSA recovery protocols where survivors are involved in intimate relationships. Supporting previous research, which suggests focusing on increasing a secure emotional attachment (Johnson, 2002) and improving the interactional patterns and problem solving skills of clients (Follette, 1991), current research indicates that
practitioners should intentionally focus on building trust and fostering appropriate and effective communication skills with couples dealing with CSA. Additionally, using these skills to facilitate improvement in boundary setting was identified as meaningful and important to full recovery. Using the strength of survivors’ intimate relationships to support establishing limits with families of origin is a new concept, but one that practitioners should bear in mind as important when engaging with CSA survivors. Each of the couples discussed the importance of this transformation to their long-term growth and it seems to be the natural next step and possibly last step in the healing process.

Participants clearly expressed the belief that without the conjoint component, the healing process is not complete and transformations experienced by survivors may be detrimental to the relationship. In contrast, when partners are involved in therapy survivors are free to engage fully in the treatment process without fear of alienating their significant other. Additionally, participant couples highlighted the fact that partners can experience significant positive growth and personal empowerment from learning how to engage with the survivor in a new and more healthy way. Through conjoint treatment, couples can learn to define themselves as a team joined in the experience of recovery. Included in recovery is intrapsychic transformation in the survivor (and possibly the partner) and transformation of the interpersonal interaction within the couple.

A treatment protocol for addressing the issues of childhood sexual abuse, which incorporates the conjoint modality, can help the survivor overcome the long term effects of CSA by using their intimate relationship as a healing resource in itself. As trust and communication increase, survivors can reframe their sense of self within the context of a loving relationship. Instead of being an isolated victim, their self-image as a worthy,
valuable, and lovable individual can be fostered. As survivors and partners learn to set boundaries both within and around their relationship a foundation of emotional engagement, effective communication, trust, and mutual support can be reinforced and provide partners with a secure base.

Participants suggested that in order for childhood sexual abuse treatment protocols to be effective, certain characteristics must exist within the therapeutic relationship. Initially, practitioners need a cognitive shift away from focusing solely on the survivor’s needs to understanding survivors within a larger context. Participant narratives vibrantly illustrated the fact that survivors are not recovering in a vacuum. Instead they are complex individuals functioning within a greater context including their intimate relationships, their immediate family relationships, and the on-going relationships with their families of origin. Therapists cannot ignore these relationship variables and anticipate successful treatment outcomes. Research demonstrates that an exclusive focus on survivor needs is most likely not going to be 100% effective and may deleteriously impact survivors’ critical bonds.

As practitioners connect with survivors and their partners, participant narratives reveal multiple therapeutic variables that must be attended to. Many of the variables, such as being non-judgmental and treating clients as unique, are generally understood as important to all therapist-client relationships. Certain factors described by participants, however, are tailored to work with a population where trust development, control issues, and concerns regarding abandonment are particularly challenging. Practitioners need to immediately recognize that survivors are often individuals who had little or no control over their lives at a key point in their identity development. They will likely be struggling
with self-esteem and self-efficacy issues and need to be encouraged to take some control of the pace and structure of therapy. Practitioners can foster survivor and partner efficacy with regards to assuming this control by approaching the couple as equals and maintaining an open and tentative approach to intervention. Additionally, research has shown that partners may use benevolent blame in conjoint therapy to protect themselves in the therapeutic process. It is hypothesized from the current research that perhaps there is a correlation between partners feeling they have control over their level of involvement in the therapeutic process and a reduction in the occurrence of benevolent blame.

Maintaining a focus on survivors’ intimate relationships throughout the recovery process is also a factor in therapy that was emphasized by participant couples. For practitioners who have worked almost exclusively or exclusively with individual survivors this may be an important shift in their treatment approach. Participants clearly conveyed the belief that therapists acting as an advocate for their relationship, cheering them on so to speak, and keeping the relationship issues as central even with only one person present in session was vital to continuing progress in recovery. Advocacy gave survivors and their partners hope that they could work through the healing process, and the relationship focus allowed partners to feel less threatened by the experience. This enabled survivors to relax and engage in the therapeutic process with less fear that their partner would leave them.

Further implicated by current results is the assertion that even as new models of therapy are developed for working with this population, practitioners need to be vigilant to the individual and unique needs of each couple. As mentioned earlier, having a sense of control over the therapeutic process was meaningful to participants and therapists
valuing the input of the couple was seen as beneficial to the recovery work. Additionally, participants discussed the value of therapists recognizing their unique needs both individually and as a dyad. It is important that practitioners utilize evidenced based models of therapy to treat this complex presenting issue, however, this current research clearly establishes that survivors and their partners benefit the most when they and their therapist are equals, each with a valued perspective. Therapists are the experts when it comes to particular models of treatment and should not be afraid to suggest interventions and guide therapy, but they need to remain aware of the uniqueness of each client and respect their right to influence the process.

One final implication from this research is the understanding that if there is not a good fit between a therapist and a client couple then clients should be supported in their right to seek alternative options. Participants all suggested that they had not “stuck” with their very first therapist. Several participants also stated that they had referred others to their own therapist only to find out that it was not a good match. It can be difficult when clients do not return or request a different professional, but therapists should not assume that they did something wrong. Although participants identified multiple therapeutic variables which would increase the likelihood of a successful fit, it was also indicated that they often just had to have the right “feeling” or immediate connection with the therapist. Practitioners will not have that perfect fit with all of their clients and they cannot take it personally, but intentionally incorporating factors described above may benefit their work with this population.
Limitations

The current study was qualitative and exploratory in nature. Results were gathered from a purposeful, but small sample of information rich cases with the purpose being to gain knowledge regarding the phenomenon of conjoint therapy with CSA survivors and their partners. Due to the sensitive nature of the topic of inquiry, identifying couples to include in the study was difficult. Approximately 200 therapists were contacted as potential sources of participants, however, a very small percentage of professionals were supportive. It must be acknowledged therefore, that couples referred by these therapists were likely more pro-therapy than the average client and could have had a closer therapeutic relationship than seen in the general clinical population.

One of the survivors in the study was also involved in a long-term, monogamous, and same-sex relationship. She and her partner were included in the interviews. Initial and later reviews of interview transcripts from this couple reflected high congruence between the sentiments they expressed and those expressed by the other participants. It was determined by the primary researcher and other committee members that inclusion of this couple in the study was appropriate, however, it is acknowledged that this couple’s experience is necessarily informed by their self-identification as lesbians.

As indicated earlier, participant reflection forms were sent to participants approximately half way through the data analysis phase of the research process. Several concerns were identified, however, that limited the usefulness of the information gathered from the participant reflection forms (Appendix I). As forms were sent to participants with only the initial coding completed, their reflections do not correspond directly with the four dimensions eventually identified by the researcher. Instead their responses are
based on the initial and only partially formed themes. Participants were also not asked to write any identifying information on the forms including if they were a survivor or a partner. Certain items on the form addressed specific interventions which would not have applied to partners, however, it was impossible to determine who was answering the question. This is of particular importance to the theme identifying helpful and unhelpful interventions. These were specifically geared to either survivors or partners, however, the format of the form precludes interpretation. As indicated above, formatting may have made interpretation of the questions difficult for participants leading to difficulty integrating their responses. Finally, incorporating the responses of one individual who disagreed with all but eight of the items skews the results of the reflection form. His/her comments clearly indicated discontent with the questionnaire in general and it is difficult to determine if his/her irritation with completing the form influenced how he or she responded to the questions. Significant revisions needed to be made in this form in order for it to be more useful.

The final limitation of this study addresses the lack of exploration of sexuality. It is generally accepted that childhood sexual abuse survivors often experience long term symptoms which negatively affect their sexual expression. It is also acknowledged that couples counseling is generally the mode of therapy that is most effective in treating couples who are experiencing sexual dysfunction. Due to the potential vulnerability of the population being studied, questions regarding sexuality were excluded from the interview guide. Understanding the experiences of clients as they therapeutically address issues with their sex life is vital to gaining a complete understanding of the process of recovery. Participants in the current study spontaneously revealed small snapshots of
their sexual experiences, however, as questions were not directly posed regarding the impact of childhood sexual abuse and therapy on their sex lives, participants shared very limited information.

Implications for Future Research

As indicated by the limitations found in the current study, future research needs to explore the sexual experiencing of couples dealing with childhood sexual abuse. Previous research supports our understanding that childhood sexual abuse significantly and negatively impacts the sexual functioning of survivors. Previous studies have also identified individual interventions that can be utilized to address sexual problems in survivors, but research is lacking that informs our awareness of how various modes of treatment (including conjoint therapy) impact survivors’ intimate relationships. Additionally, little information exists regarding specific interventions or therapeutic variables which negatively or positively impact the healing process. Further exploration of treatment protocols for addressing sexual recovery for survivors and their partners is an important and logical next step in the research process.

Specific models of therapy are being proposed to address the specific needs of survivors and their partners. Emotionally focused therapy (Johnson, 2002) and the social learning approach (Follette, 1991) are two such models. The advantages and appropriateness of each model have been discussed at length throughout the current study, however, little research has been conducted to review the relative efficacy of specific therapeutic approaches. Both Johnson and Follette incorporate the key dimensions of communication and trust in their protocols, however, there are significant differences in how change in these areas are achieved. In the current research, no
identifiable model of therapy was mentioned by participants. As these models become more widely utilized in an organized fashion, research needs to take place to either determine the best practice models or to suggest alternative approaches which may more effectively encompass meaningful change mechanisms.

The final implication for future research is to suggest that research continues to expand on the qualitative work initiated herein. The current research study offers rich and textured participant narratives, but is limited by the small number of participants. While small samples are standard when in-depth information gathering is the goal, researchers need to continue to add voices of other experts who have experienced the phenomenon of conjoint therapy in the context of treatment for childhood sexual abuse. Although the transformative and facilitative dimensions were derived from essential and recurring themes, it is vital that researchers continue to add to our knowledge by gathering more portraits of experience which can serve to inform our understanding of the phenomenon of conjoint therapy. Our ultimate goal is to identify the most meaningful and effective ways to help childhood sexual abuse survivors and their partners overcome the destructive influence of abuse and emerge healthier, stronger, and joined in mutual healing.

Researcher Transformation

The core essence of meaning experienced by participants was change. The essence of my own experience throughout this research process echoes that of the participants. I entered into this project with a passion to better understand how I, as a clinician, researcher, and teacher could improve the lives of childhood sexual abuse survivors. Trained as a marriage and family therapist I was also particularly interested in
survivors’ recovery within the context of their intimate relationships. I had interacted with CSA survivors in a variety of settings, including as their counselor, and had a fundamental respect for the strength and resiliency it takes to overcome the significant and destructive effects of sexual abuse.

What I experienced over the course of the research process reinforced my admiration for survivors, but also changed my perception of partners and even more significantly my perception of other mental health professionals. My initial perception of partners framed them as adjuncts to survivors. I viewed them as potentially helpful, possibly destructive, but consistently in the supporting role with regards to survivor recovery. Getting to know participant couples over the course of several hours in the context of their own homes altered my perspective to the point where I now recognize survivors and partners as mutually invested dyads defined both as separate individuals, but also as a cohesive unit interacting with each other as equals. When interacting with these couples I was struck by the strength of their bonds, the easy way they communicated with each other, the overwhelming sense that they had gone through something very difficult together and had emerged confident in themselves and in their relationship. I was surprised by the sense of investment and ownership in the recovery process expressed by the partners. They were not just adjuncts to the healing process, but were instead invested participants who gained personal satisfaction and fulfillment from the therapeutic experience. Prior to my experience I underestimated the role of partner in survivors’ recovery. This knowledge will certainly change my approach to working with this population and will hopefully influence the work that others are doing in the field.
One of the most disconcerting experiences throughout this process involved my interactions with other mental health professionals. I received many responses from other counselors/therapists and psychologists that reflected a strong concern with the resiliency of childhood sexual abuse survivors. Several professionals expressed disapproval regarding my desire to interview survivors and many expressed significant concerns regarding survivors’ ability to participate in such research without being retraumatized. Even those that were supportive conveyed their belief that getting survivors to talk may be difficult or impossible. The participants themselves, however, expressed gratitude for having an opportunity to share their stories with others. Several also stated that it was good to “see how far we have come”. I am not suggesting that all CSA survivors are eager to broadcast their history to the world, but I am suggesting that mental health professionals underestimate the strength and resiliency of survivors. I take from this research the renewed determination to expand my own understanding of this population and continue to educate my colleagues and future professionals.
REFERENCES


APPENDIX A

INFORMED CONSENT TO ACT AS A RESEARCH PARTICIPANT

TITLE: A Qualitative Analysis of Couple Therapy with Adult Survivors of Childhood Sexual Abuse and Their Partners

INVESTIGATOR: Michele Heberling, P.C.
Doctoral Student
University of Akron,
Department of Counseling
Akron, OH 44325
330-607-4471

DISSERTATION ADVISOR: Dr. Patricia Parr, Chairperson
University of Akron,
Department of Counseling
Akron, OH 44325
330-972-8151

DESCRIPTION:
This research project is a qualitative study designed to help researchers and counselors better understand the needs of childhood sexual abuse (CSA) survivors and their partners who have participated in couples counseling. The participants involved in this study will be asked to share information about their past experiences with couples counseling as part of the treatment process for CSA recovery. This information will be shared by taking part in a three step interview process with the researcher, Michele Heberling.

The researcher will contact prospective participants via telephone and complete an initial interview with both participants to ensure their match with the study parameters. Participants will subsequently share in one couple interview and will then be interviewed individually at a separate meeting. The first interview will take approximately two hours. Each individual interview will take approximately one hour. Both interviews will be audiotape recorded to help the researcher remember what was discussed. These audiotapes will be destroyed within three years after the completion of this research study.

After the researcher has listened to the audiotapes, a follow-up phone call may take place to clarify information or the participant’s thoughts on a particular topic. Participants who have agreed during the initial interview may be contacted via certified
mail or telephone during the data analysis phase and asked to provide personal reflections on an initial summary of research findings.

Findings from this study may be published for scientific purposes. Publications will include descriptions of themes which emerged during interviews. Individual identities of research participants will not be revealed in any published materials.

SAMPLE OF INTERVIEW QUESTIONS:
The following are questions that may be asked in either the couple or individual interview sessions. Information gained during the individual interviews will not be directly shared with the other partner, however, information from all interviews may be included in future research publications. Individual identities will not be revealed in any publication materials.

1. How would you describe your experience of couples therapy?
2. How did your participation in couples therapy impact your relationship?
3. What would you have changed about the couples’ therapy you received?
4. How did you feel about becoming involved in the counseling process?
5. How did you feel about your partner becoming involved in the counseling process?
6. Did you ever regret talking about something in couples counseling after you left the session? If yes, can you describe why?

POTENTIAL RISKS:
There may be some risks to taking part in this study. Feelings of mild anxiety may arise after reflecting on the impact of childhood sexual abuse on your life and relationship. You and your partner may experience conflict related to differing opinions regarding the couples counseling experience. In an effort to minimize any possibility of participants being identified, pseudonyms (fake names) will be assigned in order to protect your privacy and that of your partner. If you experience greater than mild distress, you can talk to the researcher about this. The researcher is not responsible for the provision either directly or financially of counseling services, but will provide a referral list of mental health centers that are available to provide counseling services should you desire them. You may also choose to contact the therapist who provided the couples counseling. In the unlikely event that you experience active or distressing thoughts of self harm or harm to another person, the researcher will stop the interview and assist you in obtaining immediate help. If this situation arises, you agree to cooperate with the efforts offered by the researcher.

POTENTIAL BENEFITS
There may be benefits to participating in this study. You may learn more about yourself and have an opportunity to reflect on the positive changes you have made in your life and your relationship. Others may also benefit from your knowledge and the information that is gained from this study. Counselors may learn to more effectively provide assistance to CSA survivors and their partners. There may also be no direct benefit to you from participating in this research.
COSTS AND PAYMENTS:
There is no cost to participate in this study. You will receive a $15.00 gift certificate to thank you for participating.

CONFIDENTIALITY:
Information that you share during this study, including personal information, will be confidential. The interviews will be tape recorded and then typed out so the information can be studied. Pseudonyms (fake names) will be assigned in order to protect your privacy. Anyone else’s name that is mentioned during your interviews will also be changed to protect their privacy. The signed informed consent forms will be kept separate from all the interview information; the tapes, and the typed out transcripts. Signed consent forms will be maintained in a locked filing cabinet in a secure office at the University of Akron. Only the researcher and her advisor will have access to this information. Tape recordings, transcripts, and cross-file will be destroyed within three years after the completion of this research study. Your identity will never be revealed in any description or publication of this research. The findings from this study may be published for scientific purposes.

RIGHT TO REFUSE OR END PARTICIPATION:
You have the right to refuse to take part in this study or stop at any time. I may stop this study if it is in the best interest of a participant. You may also request to take a break during the interview or refuse to answer particular interview questions.

CONTACT INFORMATION:
You can reach Michele Heberling at 330-607-4471 if you have questions about this study at any time. You may also contact Dr. Patricia Parr at 330-972-8151 with any questions or concerns. For questions concerning your rights as a research participant, you can contact Ms. Sharon McWhorter, Interim Director of Research Services at 330-972-7666 or 1-888-232-8790 (toll-free). By signing this form, you are agreeing to take part in the study.

VOLUNTARY CONSENT:
Michele Heberling has explained all of the above information and has answered questions about this study. I understand that participation in this study will include an initial phone interview, a couple interview with my partner, an individual interview, and completion of a brief demographic form. I understand that she will be contacting me at the number I have provided below to arrange the initial telephone interview. By signing this form, I agree to take part in this study.

_______________________________________  ____________________
Signature of Participant     Date
TAPE RECORDING:
I also agree to allow my interviews to be audiotaped by the researcher. I understand the tapes will be destroyed within three years after the completion of this research study.

_______________________________________  ____________________
Signature of Participant     Date

_______________________________________
Please Print Name

INVESTIGATOR'S CERTIFICATION: Michele Heberling certifies that she has explained to the above individual the nature, the purpose, the potential benefits and possible risks associated with participating in this research study, has answered all questions that have been raised, and has witnessed the above signature.

_______________________________________  ____________________
Signature of Investigator                Date

CONTACT INFORMATION:
Please provide a phone number where you can be contacted. _______________________
LETTER TO THERAPISTS

Michele Heberling

Therapist Name
Therapist Address

Dear :

I am writing to request your assistance in completing the research for my doctoral dissertation. I am currently enrolled in the marriage and family therapy Ph.D. program at the University of Akron. I am working with both Dr. Patricia Parr and Dr. Maryhelen Kreidler on this project. The title of my dissertation is *A Qualitative Analysis of Conjoint Therapy with Adult Survivors of Childhood Sexual Abuse and their Partners*. Authors have recently been proposing the addition of couples counseling to the treatment protocol for addressing childhood sexual abuse (CSA) recovery issues, however, there is little information available from the experts…the individual couples who have participated in this experience. I am hoping that by talking to survivors and their partners who can share their experience; I will be able to help counseling professionals provide more effective treatment options.

I plan to do a qualitative study in which I explore the therapeutic experiences of survivors and their partners who have participated in couples therapy. I would like to interview couples in which one partner is a CSA survivor while the other is not. It would be most helpful if these participants have completed couples therapy within the last three years and have been engaged in a committed monogamous relationship for at least two years. I anticipate that the only way to connect with these individuals is through therapists willing to discuss my research with their clients. I have enclosed several self-addressed stamped envelopes, consent forms and fliers outlining my research project. I would greatly appreciate your willingness to pass this information on to CSA survivors and their partners whom you feel may be willing to participate.

I have enclosed a copy of my curriculum vitae so that you are familiar with my background and the experiences I am bringing to this project. I will be in touch in the next week to confirm your receipt of my information. I thank you for your consideration and look forward to hearing from you.

Sincerely,
Michele Heberling, P.C.
Dear [Therapist’s Name],

I am Michele Heberling, a licensed professional counselor and a doctoral student in Marriage and Family Therapy at the University of Akron. I am conducting a research study that aims to explore and better understand the process and effectiveness of therapy focused on couples counseling for adult survivors of childhood sexual abuse and their partners. I would like to talk to former clients about their experience with couples counseling and the impact of childhood sexual abuse on their relationships.

This research is part of my doctoral dissertation and will be used to help develop more effective treatments for couples who have been impacted by childhood sexual abuse. Participants will not be asked to explore their abuse experiences.

I am asking interested couples to participate in two private interviews. For purposes of this study, each couple must have completed couples counseling within the last three years and have had childhood sexual abuse recovery issues addressed as one of the treatment concerns during counseling.

Please read the enclosed consent form and discuss it with anyone you choose. It contains additional information about the study and its potential risks. If you are interested in participating, both you and your partner should sign a separate copy of the enclosed consent forms and return the extra copy of the last page in the enclosed envelope.

If you have additional questions about the study please call and leave a confidential voice mail at 330-607-4471. When I receive the copies of the consent form I will contact you by phone to answer any questions and discuss possible arrangements for an interview.

This study has been approved by the Institutional Review Board at the University of Akron, Office of Research Services 1-888-232-8790 (toll-free).

Thank you for your time and consideration!

Michele Heberling
APPENDIX D

INITIAL PHONE INTERVIEW GUIDE

Thank you for your interest in my study and for contacting me. Do you have a moment so I can briefly explain the purpose of this research and what it will entail?

I am a licensed professional counselor and a doctoral student at the University of Akron and am completing this study as part of that program. I am being supervised throughout by Dr. Patricia Parr, an independently licensed marriage and family therapist and professional clinical counselor, in the counseling department. My hope in completing this study is to better understand your experiences with couples counseling as part of a treatment program for recovery from childhood sexual abuse. I am trying to connect with couples who may be able to better help us as counselors address the needs of survivors and their partners.

As part of this study I would like to meet with both you and your partner and talk to you together about your experiences with couples counseling. I would also like to take an opportunity to speak with each of you individually at a second interview time. I am willing to drive to your home for each of the interviews or meet with you at a secure location of your choice. I anticipate that the first interview with you as a couple will take approximately 1 ½ to two hours and each of the second individual interviews will take approximately one hour to complete. Does that sound like something that would be interesting for you to be a part of?

Do you have any questions about the informed consent information you sent to me? Do you have any other questions I could answer for you?

Couples that I include in this study have to meet certain criteria in order for me to include them in the research. May I ask you a few brief questions?

1. Have you and your partner completed couples counseling within the last three years? (Must answer yes to be included in study)
2. Was at least one goal of that counseling to address issues related to your (or your partner’s) experience with childhood sexual abuse? (Must answer yes to be included in study)
3. How long have you and your partner been together? (Must answer at least two years to be included in study.)
4. Has one of you or both of you experienced past sexual abuse?
(Must be only one partner of the couple that has experienced past sexual abuse.)

5. Are you or your partner currently under the care of a mental health professional?
   (Must answer no to be included in study.)

If the answers to questions one through five meet the research criteria, then I will ask questions six through nine. If a respondent answered “no” to any of questions one through five, I will stop the interview and explain how the couple needed to meet this criteria to be accepted as part of the study (e.g. “Thank you so much for your willingness to be a part of this study. Unfortunately, I am limited to couples in which only one partner has experienced abuse. I really do appreciate your willingness to be a part of this study and I wish you well as you continue on your journey.”). If respondents meet the research criteria outlined in questions one through five, I will continue with the following protocol.

In order to be sure that you will feel comfortable talking about the process of couples therapy I would like to ask you four additional questions. The answers to these questions will help you and I decide if your volunteering for this study at this time would be in your best interest.

6. During the past 3-6 months have memories of the past abuse affected your daily routines or relationships?
   (*** If answer is yes will inform them of my concern that the interview process may not be emotionally comfortable for them)

7. During the past 3-6 months have you thought about your or your partner’s abuse when you did not want to?
   (*** If answer is yes will inform them of my concern that the interview process may not be emotionally comfortable for them)

8. During the past 3-6 months have you felt numb or detached from others, activities, or your surroundings?
   (*** If answer is yes will inform them of my concern that the interview process may not be emotionally comfortable for them)

9. After answering all of these questions are you still willing to participate as part of this research study?

If the potential participants fit the selection criteria, I will then arrange a time and location to complete the first conjoint interview.

*** If my concern lies with the potential for emotional distress I will say “My first concern is protecting the welfare of those individuals I work with. I am concerned that the in-depth nature of the interview process may be significantly distressful. I really do appreciate your willingness to be a part of this study and I wish you well as you continue on your journey.”
I appreciate both of you agreeing to participate. I am asking you and other couples in which one person is an adult survivor of childhood sexual abuse to help us as therapists better understand how we can be of greater assistance to both survivors and their partners.

The focus of this interview will be on your therapeutic experiences with couples counseling and not on exploring your or your partner’s experience with sexual abuse. Your answers to these questions will help us as therapists better understand the therapeutic process you went through – what seemed to help, what seemed to get in the way.

I ask that you do not reveal the name of any of your therapists throughout this process. This is intended to allow you to speak freely while also protecting the confidentiality of your counselors.

I would also like to invite you to choose a pseudonym (fake name). The name that you choose will be used in all future publications stemming from this study and is intended to protect your confidentiality. What name would you like me to use?

I would like to remind you that you are free to request a break during the interview process, you can choose to not answer a particular question, and you are free to end this interview and withdraw from the study at any time. If you find that the process is becoming too stressful, please let me know and we can take a break.

I have some specific questions that I would like to address as we discuss your experiences, so I may refer to this list from time to time. I will also be audiotaping our conversation so that I do not have to try to write everything down and I can review the tape at a later time. Do you have any questions I can answer for you before we start?

I would like to start by asking you

1. How would you describe your experience of couples therapy?
2. How were each of your needs addressed in couples therapy?
3. How were relationship needs addressed in couples therapy?
4. What was most helpful about couples therapy?
   a. Can you describe specific interventions or therapeutic experiences?
5. What was least helpful about couples therapy?
   a. Can you describe specific interventions or therapeutic experiences?
6. What, if anything, would you have changed about the couples therapy you received?
7. How did your participation in couples therapy impact your relationship?
8. How did your participation in other types of therapy (group or individual) impact your relationship?
9. What advice would you give couples who are considering attending couples therapy?
10. What advice would you give to therapists who are conducting couples therapy with CSA survivors and their partners?
APPENDIX F

SURVIVOR SECONDARY INTERVIEW GUIDE

Thank you for agreeing to participate in this second interview. I wanted to provide each of you with an opportunity to share information that you felt important to add to our first conversation or to share information you were hesitant to share in front of your partner. Information shared during this individual interview will not be shared with your partner, however, information from all interviews may be included in future research publications. Individual identities will not be revealed in any publication materials.

I would like to remind you that you are free to request a break during the interview process, you can choose to not answer a particular question, and you are free to end this interview and withdraw from the study at any time. If you find that the process is becoming too stressful, please let me know and we can take a break.

I would like to start by asking you

1. Now that you have had an opportunity to reflect on our first conversation, is there anything you would like to clarify or add to what you shared?
2. What was your experience like with other forms of therapy besides couples counseling?
3. What was most/least helpful with regards to the entire therapeutic journey?
4. How did you feel about your partner becoming involved in the counseling process?
5. In what ways did you encourage or discourage your partner to become more involved?
6. Did you ever regret talking about something in couples counseling after you left the session? If yes, can you describe why?
7. What would you have changed about your therapeutic experiences?
8. What advice would you give to survivors who are considering participating in therapy?
9. What advice would you give to partners who are considering participating in therapy?
10. What additional advice would you like to give to therapists who are working with CSA survivors?
APPENDIX G

PARTNER SECONDARY INTERVIEW GUIDE

Thank you for agreeing to participate in this second interview. I wanted to provide each of you with an opportunity to share information that you felt important to add to our first conversation or to share information you were hesitant to share in front of your partner. Information shared during this individual interview will not be shared with your partner, however, information from all interviews may be included in future research publications. Individual identities will not be revealed in any publication materials.

I would like to remind you that you are free to request a break during the interview process, you can choose to not answer a particular question, and you are free to end this interview and withdraw from the study at any time. If you find that the process is becoming too stressful, please let me know and we can take a break.

I would like to start by asking you

1. Now that you have had an opportunity to reflect on our first conversation, is there anything you would like to clarify or add to what you shared?
2. What has your experience been like with other forms of therapy besides couples counseling?
3. What was most/least helpful with regards to the entire therapeutic journey?
4. How did you feel about becoming involved in the counseling process?
5. In what ways did you feel encouraged or discouraged to become more involved?
6. Did you ever regret talking about something in couples counseling after you left the session? If yes, can you describe why?
7. What would you have changed about your therapeutic experiences?
8. What advice would you give to partners who are considering participating in therapy?
9. What advice would you give to survivors who are considering participating in therapy?
10. What additional advice would you like to give to therapists who are working with CSA survivors?
Pseudonym: ______________________________________

1. What is your age? ________

2. What is your race/ethnicity?
   ______ Caucasian
   ______ African-American
   ______ Hispanic
   ______ Native American
   ______ Asian or Pacific Islander
   ______ other

3. What is your current marital status?
   ______ married: If yes, for how long?
     ______ years.
   ______ living with a significant other
   ______ other

4. What is your previous marital history?
   ______ previously married:
     Number of marriages ______
   ______ divorced
   ______ separated
   ______ widowed
   ______ not previously married

5. What is the highest grade in school or college that you have completed?
   ______ less than high school
   ______ high school
   ______ some college
   ______ bachelor’s degree
   ______ master’s degree
   ______ doctoral degree
   ______ other (please specify)

6. What is your current labor force status?
   ______ full time paid employment
   ______ part time paid employment
   ______ full time employment within the home
   ______ unemployed due to disability
   ______ retired
   ______ unemployed

7. Counting all sources of income, what is your family income level before taxes?
   ______ under $25,000
   ______ $25,001 to $49,999
   ______ $50,000 or more
APPENDIX I

PARTICIPANT REFLECTION FORM

Participant Reflection Form (to be completed by both survivors and partners)

*Instructions:* Listed below are initial themes identified from participant interviews regarding their experiences with therapy. For each of the 43 numbered items below please place a check mark in the box to the right indicating that you either agree with the numbered item, disagree with the numbered item or that you have had no experience with the item.

<table>
<thead>
<tr>
<th>Themes: Individual and Group Therapy</th>
<th>Agree</th>
<th>Disagree</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Positives of Individual Therapy</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Survivors are able to discuss abuse experiences and emotions without worrying about the reaction or needs of their partner.</td>
<td>5</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Positives of Group Therapy</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Survivors experience reduced shame</td>
<td>4</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>3. Survivors are able to develop trust with other survivors</td>
<td>5</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>4. Survivors are able to support one another</td>
<td>5</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td><strong>Negatives of Individual Therapy</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>5. Partners may feel excluded from therapeutic process if couples therapy is not included in the treatment process.</td>
<td>4</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>6. Survivors and partners may experience reduced trust in their relationship</td>
<td>2</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td><strong>Negatives of Group Therapy</strong></td>
<td></td>
<td></td>
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<tr>
<td>7. Partners may feel excluded from therapeutic process if couples therapy is not included in the treatment process.</td>
<td>4</td>
<td></td>
<td>2</td>
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<tr>
<td>8. Survivors and partners may experience reduced trust in their relationship</td>
<td>3</td>
<td></td>
<td>3</td>
</tr>
</tbody>
</table>
**Themes: Positives of Couples Counseling**

**Boundary Setting**

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>9</td>
<td>Survivors learn to set boundaries in their relationships</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>10</td>
<td>Partners learn to support survivors as they begin setting</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>boundaries in relationships</td>
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</tr>
</tbody>
</table>

**Themes: Positives of Couples Counseling Continued**

**Communication**

<p>| | | | |</p>
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<thead>
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</thead>
<tbody>
<tr>
<td>11</td>
<td>Survivors and partners experience increased awareness of patterns of miscommunication</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>12</td>
<td>Survivors and partners both learn skills which improve their ability to communicate</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>13</td>
<td>Survivors and partners gain better understanding of the emotional and physical reactions of the survivor</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Counselors can act as a mediator or translator facilitating improved communication</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>15</td>
<td>Partners gain increased understanding of emotional, psychological and personality changes survivor is going through</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Survivors and partners are able to discuss their feelings and better understand each other’s feelings</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>17</td>
<td>Therapists are able to normalize emotional reactions of both survivors and partners</td>
<td>5</td>
<td>1</td>
</tr>
</tbody>
</table>

**Trust**

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>18</td>
<td>Survivors and partners experience increased trust in their relationship</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>

**Partner Support**

<p>| | | | |</p>
<table>
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<tbody>
<tr>
<td>19</td>
<td>Partners are able to develop patience as they are aware of experiences of survivor</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>20</td>
<td>Partners are better able to understand survivor reactions</td>
<td>5</td>
<td>1</td>
</tr>
</tbody>
</table>
21. Partners are less likely to take survivor reactions personally 4 1 1

22. Partners are better able to recognize when survivors need more closeness or more distance 5 1

**Themes: Shared Experiences**

**Focus in Sessions**

23. Therapists retained a focus on couples issues even during individual sessions 5 1

**Themes: Advice for Couples**

**Therapist Characteristics**

24. It is very important to feel comfortable and connected with your therapist 5 1

25. A similar communication style between therapist and couple is important 5 1

26. Try several therapists (if necessary) until you find a good fit 5 1

**Types of Therapy**

27. Individual, group, and couples therapy are all important to a successful treatment outcome 4 1 1

**Themes: Advice for Therapists**

**Therapeutic Style**

28. Be open to trying new things 5 1

29. Recognize the individuality of each couple 6

30. Be an advocate and provide support for the couple 6

31. Maintain equality with couple – offer suggestions not directives 4 1 1

32. Allow partner freedom and flexibility regarding how intensely they are involved in the therapeutic process. 5 1

**Themes: Interventions**
### Helpful Interventions

(Instructions: For each of the numbered interventions listed below please place a check mark in the box to the right indicating that you either agree that the numbered item was helpful, disagree that the numbered item was helpful, or you have had no experience with the item.)

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Agree</th>
<th>Disagree</th>
<th>No Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>33. Homework to be completed between sessions</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>34. Bibliotherapy (Self-help books, articles, scripture)</td>
<td>4</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>35. Hypnosis</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>36. Communication Exercises</td>
<td>5</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>37. Massage/Touch Therapy</td>
<td>3</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>38. Art Therapy</td>
<td>1</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>39. Journaling</td>
<td>4</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>40. Dream Analysis</td>
<td>4</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>41. Increasing Time Spent in Positive Individual Activities</td>
<td>3</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>42. Increasing Time Spent in Positive Couples Activities</td>
<td>5</td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

### Unhelpful Interventions

(Instructions: For each of the numbered interventions listed below please place a check mark in the box to the right indicating that you either agree that the numbered item was unhelpful, disagree that the numbered item was unhelpful, or that you have had no experience with the item.)

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Agree</th>
<th>Disagree</th>
<th>No Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>43. Group activities which included both survivors and partners</td>
<td>2</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>

### Additional Comments

(Please add any comments or information that you feel would add to this study.)

1. We did not have boundary or trust issues before, during, or after therapy related to the abuse.
2. Not all people respond positively to group activities as a couple so do not force that on one of the couples.
3. If the survivor is already in a couple relationship during the therapy process focusing on couples issues in all sessions keeps the relationship in a direction equal to the survivor healing.
4. I don’t like surveys
5. This is an unwelcome reminder of the past.
APPENDIX J

HUMAN SUBJECTS APPROVAL

June 10, 2003

Ms. Heberling:

The University of Akron’s institutional Review Board for the Protection of Human Subjects (IRB) processed your Application for Review of the research project entitled: “A Qualitative Analysis of Counseling Therapy with Adult Survivors of Childhood Sexual Abuse and Their Partners” . After initial review, it was determined that your project required a convened meeting held on June 1, 2005. The IRB application number assigned to this project is 20050408.

Your research is now approved without further qualifications for one year from the convened meeting date. Per federal guidelines, if you wish to continue the project beyond one year, you must submit a request for continuing review to the IRB. Any changes in the original research protocol must be approved by the IRB prior to implementation.

Enclosed are the informed consent documents, which the IRB has approved for your use in this research. Copies of these documents are to be submitted with any application for continuation of this project.

Please note that within two months of the expiration date of this approval, the IRB will forward an annual renewal request to you by email as a courtesy. Nevertheless, please note that it is your responsibility as principal investigator to remember the renewal date of your protocol’s review.

If your project terminates prior to the annual renewal date, please complete the Final Report Form in order to close your IRB file.

Please retain this letter for your files. If this research is being conducted for a master’s thesis or doctoral dissertation, you must keep a copy of this letter with the thesis or dissertation. If you should have any questions, please do not hesitate to contact me.

Good luck with your research!

Sincerely,

[Signature]

Paul Allen, Ph.D.
Chair, Institutional Review Board

cc: James R. Rogers, Department Chair
    Patricia Parr, Advisor
    Phil Allen, IRB Chair
May 12, 2005

Michele Heberling
5141 Quail Hills St. NW, Apt. B
North Canton, Ohio 44720

Ms. Heberling:

The University of Akron's Institutional Review Board for the Protection of Human Subjects (IRB) processed your Application for Continuing Review of the research project entitled: "A Qualitative Analysis of Conjoint Therapy with Adult Survivors of Childhood Sexual Abuse and Their Partners". This project was reviewed at a convened meeting held on May 10, 2005. The IRB application number assigned to this project is 20030082-Z.

Your research is now approved without further qualifications until June 1, 2007. Per federal guidelines, if you wish to continue the project beyond one year, you must submit another request for continuing review to the IRB. Any changes in the original research protocol must be approved by the IRB prior to implementation.

Enclosed is the informed consent document, which the IRB has approved for your use in this research. A copy of this form is to be submitted with any application for continuation of this project.

Please note that within one month of the expiration date of this approval, the IRB will forward an annual review reminder notice to you by email as a courtesy. Nevertheless, please note that it is your responsibility as principal investigator to remember the renewal date of your protocol's review.

If your project terminates prior to the annual renewal date, please complete the Application for Continuing Review and Final Report Form in order to complete your IRB file.

Please retain this letter for your files. If this research is being conducted for a master's thesis or doctoral dissertation, you must file a copy of this letter with the thesis or dissertation. If you should have any questions, please do not hesitate to contact me.

Good luck with your research!

Sincerely,

[Signature]

Phil Allen, Ph.D.
Chair, Institutional Review Board

cc: Patricia Parr, Advisor
Department Chair
Phil Allen, IRB Chair