12-1-2012

CSA Survivors: What Heals and What Hurts in a Couple Relationship

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CSA SURVIVORS: WHAT HEALS AND WHAT HURTS IN A COUPLE RELATIONSHIP

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Bachelor of Science in Nursing

Brigham Young University

1991

A thesis submitted in partial fulfillment

of the requirements for the

Master of Science in Marriage and Family Therapy

Marriage and Family Therapy Program

Greenspun College of Urban Affairs

The Graduate College

University of Nevada, Las Vegas

December 2012

UNLV
UNIVERSITY OF NEVADA LAS VEGAS

THE GRADUATE COLLEGE

We recommend the thesis prepared under our supervision by

Laura S. Smedley

entitled

CSA Survivors: What Heals and What Hurts in a Couple Relationship

be accepted in partial fulfillment of the requirements for the degree of

Master of Science in Marriage and Family Therapy
Marriage and Family Program

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December 2012

Abstract

Childhood sexual abuse (CSA) is a significant trauma that affects a person's self-concept and the ability to form healthy intimate relationships later in adulthood. Approximately 20% of adults who experience childhood sexual abuse go on to evidence serious psychopathology in adulthood (Harway & Faulk, 2005).

Besides individual disturbances, CSA survivors struggle with many relational difficulties. These difficulties are usually most pronounced among their intimate partners (Reid, et al., 1995). According to attachment theory, attachment injuries are best healed in the context of a healthy, intimate relationship (Kochka & Carolan, 2002) (MacIntosh & Johnson, 2008). Conversely, the couple relationship may be a stumbling block and even an insurmountable obstacle to healing (Miller & Sutherland, 1999).

The purpose of this study is to increase understanding of the survivor's experience of what is helpful and what is counterproductive in their healing process within the construct of their couple relationship. This is a qualitative study employing phenomenological theory. Qualified participants were CSA survivors in a committed relationship of at least one year. 8 participants were interviewed using semi-structured interview questions. Results of the study yielded helpful themes of 1) a sense of safety and trust 2) acceptance and validation 3) open communication 4) emotional intimacy and the perception of being truly loved by their partner 5) support 6) empathy 7) freedom of choice and 8) positive growth with their partner. Themes of what was hurtful included 1) criticism and rejection 2) betrayal 3) disrespect of personhood 4) lack of choice 5) lack of communication 6) partner mistrust and 7) lack of growth.

Table of Contents

Introduction

Healthcare professionals in the helping professions, such as marriage and family therapists, counselors, social workers and psychologists, often encounter mental illnesses that are either caused by, or linked to, experiences of interpersonal trauma. Interpersonal trauma may be understood as an event where the perpetrator is an individual who is personally close to the victim. The motivation of the perpetrator is either the desire to hurt the victim and/or the desire to pursue his or her own goals, irrespective of harm and costs to the victim (Widera-Wysoczańska & Kuczyńska, 2010). Interpersonal trauma, such as childhood sexual abuse, often causes deep turmoil in one's internal state and may severely rupture one's ability to maintain intimate connections with those around them (Conklin & Padykula, 2009; Wallin, 2007). Childhood sexual abuse (CSA) is a significant trauma that affects a person's self-concept and the ability to form healthy intimate relationships later in adulthood. Relationship attachments appear to be a central mechanism when survivors are healing from severe interpersonal trauma (Hecker, 2007). The couple relationship, as a primary source of attachment, can be very powerful in the healing process (Hecker, 2007; Kleinplatz, 2007).

The author of this study is interested what impact a couple relationship has on a survivor. Of specific interest is what the survivor perceives as being healing or harmful within the context of the couple relationship. The purpose of this study is to explore how the intimacy and proximity of the couple relationship affects the CSA survivor who is healing from that particular trauma. The study seeks to understand the individual's experience of their partner's influence on their healing process. This is a phenomenological inquiry into those words and actions that are healing and those words

and actions that are detrimental to a CSA survivor within the framework of an intimate, partnered relationship. The author expects the results to yield increased understanding regarding the perceived experience of the CSA survivor within their most intimate relationship. Knowledge of how those experiences affect the healing of the survivor may be very beneficial to couples' therapists, to survivors themselves, and to their intimate partners.

Literature Review

Definition, Incidence, and Impact

The DSM IV defines trauma as an event that involves death or the threat of death or serious injury in which one's response to the event involves fear, helplessness, terror, or horror (APA, 2000). Trauma has been referred to as a wound to the mind, body, and soul and usually involves some form of loss (Baima & Feldhousen, 2007). Childhood sexual trauma may occur in a wide variety of ways. It can refer to sexual contact between a child and a perpetrator at least 5 years older than the child, in which the contact is coercive or perceived by the child as such (Cobia, Sobansky, & Ingram, 2004; McCarthy & Sypeck, 2003) or any incident that causes an individual to perceive sex-related shame (Reid, Taylor & Wampler, 1995), or. The exact extent of child sexual abuse is often difficult to determine because of a preponderance of underreporting, but it is estimated that between 28% to 33% of adult women and 12 to 18% of men have experienced some type of sexual abuse during childhood or adolescence (Cobia, et al., 2004; Koedam, 2007).

Approximately 20% of adults who experienced childhood sexual abuse go on to evidence serious psychopathology in adulthood (Harway & Faulk, 2005). The DSM IV diagnoses common to an adult survivor of childhood sexual abuse include depression,

post-traumatic stress disorder (PTSD), dissociative identity disorder (DID), personality disorders, somatization disorders, eating disorders and substance abuse disorders (APA, 2000; Harway & Faulk, 2005; Nadelson & Polonsky, 1991). When compared with control groups, CSA survivors evidenced 5 times higher rates of personality disorders and 3 times higher rates of anxiety disorders (MacIntosh & Johnson, 2008). The risk of depression and suicide increases 150% for CSA survivors among the general population (Chen & Carolan, 2010). Any or all of these psychological diagnoses significantly increase the strain upon the couple relationship, greatly compounding the difficulties of negotiating important relational constructs, such as intimacy and trust.

PTSD is one of the most common disorders seen in CSA survivors and includes such symptoms as hypervigilance, hostility, intrusive thoughts, flashbacks, social anxiety, sleep disturbances, irritability, sensory memories, nightmares and difficulties maintaining concentration and normal cognitive functioning (Baima & Feldhousen, 2007; Cobia, et al., 2004; Goff, Schwerdtfeger, Osby-Williams, Hoheisel, Nue, Reisbig, Archuieta, Henry, Bole, Hanes, Sanders-Hahs, Scheer & Smith, 2008; Harway & Faulk, 2005; Miller & Sutherland, 1999; Reid, et al., 1995). Feelings of worthlessness, low self-esteem, mistrust, guilt, shame, fear, anger, isolation, sexual confusion, feelings of stigmatization, self-destructive coping strategies and suicidality are also commonly associated with CSA survivors (Baima & Feldhousen, 2007; Cobia, et al., 2004; Goff, et al., 2008; Kochka & Carolan, 2002; MacIntosh & Johnson, 2008; Nadelson & Polonsky, 1991). Defensive strategies such as repression, can take the form of avoidance behaviors, physical or emotional numbing, depersonalization, dissociation, obsessions and compulsions, overwork, sexual promiscuity, and patterns of self-destructive relationships (Goff, et al.,

2008; MacIntosh & Johnson, 2008; Cobia, et al., 2004; Miller & Sutherland, 1999; Harway & Faulk, 2005).

These individual disturbances naturally lead to a preponderance of relational difficulties for CSA survivors. These difficulties are usually most pronounced within the intimate partner relationship, as sexuality and healthy emotional attachments have been compromised by the invasive nature of the abuse (Hughes, 1994; Reid, et al., 1995). It is not uncommon for the abusive experience to be overgeneralized to include current partners, sex having been associated with pain, trauma and anxiety (Cobia, et al., 2004; Hughes, 1994). The intimate emotional and sexual proximity of the relationship may bring up flashbacks, body memories and dissociative experiences related to the original abuse, confusing current experiences and past trauma (Harway & Faulk, 2005; Hughes, 1994; Maltas, 1996; Miller & Sutherland, 1999). Survivors often have a lack of confidence that significant others can be counted on and have difficulties confiding in and discussing personal concerns with their partners. "No meaningful communication" was reported by 23% of CSA survivors, while non-abused men and women reported only 6% of the same (Cobia, et al., 2004).

Among couples where one partner is a survivor of CSA, relational issues surrounding emotional expression, sexual ambivalence and dysfunction, trust, boundaries, power and control, conflict negotiation, negativity, poor communication, emotional cutoff and commitment volatility are common (Goff, et al., 2008; Harway & Faulk, 2005; Kachka & Carolan, 2002; Koedam, 2007; Oz, 2001). CSA survivors among the general population report more marital disruption, less sexual satisfaction and higher incidence of divorce (Baima & Feldhousen, 2007; Hughes,1994; Koedam, 2007). They are more

likely to choose physically, emotionally, verbally or sexually abusive partners, and to be both a victim and a perpetrator of domestic violence (Baima & Feldhousen, 2007).

Sexual disorders figure prominently in CSA survivors' couple relationships. Over 50% of both men and women who have experienced CSA report some type of adult sexual difficulty (Cobia, et al., 2004; Hughes, 1994). Women often evidence deficits in integrating intimacy and eroticism, resulting in hypoactive sexual desire, non-orgasmic response, arousal disorder and vaginismus, especially if the abuse involved sexual penetration and force (Baima & Feldhousen, 2007; Brown, 1995; Cobia, et al., 2004; McCarthy & Sypek, 2003). Women's feelings toward their partner are a major determinant of sexual functioning, and women survivors show an increased tendency to evaluate their partner negatively (Dennerstein, Guthrie & Alford, 2004).

Etiology

The severity of psychological damage and personal impairment realized in the victim of CSA depends in part on certain factors pertaining to the abuse (Harway & Faulk, 2005); the age of the victim, whether there was a single or multiple perpetrators, the child's relationship to the perpetrator, the exact form and intensity of the abuse, its duration and frequency, and the circumstances surrounding the disclosure of the abuse and the subsequent response received by the victim (Cobia, et al., 2004; Harway & Faulk, 2005). Based upon their response to the trauma and subsequent interaction with the victim, a child's family and closest associates will serve to significantly influence the subjective severity of the trauma and the nature of the psychological and emotional sequelae (Cobia, et al., 2004; Harway & Faulk, 2005). Sexual penetration, the use of force or violence, the frequency and intensity of abuse, a younger age for the onset of

victimization, a close family member as perpetrator(s) and an extended time period of abuse all serve to increase the degree of trauma to the survivor (Brown, 1995; Cobia, et al, 2004; Harway & Faulk, 2005) (Hughes, 1994; McCarthy & Sypeck, 2003). In one study of mid-life women in the community, those who experienced penetrative CSA had significantly shorter couple relationships than those who had not (Dennerstein, et al., 2004). A large survey of women in New Zealand revealed that if the childhood sexual abuse involved penetration; survivors were 7 times more likely to suffer from an eating disorder, 74 times more likely to have suicidal ideation or behaviors, 5 times more likely to have depressive or anxiety disorders, 3 times more likely to engage in substance abuse, and 16 times more likely to have been admitted to a psychiatric hospital (Miller & Sutherland, 1999).

Those CSA survivors who were abused by a father figure evidence the most long-lasting effects and the worst long-term adjustment outcomes (Harway & Faulk, 2005). The terror of victimization within the family creates a powerful regressive pull in subsequent relationships (Maltas, 1996). As personal identity is in part shaped by the emotions and cognitions surrounding one's life story, the survivor's emotions and cognitions surrounding the abuse heavily influence the psychological sequelae. Thus, extended abuse coupled with the secrecy, shame, and betrayal of incest, lead to a more negative, hopeless and powerless personal narrative (Anderson & Hiersteiner, 2008; McCarthy & Sypeck, 2003; Kochka & Carolan, 2002). This negative personal lens can be managed via coping strategies developed in adulthood. Some of these include verbalization, repression/avoidance, lowered expectations, severed relationships,

emotional cut-off, and sleep. Interestingly, couple relationships can serve to increase effective coping strategies for the survivor (Goff, et al., 2008).

Relational Factors

It is no easy thing to be intimately partnered with a CSA survivor. There has been an increasing amount of evidence supporting the idea that partners and families may suffer secondary trauma as a result of being exposed to the traumatic material and distressing symptoms associated with the survivor's trauma (Miller & Sutherland, 1999). When awareness or discovery of CSA and/or healing of a survivor begins during marriage, it often results in the systemic upheaval of the relationship. Healing from CSA often brings about a newly framed identity and alterations in the survivor's personality. Abuse survivors often enter into a marital contract that reflects the negative self-perceptions frequently seen among CSA victims. Survivors who engage in self-pathologizing attitudes and behaviors invite others, including their partners, to interact with them in a disqualifying manner (Adams-Wescott & Isenbart, 1996). Partners are accustomed to the current or previous systemic contract and the couple may have difficulty negotiating a new way of being in the marriage. As one partner put it, "I don't know who you are anymore, and it scares the hell out of me" (McCollum, 1993, p. 35).

Partners are faced with grieving a number of losses. Survivors may withdraw emotionally and/or physically during intense periods of healing, and partners may suffer negative and rejecting responses (Miller & Sutherland, 1999). They may end up taking over tasks and roles that previously belonged to their partner (Button & Dietz, 1995). They may feel overwhelmed, helpless, isolated and left out of the healing process going on between their spouse and his or her therapist (MacIntosh & Johnson, 2008). They

may feel anger at the perpetrator and guilt at being unable to "fix it", or anger, frustration, pain and resentment at the injustice of having to expend the energy and resources to pick up the pieces and suffer the consequences of the crimes committed by someone else (MacIntosh & Johnson, 2008). They may wrestle with guilt over their partner's suffering and their own dissatisfaction at the loss of their personal needs being met. Acute distress may occur if terrible memories intrude on intimate moments with their spouse or if their spouse begins to treat them like the perpetrator (Button & Dietz, 1995; MacIntosh & Johnson, 2008.

Difficulties with sex are not confined to the CSA survivor. One study found that partners tried to avoid sexual behaviors that might cause flashbacks or implicit abuse memories for their spouse. They tended towards hypervigilance with regards to the possibility of their sexual expressions being experienced as coercive by their partner. Some men developed erectile dysfunctions and problems with premature ejaculation. Many partners of CSA survivors perceived their companions' emotional detachment during sex as uncomfortably alienating (Baima & Feldhousen, 2007).

As stress and pressure in the relationship increase, the partner may experience "trauma contagion" or "compassion fatigue", with symptoms similar to those of a survivor; including emotional, physical and spiritual fatigue, victimization, sleep disturbances, hypervigilance, nightmares, denial, emotional withdrawal, depression, low self-esteem and secondary shame (Goff, et al., 2008; Miller & Sutherland, 1999; Wiersma, 2003). Living with a survivor can trigger emotional and relational issues related to the partner's own developmental history. They may also develop difficulties with communication, emotional expression, intimacy, addictions, parenting or time

management (Oz, 2001). They may question their ability or willingness to stay committed to the relationship (Button & Dietz, 1995).

Abuse victims may unconsciously seek out familiar relationships. This could lead them to enter relationships with aspects that reflect their earlier abuse (Nadelson & Polonsky, 1991). Among intimate partners of abuse survivors, reenactments of abusive experiences or archetypal roles may be acted out. Common scenarios are the abuser and the abused, idealized savior and needy child, or seducer and seduced. If these reenactments are not recognized for what they are, they may be misinterpreted as present reality. These interactions can breed anxiety and conflict, undermining the couple relationship (Maltas, 1996).

Emotional process within the couple relationship affects heavily the process of "trauma contagion" experienced by survivors and their partners. Emotional dysregulation is common among survivors and their partners (MacIntosh & Johnson, 2008). Many CSA survivors demonstrate a fear/avoidant style of attachment. This can lead to dramatic swings of closeness, then avoidance, and a process of sharing high anxiety with and about their partner (MacIntosh & Johnson, 2008). High amounts of relational conflict are common to couples dealing with issues related to CSA (Cobia, et al., 2004; Hughes, 1994). The dyadic alliance of partners in healing may be threatened if stress and conflict spiral out of control. Chronic anxiety can create reactivity within the emotional dyad and erode the couples' ability to maintain or build trust (Kochka & Carolan, 2002). From a feminist perspective, the person with the least power and the strongest needs are the most motivated to maintain the relationship (Kochka & Carolan, 2002). This puts the survivor at risk for subverting their individual needs in order to

maintain the relationship. Women survivors in one study chose to accept discomfort or abuse in order to decrease the level of relational stress, resulting in situations of revictimization (Kochka & Carolan, 2002).

Intergenerational patterns, cultural beliefs and societal practices strongly influence the way individuals interpret and respond to sexual victimization. Gender beliefs and practices play a significant role in the incidence of sexual abuse and society's and individuals' responses to it. Gender biased interpersonal expressive and receptive communication, motivations, and perceived abilities serve to inhibit open and accurate communication between men and women (Wiersma, 2003). Studies have found that CSA survivors and their partners often have similar developmental histories. Marriage partners tend to replicate the degree of fusion found in their family of origin, finding partners that validate their own attachment style (Chen & Carolan, 2010). Partners with comparative developmental experiences may contribute to couple conflict and may not be able to support their companions' recovery process. Conversely, they may be more empathic and understanding of a CSA survivor's experience because of their own developmental history (Chen & Carolan, 2010).

Ramifications for Couples in Treatment

Historically, individual and group therapy has been the treatment of choice for adult survivors of CSA (Reid, et al., 1995). However, this approach has ignored the difficulties and needs inherent in an intimate couple relationship, and left the survivor's partner feeling isolated, frightened, and left out (MacIntosh & Johnson, 2008). Couples therapy has been shown to help the partner become more educated, understanding and involved in the survivor's healing process (McCarthy & Sypek, 2003; Reid, et al., 1995).

For the survivor, positive partnerships can go a long way towards moderating and buffering a survivor's distressing symptoms (Chen & Carolan, 2010; MacIntosh & Johnson, 2008). Both survivors and partners have reported the marriage relationship to be a primary source of support during the process of healing from CSA (Goff, et al., 2008; McCollum, 1991).

It is not uncommon for couples to present in therapy with issues they perceive to be unrelated to CSA. Typical complaints include infidelity, problems with intimacy and attachment, issues surrounding numbing and distancing, sexual anxiety and sexual disorders, increased relational conflict, anger and rage, substance abuse, power and control issues, feeling of entrapment or betrayal, codependency, and low self-esteem (Hecker, 2007; Koedam, 2007). Ignoring sensitive relational issues, such as emotional and sexual intimacy, while focusing therapy on rape trauma, is a hazardous proposition for the marriage (McCarthy & Sypek, 2003). Neglect of sexual issues may foster resentment, blame and avoidance, resulting in dysfunctions becoming chronic and more severe (Brown, 1995). Often survivors require several years of therapy, and by then intractable relational patterns regarding sexuality may have taken hold. Integrating couples therapy into individual trauma therapy is usually more successful (McCarthy & Sypek, 2003).

Couples generally express a preference to stay together and work out their problems in tandem (Kochka & Carolan, 2002; McCarthy & Sypek, 2003). In one study, healthier relationships were the ones in which the partner was engaged in their companion's healing process (Kochka & Carolan, 2002). By engaging in therapy together as a survivor heals, partners have a unique opportunity to evaluate what is truly

important to them as couple, confront their own issues, develop new life skills, and deepen interpersonal bonds and commitments (McCollum, 1991). Intimacy affords the opportunity for couples to share and co-create meaning (Adams-Westcott and Isenbart, 1996; Kleinplatz, 2007). Couples who successfully negotiate the volatile conditions surrounding sexual abuse are rewarded with the establishment of a lasting trust and often enjoy a feeling of great accomplishment (Button & Dietz, 1995; Oz, 2001).

The emotional and psychological risks for both parties are substantial when undergoing treatment for CSA (Nadelson & Polonsky, 1991; Reid, et al., 1995). Emotional safety within the relationship is essential for healing to occur, and it can be helpful for partners to discuss and refine their definition of trust (Button & Dietz, 1995; Hecker, 2007; Kochka & Carolan, 2002). However, unstructured partner involvement can be perceived by the survivor as intrusive, disrespectful, and detrimental to recovery, and yet some significant issues are never addressed if recovery is treated separately from the couple relationship (Hecker, 2007; Reid, et al., 1995).

While the marriage relationship may be the arena in which the negative effects of sexual abuse are played out and intensified, it is also a powerful potential healing site (MacIntosh & Johnson, 2008; Maltas, 1991). Many CSA survivors may disclose their abuse for the very first time to their intimate partner, as nondisclosure is normative for child sexual abuse (Miller & Sutherland, 1999). Trauma theory points to the importance of having loved ones bear witness to human suffering, deeply acknowledging the experience of the other (Kleinplatz, 2007; McCarthy & Sypek, 2003; Miller & Sutherland, 1999). Survivors report the profound helpfulness of having their partner listen compassionately and express sorrow for their pain and suffering (Kleinplatz, 2007; Oz,

2001). If the survivor is remembering or disclosing their abuse for the first time, it may unleash a maelstrom of emotions and needs in the couple relationship (Button & Dietz, 1995). It is imperative that survivors and partners be educated and prepared to deal with surprising occurrences in their relationship associated with the process of remembering and healing (Harway & Faulk, 2005).

Marital distress tends to maintain and exacerbate the symptoms associated with trauma (Cobia et al., 2004), so understanding the contributions and interactions of each partner can aid in the recovery process for the survivor and the marriage (Chen & Carolan, 2010). The recursive interactional process of the couple relationship is a place where both partner and survivor are affected by and influential in the healing process (Wiersma, 2003). Survivors' symptoms are often activated during sexual intimacy, which may bring about extreme fear, dissociation, flashbacks, rage, or repressed memories (Oz, 2001). Survivors may react to sexuality with depersonalization and emotional numbness, causing their partner to experience them as distant and cold. Survivors may regress to the age of onset of the abuse, resulting in a fear of abandonment and an abnormal amount of dependency on their partner (Harway & Faulk, 2005; Nadelson & Polonsky, 1991).

Early childhood sexual trauma can significantly alter an individual's ability to form intimate attachments, both in childhood and later in life (Wallin, 2007; Hecker, 2007). However, relationship attachments are often a central feature in healing from childhood trauma. As such, the couple relationship can be a great source of power when a survivor is healing from the effects of CSA (Conklin & Padykula, 2009; Hecker, 2007). According the attachment theory, attachment injuries are best healed in the context of a

healthy, intimate relationship (Hecker, 2007; Kochka & Carolan, 2002; MacIntosh & Johnson, 2008). This indicates that the care, nurturance and support of the couple relationship may be key in restoring the damage CSA does to trust, intimacy, self-esteem, and sexuality. Couples therapy, or a survivor working closely with their partner, can contribute to positive changes in a shorter amount of time than individual therapy alone (Hecker, 2007; McCollum, 1991; Miller & Sutherland, 1999). Conversely, the couple relationship may be a stumbling block and even an insurmountable obstacle to healing, if the partner obstructs or sabotages the process through blame, disbelief, minimizing the impact of the abuse, or ignorance (Hecker, 2007; Miller & Sutherland, 1999).

Purpose of Current Research Study

This phenomenological inquiry into those words and actions that are healing and those words and actions that are detrimental to a CSA survivor within the framework of an intimate, partnered relationship is intended to yield increased understanding regarding the perceived experience of the CSA survivor within their most intimate relationship. Knowledge of how these intimate couple interactions affect the healing of the survivor may be very beneficial to couples' therapists, survivors, and their intimate partners. The purpose of this study is to investigate the efficacy and importance of the couple relationship during the healing process of a CSA survivor. This study seeks to answer that question via qualitative, phenomenological inquiry into what, in their own experience, survivors perceive as helpful and what they perceive as harmful when interacting with their intimate life partner.

Disclosure of Researcher's Philosophical Lens

The researcher is currently a practicing student clinician seeking to specialize in the treatment of sexual trauma, especially that which occurs in the victim's childhood. Based on experience and research, the author's primary philosophical lens reflects attachment theory and trauma theory.

Attachment can be conceived of as an intense and enduring bond biologically based in the function of protection from danger. Attachment is a deeply rooted emotional bond that involves a tendency to seek and maintain proximity to a specific person, particularly when under stress (Potter-Efron, 2006). It functions as a regulatory system that provides safety, protection and a sense of security. Although it may have its roots in physical safety, the goal of the attachment bond is felt security, or psychologically experienced feelings of safety and security (Potter-Efron, 2006). Attachment theory postulates that relationships of attachment are a key context for development (Wallin, 2007). Interpersonal traumas that interrupt the development of the self and impair one's ability to securely attach to another person are referred to as attachment injuries (Wallin, 2007). Attachment theory holds that attachment injuries can be healed through a transformation of the self through a securely attached relationship (Hecker, 2007; Wallin, 2007).

Trauma theory defines trauma as an event that involves death or the threat of death or serious injury, wherein one's response to the event involves fear, helplessness, terror, or horror (APA, 2000). Trauma has also been referred to as a wound to the mind, body, and soul, resulting in the temporary disorganization or dismantling of a person's schema (Baima & Feldhousen, 2007). Healing from trauma involves a renewed sense of

safety and a validation of the traumatic event (Hecker, 2007; Kleinplatz, 2007). It is important to trauma survivors to have their experience compassionately witnessed and appreciated by the significant attachment figures in their lives (Kleinplatz, 2007; McCarthy & Sypek, 2003; Miller & Sutherland, 1999). Survivors report the profound helpfulness of having their partner listen compassionately and express sorrow for their pain and suffering (Kleinplatz, 2007).

Based on attachment theory and trauma theory, one might hypothesize that the intimacy of the couple relationship will have a profound impact on how the survivor feels about and experiences their healing from the trauma of childhood sexual abuse. The author acknowledges these potential theoretical biases in the analysis of this research. Specific methodological rigors to guard against researcher bias are listed and explained in the methods section.

Method

A qualitative, phenomenological method of inquiry is appropriate for this study for a number of reasons. This study claims no specific hypothesis about its outcome, but rather seeks for an in depth look at themes and patterns of how CSA survivors heal from the effects of their trauma and how that healing is specifically influenced by their experience in a couple relationship. The exact nature of an individual's experience with sexual abuse is uniquely contextual. The personal sequelae of the survivor's sexually abusive experiences are also uniquely contextual. They cannot be quantifiably predicted as to their exact effect on a survivor. Additionally, the process of healing is wholly influenced by a variety of individual circumstances and relational and cultural contexts. Thus, when seeking themes and patterns that would be helpful to the clinician working

with CSA survivors and their partners, it is necessary to understand the unique perspective of the survivor and the meanings and significance that they give to their experience. Therefore, a descriptive, phenomenological qualitative inquiry into such a uniquely contextual experience is appropriate for this study (Larossa, 2005).

These non predetermined findings may be valuable for future research, and to clinicians in the field, and to partners of CSA survivors. The semi-structured interview questions yielded information regarding the specific research question, while allowing for probing follow-up questions that helped reveal the unique perspective and experience of the individual participant. Thus the researcher ascertained the participants' subjective experience of how their couple relationship affected the personal sequelae of their abuse and their own personal journey of healing.

While the preponderance of reported CSA victims is women and girls, boys also encounter this bitter experience. This study aspired to be broadly inclusive of all genders and sexual orientations. Gender, marital status, and sexual orientation were not exclusionary factors in the selection of participants for this study.

Data Collection

In order to increase overall understanding of a CSA survivor's experience of healing within the context of their couple relationship, semi-structured interviews were conducted with adult individuals who were CSA survivors and had been in a committed relationship for at least one year. A committed relationship was defined as married or living together. The partner did not need to be aware that their companion was a CSA survivor, as it was the subjective experience of the survivor that was sought. A minimum of 6 participants was required to complete this study, but the authors sought for and

allowed up to 20 participants to be included in the research. 8 qualified participants were successfully recruited and voluntarily participated in the research study. Research participants were recruited via local practicing marriage and family therapists as well as current marriage and family therapy students treating clients at the Center for Individual, Couple, and Family Counseling (CICFC) on the campus of UNLV.

Selecting local therapists began with referrals from the UNLV Marriage and Family Therapy (MFT) program faculty and adjunct instructors. Additional therapists were identified by snowball sampling through referrals from the MFT faculty. Therapists were contacted face-to-face, by telephone, and via email, informing them of the study's purpose and asking for their help identifying potential research participants using the "Therapist Recruitment Letter" (see Appendix A). For therapists referring clients to the study, they contacted prospective participants in person, by phone, or email, and described the purpose of the study and forwarded to them the "Research Participant Information Letter" (see Appendix B).

For student therapists, the author visited each MFT practicum and announced the study's purpose. Students were asked to refer clients who had previously been or currently were in treatment for CSA and met the study's criteria for inclusion. Student therapists were provided a printed "Research Participant Information Letter" to review and give to potential participants. Clients of local therapists and students electing to participate in the study were given the author’s contact information (via the letter) and initiated scheduling for the interview. Participants selected the time and location of the interview or whether they wished to do it by phone.

It should be noted that two separate members of the research team performed the participant research interviews. The author conducted 5 of the interviews, and a graduate student research team member conducted the interviews of those 3 participants who happened to be clients of the author. These participants were not aware that their therapist had any personal investment or involvement in the study when they agreed to participate in an interview.

At the location of the face-to-face interviews, the researchers obtained informed consent and proceeded with the interview. At the time of the interview, participants were read the informed consent and were asked to give verbal consent as part of the audio recording. The recorded interviews were transcribed and then analyzed using qualitative analysis methods guided by phenomenological theory procedures (Harry, Sturges and Klingner, 2005).

The semi-structured interview guide contained the following questions:

Demographic questions:

1. Age
2. Gender
3. Race/ethnicity
4. Sexual Orientation – Type of relationship they're in
5. Length of time in current relationship or previous couple relationship
6. Religious affiliation

Semi-structured interview questions:

Lead in: Many survivors of childhood sexual abuse describe change and healing as a process or journey, and there are often specific things or events that occur in their

relationship with their partner that help or hurt them with regards to their healing. We are interested in how your relationship with your partner has affected your healing.

- Does (did) your partner know about the abuse? At what point in your relationship did you decide to share? How did they find out? What went into your decision to tell? How much time did the two of you spend talking about it? What was your partner's response? How did you feel about that?

- Will you describe some of the significant relational moments, wherein your partner said or did something that helped you in your healing? How did your feelings change as a result of that?
- What events do you consider to be the most impactful with regards to your healing? What words or actions by your partner did you feel were the most significant for you? Why do you think your partner's actions made such a difference for you?
- What did your partner do to help build trust? Will you describe some of the moments wherein your ability to trust was strengthened by the words or actions of your partner? Why do you think these events were a game changer for you?
- Were there specific moments when your partner was able to help you handle difficult emotions, such as anger, fear or pain? Could you describe those situations where your partner helped you to release or let go of pain, fear or anger?
- How did you know that your partner was there for you?
- What else did your partner do that was supportive of your healing process?
- Was there anything your partner said or did that you felt hindered your healing process? Why do you think that those things felt harmful to you?

- Was there anything your partner said or did that hindered your ability to trust him/her? Do you think this influenced the progress of your healing, or your perception of your childhood abuse experience?
- Will you describe any setbacks or negative experiences you experienced with your partner over the course of your healing? Why do you think those experiences set you back? How did you know your partner wasn't there for you?
- Which events do you think were most harmful to your healing? Why?
- How did being a CSA survivor affect your couple relationship (sex, roles, self-concept, perception of love and intimacy…)?
- Is there anything else about your couple relationship that you feel was/is significant for your healing?
- Is there anything else you would like to tell me?

Data Analysis

Methodological rigor is defined as the attempt to make data and explanatory schemes as public and replicable as possible (Anfara, Brown, & Magione, 2002). The credibility, dependability, and confirmability of this research were addressed in a variety of ways. Triangulation occurred through blind peer review and collegial oversight. The primary researcher disclosed her theoretical lens as being influenced by both attachment theory and trauma theory. The author, collegial advisor, and other research team members were alert for potential biases on the author's part during the analysis and interpretation of the data. Code mapping, which linked interview questions to specific participant responses, was employed to help ensure the dependability of the qualitative analysis (Anfara, Brown, & Magione, 2002).

The participant interviews were transcribed by research team members and analyzed according to qualitative analysis principles (Harry, Sturges and Klingner, 2005). The interviews were first read for overall content, without any attempt at analysis. During subsequent readings, participant answers to interview questions were coded with descriptive labels. Similar answers both within and across participant responses were identified and categorized. Themes and categories were emergent, rather than pre-set, according to the results of the participant responses. Themes that captured and unified the nature and basis of the participants' experiences were identified. The researchers accurately identified and correlated themes by looking for the five elements of a theme, as postulated by DeSantis and Ugarriza (Beck, 2003). These included the overall entity of the participant's experience; the structure or nature of the experience; the functional nature of the experience in its meaning to the participant; the forms, or various manifestations, of the thematic experience; and the mode, or recurrence, of the experience (Beck, 2003). Analysis was an iterative process, with attention given to the frequency of common responses, as well as to the overall significance or weight that each participant gave to the processes in their couple relationship that most affected their healing.

As codes, categories and themes were identified and refined, conceptualization and interpretation of the data was confirmed and triangulated through the use of three different researchers in the analysis process (Harry, Sturges and Klingner, 2005). Care was taken such that the themes were analyzed and reviewed independently, the author wielding no power or influence over her fellow researchers. The author took precautions to receive and review the results with colleagues who do not have a personal theoretical

bias concerning the results, nor an academic or professional stake in the results of the study. Results were correlated with existing CSA literature and through a separate, blind review performed by research team members.

The research team consisted of three members. Two interviews were analyzed independently by each member using open coding and then independent analyses were compared and contrasted in a research team meeting. An audio recording was made of the research team's discussion surrounding the results and analysis of the first two interviews. Initial themes and categories were identified, and the audio recording assisted the author in remembering certain points of discussion. It was noted that the interviewer received greater richness and detail when asking more individual process questions and less 'yes or no' questions. The interview guide was refined to reflect these observations.

A second team meeting convened to review two more independently analyzed interviews. Analysis discussion of this research meeting was also audio recorded for further review. It was noted during the second team meeting that participant responses to the primary research question were organized around the participants' response as to how they were personally affected by their experiences of childhood sexual abuse. It became apparent that how their partner interacted with them around those individual issues of CSA sequelae were the things that were most impactful to them with regards to their healing. The author had wanted the focus of this research study to be about how a survivor's partner affects them within the context of the couple relationship. The author had therefore shied away from questions focusing on the participants' personal sequelae of the abuse. As it became apparent that the survivors' partners' actions mattered most in areas where the participant perceived the most damage, questions regarding the personal

effects of CSA were moved toward the beginning of the interview for the remaining participants. This allowed for follow up questions about the couple relationship to be framed around those issues that were most personal and pertinent to the participant.

A third research team meeting was held in which themes and categories were further analyzed and defined. Notes with regards to ideas and thought processes were taken. The author then conducted the remainder of the analysis by coding the final two interviews and then conducting an in-depth comparative analysis of the data and preliminary themes and categories. All eight interviews were reviewed to ensure that no significant theme, category or response was overlooked. Themes and categories were further refined by either combining or expanding the themes to ensure that they were inclusive and representational of all significant participant responses. Attention was paid to both the incidence of common responses across participant interviews and the importance or weight given by the participants to those things that were most impactful to them in their healing.

Participants

We were able to recruit and interview eight participants for this study, four women and four men. It has been historically difficult to find male participants for CSA studies. This may be due to the fact that the greatest percentage of reported CSA survivors is women rather than men and also to cultural mores and perceived social stigma regarding men as sexual victims. The author was pleased to achieve equal representation of gender in this study.

Participants ranged in age from 28 years to 67 years. The average age was 43. The length of the participants' primary couple relationships ranged from 3 years to 21

years, with the average length being 10 years. Five of the participants were currently married and living with their primary partner. Two of these participants had been married previously. Three of the participants had separated from their partners and were currently living singly. One participant had never married their partner. Two of the participants had been married and were now divorced.

Racial or ethnic representation was not quite as diverse as hoped for. One participant identified as African-American, two as Hispanic, four as Caucasian and one as Western European specifically.

Sexual orientation was fairly well represented. Two participants identified as bisexual, two as homosexual, and four as heterosexual. One bisexual participant was in a homosexual relationship, the other bisexual participant had been predominantly in a heterosexual relationship. One homosexual participant was in a homosexual relationship, the other homosexual participant was in a heterosexual relationship. The four participants who identified as heterosexual were all currently in, or had been in, heterosexual relationships.

All of the participants seemed to have a Judeo/Christian background. When asked about religious affiliation, three of the participants identified as Christian, three participants identified as belonging to the Church of Jesus Christ of Latter-day Saints, one as belonging to the First Assembly of God, and one as simply "spiritual".

It should be noted that the participants varied in terms of their stages of healing. Two felt that they had mostly dealt with their abuse and moved past it. The other six expressed being in various stages of healing and growth with regards to their abuse. Two participants repressed the memories and awareness of their abuse and didn't begin

remembering until well into adulthood. Both of these participants were in a second marriage that they perceived as healthy and trustworthy at the time the memories began to surface. One participant was still in an active phase of memory recovery at the time of the interview.

Results

The purpose of this study was to explore the effect that the intimacy and proximity of the couple relationship has on a survivor of childhood sexual abuse. We were specifically interested in what the partners of the participants said or did that was perceived as being either helpful or harmful to their healing from CSA. Data analysis of participant interviews resulted in the development of several themes related to those things which participants' partners did that they found helpful to their healing. These were 1) a sense of safety and trust, 2) acceptance and validation, 3) open communication, 4) emotional intimacy and the perception of being truly loved by their partner, 5) support, 6) empathy, 7) freedom of choice, and 8) positive growth with their partner. Those things in the couple relationship that were found to be hindering to healing were in near opposition to those things that were healing. Those themes include 1) criticism and rejection, 2) betrayal, 3) disrespect of personhood, 4) lack of choice, 5) lack of communication, 6) partner mistrust, and 7) lack of growth.

Although not directly answering the research question, it became apparent in the interviews and analysis that the participants' decision to disclose the abuse to their partner and the personal effects that the abuse had upon their lives were essential aspects of the survivors' couple relationship and healing experience. Therefore, we will begin the results by presenting the themes of the participants' decision to tell about their abuse

and the results that childhood sexual abuse had on them individually. A summary of the themes and categories found in the results is listed in Appendix C.

Decision to Tell

All of the participants were asked if they had disclosed their abuse to their partner and what prompted their decision to tell. While two of the participants listed a night of heavy drinking as being the main reason for disclosure ("Two drunk Mexicans on tequila, sharing every secret of their lives." (P 3)), most participants disclosed their abuse to their partner as a result of being emotionally or sexually triggered within the context of the relationship. For example, Participant 8 said, "It was impossible to have a real relationship or co-exist with a man and do what you are supposed to do as husband and wife [sexual relations] without explaining to him why I had certain behavior and respond to certain things during that time." Another indicated that he decided to disclose the abuse "because she knew there was something wrong. She could tell that, you know I was out of it or feeling stressed, or whatever. Somehow she knew when the memories started coming." (P 6). Participant 5 had a similar sense that he needed to tell his wife: "I was studying to be an actual counselor too. It triggered me emotionally. It triggered me to the point where I kind of sat down and I made it clear that my wife at least was aware of what had gone on in the past, and why this was a difficult job." All of the participants discussed their abuse with their partner at some point, most at the beginning of the relationship. Two disclosed approximately 4 or 5 years into the relationship. Two participants disclosed when they remembered the abuse.

The participants all indicated that the level of trust and safety that they felt with their partner influenced the degree of comfort or anxiety that came with their decision to

disclose their abuse. "Before we ever got completely committed, I was very hesitant to be in a committed relationship, and I told her this was why. I didn't want to become emotionally attached to her, more than I already was, if she was going to run when she found out how screwed up I was" (P 2). Participant 5 noted, "I was very guarded, yet I do think she needed to know some things. And I was starting to work with it, and it was getting harder and harder. So I told her bits and pieces throughout the whole…marriage." In contrast, another participant said that the decision to disclose was relatively easy, given the level safety he already felt in the relationship. "We have a really good relationship. We talk about literally everything, and it really wasn't a decision. It was just 'Guess what I remembered today,' kind of thing. Quite frankly, if I hadn't have had some pre-contemplation about her response, I probably wouldn't have said anything" (P 7).

Results of Abuse

All of the participants were asked how they felt that the abuse had affected their perception of roles and processes within the couple relationship. They were also asked how the abuse had affected them personally. 100% of participants expressed that their childhood abuse had affected them in a profoundly negative way. These affects tended to cluster around four themes; self-concept, emotional distress, sexual identity confusion, and interpersonal relational problems.

Self-Concept.

All of the participants discussed low self-esteem, worthlessness, or a perception of being dirty, bad, broken, flawed, or disgusting as a result of experiencing CSA. This commonly resulted in a feeling of unlovability or a fear of being unlovable. Many confused sexual relations and body perception as somehow being tied up in their self-

worth. Participant 3 explained, "I get into a place, or I used to get into a place of low self-worth. I would use sex as a conquest kind of thing to make me feel better about myself. You feel that your worth is in . . . has to do with your sexuality". Participant 2 expressed a similar sentiment: "At times it felt like the only way I felt worthwhile was having sexual conquests. When I would feel that people were sexually attracted to me, I would feel… that was somehow validating." Several participants said that it was difficult to separate themselves from their body. "That's a big impact on people that have been sexually abused. In my opinion, people make you feel like your body is it" (P 1).

Nearly all of the participants felt a pervasive and profound sense of worthlessness or "badness" associated with the abuse. "I think it affected it in a very worthless way. I felt worthless" (P 8). The concept of low self-esteem was not something that just surfaced on occasion. Several participants indicated that it was a pervasive, continual battle. Participant 6 expressed it this way: "I saw myself as probably the lowest thing on the face of the earth. There was something wrong with me. I wasn't worth anything.… Funny, I can never think of a word bad enough for what I thought of myself. Closest thing I can come to is a snake's belly on the bottom of the Marianus Trench, which is the lowest spot in the entire world, in the ocean, the Marianus Trench... It's been a constant battle. It's something I deal with every day." Participant 5 described himself thus: "I was two people. I was a professional, pretty decent guy who got up in front of congregations who said some wonderful things one minute, and the next minute, I'd go into a closet and shut the door and just say 'I hope they don't see me right now because I feel so bad.' Yeah. I really wasn't lovable. And I can scream from the housetop, my talent, my abilities, but it really deep down doesn't matter. I can give a speech in front of

thousands and make them roll in the aisles, and in the end, it doesn't really matter. It's hard to have self-esteem."

Another aspect of self-concept that came up frequently was the idea of self-blame, that the survivor was not only at fault for the abuse, but also for most any problem in a relationship. This was often a result of specific messages incurred during their abuse, as in Participant 4's experience. "I was told that I was a slut, and it was my fault that everything had happened. I very much blamed myself for what had happened" (P 4). Participant 6 described, "It's tough not to look at yourself in the mirror and be disgusted with yourself. Actually one of the hardest things I had to deal with, was I always tended to blame myself for everything that happened. Not just the abuse but everything else too. So I always felt it was my fault somehow."

Emotional Distress.

All of the participants emphasized an overwhelming degree of emotional fallout from the abuse. The most common emotions mentioned were anger, rage, guilt, shame, fear and anxiety, and a general psychic pain. Several participants struggled to describe the severity of their overwhelming and confusing emotions. Participant 4 stated, "I was raw and bitter and angry. It hurt me so deeply. At times I would come home angry or frustrated, in an overwhelming emotional state where I didn't know what I felt. I just felt everything at once, and it was just overwhelming for me." Participant 8 explained, "My emotions were all messed up. I didn't know how to read my emotions. Now I can articulate what was happening, but then it was just a whirlwind of shit in my head. I had some really bad anger issues." Participant 6 described what it was like for him. "Getting these memories back.… You know when they hit it's like an earthquake and a tsunami

hitting at the same time sometimes. It's just so unbelievably disturbing and upsetting. The main perpetrators are dead, there's nothing I can do about it. And that in itself, kind of makes me angrier, because there's really no way to give any of this back to somebody else."

One participant mentioned the shock of remembering his abuse. "There was a lot of anger over it. Mostly shock, like 'Holy hell! That happened to me!' And shame, to an extent" (P 7). Participant 3explained the weight of guilt she felt: "It caused a lot of guilt because the act happened, because abusers like to put seeds of guilt into you as well. 'If you tell on me your family won't love you because that means you're dirty' and so the abusers help with that. And also acting out and that was extra guilt because I should have known better. It was a lot to carry."

Other frequent emotions were hopelessness, powerlessness, blame, emotional numbing, and depression. The process of emotional numbing was described by one participant. "I had to go through what I went through alone. There was nobody there for me, so I learned how to be strong, and in being strong, I push away all emotion. So at times I've been very blank. I have had periods of time, long periods of time, where I'm just numb, and I go through life on autopilot. It is so painful to me that I can't do it, so I shut down" (P 4). Participant 6 explained his depressive response like this: "I didn't have an effective means of dealing with it. It just kind of took me over to where I was almost like a zombie. I did what I had to do and that was all I could do."

Several participants expressed progress and improvement in dealing with their emotions, but there was often a perception of hopelessness regarding their ultimate healing. For example, Participant 3 said, "I was very blameful. You know my Mom

wasn't there, watching me. It's better now, but nobody ever goes through complete healing."

Sexual and Identity Confusion.

Confusion around one's identity was very common among the participants. All but one survivor expressed difficulties around who they were and who they were supposed to be. This was especially true in the arena of sexual identity, sexual orientation, and what sexuality was. All participants, to varying degrees, saw sex as love, sex as power, sex as bad, or sex as completely separate from emotions, as described by Participants 8 and 3. "Sex is a numb place" (P 8). "I can say it's definitely shaped the way I feel about sex, the act of sex is . . . an act of sexual intercourse. It has absolutely nothing to do with emotions for me" (P 3). Participant 8 noted her complete confusion, "Intimacy was….I didn't know what sexual intimacy was".

Several viewed sex with fear, pain, victimization, or an inevitable obligation to anyone and everyone. Several could not keep feelings from the abuse from bleeding into the sexual intimacy they experienced with their partner. Participant 6 explained, "I associated sex with pain. And it was like, if I was the aggressor I was trying to hurt my partner." Participant 5 stated, "It affected me drastically; sexual orientation, the ability to be self-loving and trust the love and sexual relationship with anybody." Participant 2 confessed, "Sometimes it's challenging for me to be intimate, sexually. It makes me feel like a bad husband." Participant 8 described her struggle with sexual intimacy: "I would put a pillow over my head or I would put my face on a pillow. Anything, as long as I didn't have to look at him. Again it just freaked me out. I didn't know how to control

the images in my head or how I felt… it's supposed to be this amazing thing and I was terrified of it."

The idea that personal value and power came from sexuality was common. Several struggled to separate their sense of personhood from being only about their body and their sexuality. All but one expressed periods of sexual promiscuity that they thought exceeded what would have been normal for them. Participant 3's response was typical: "Some of us end up on the prudish sexual side and some of us are on the other side, and are promiscuous and multiple partners, and I am definitely, was on that side of things for a long time." Participant 4 stated, "Me trying to get that attention from other people in a sexual manner was part of my abuse. I'm looking for validation in a sexual relationship."

Participants' feelings regarding sexuality often swung wildly in different directions. "I had had issues with sexuality, issues with feeling loved, issues with using sex as love.… Sometimes I feel like I'm all over the map" (P 5). Participant 8 explained, "I didn't feel like I even deserved him. So, I tried to do other things to try to keep him in love with me, sexual things. It hurts me to think that I couldn't… like once we actually had sex after we were married… it changed. I think the act of sex [intercourse] really… I hate it."

Interpersonal Relations.

Childhood sexual abuse affected the participants in many areas of interpersonal relationships. This was true of all types of relationships, but it was especially intense and poignant in romantic relationships. Throughout all of the interviews, trust was the most common and constant theme with regards to the negative effects of CSA. This included a fear of abandonment, fear of being trapped, fear of rejection, a need for control and an

overall sense of interpersonal insecurity. A decreased ability to both love and trust was noted among almost all participant relationships, along with an increased need for love and security.

Decreased ability to trust one's intimate partner was manifest in nearly all the participant interviews. Problems with trust in couple relationships usually centered around sexual intimacy and the ability of the participant to trust their partner's love for them. For example, one participant described their feelings about trust in this way: "My abuse affected more than anything my ability to trust people. It makes me feel like I have to be able to depend on myself. You can't trust them. And the one thing that I said when I was younger, was that I'm never going to have to depend on a man" (P 1). Another said, "It hinders my ability to trust everything, even God in Heaven kind of thing" (P 5).

Decreased trust was often coupled with a fear of rejection, as with Participant 2: "I feel the abuse has influenced me to be wary of trusting people. I am hesitant to open to people, to trust them. I am scared of how people would view me." Participant 6 explained, "I always just expect everyone to run away as fast as they can. I thought they'd look at me like there's something wrong with me or whatever." Trust issues commonly affected the couple relationship, as noted by Participant 6. "I can see instances where it hurt my first marriage; areas where I didn't trust her, and I had a lot of abandonment issues, and I was always worried about her leaving me.… And just the way I trusted her and how I treated her."

A sense of emotional/relational disconnect was not uncommon in all the participants' relationships, but it came out more noticeably in romantic relationships. For the participants' couple relationships, it tended to center especially around the arena of

sexual relations. Participant 7 stated, "There certainly was an [sexually] intimate dysfunction, an emotional dysfunction that didn't allow me to get close." Participant 8 explained, "Like when he wanted to be all cuddly at times afterwards [sex], it was weird for me. I would just get up and it was over. I didn't know any… that's what was comfortable you know? After something like that, I did my duties and then I was done."

Several participants indicated that sex was easy if they were not in a committed relationship. However, if they were in a relationship in which they felt emotionally vulnerable, sexual intimacy involved more anxiety and difficulty for them. Participant 3 described it thus: "If I meet somebody and I know that there is never going to be any way that I would have a relationship with this person, sex is really easy. I don't care. I don't even know your last name, don't exchange your phone number . . . very easy because it is the act of. But however, if I meet somebody and I feel an emotional, or there could be a relationship with an emotional attachment, then you have to wait for sex and be cautious. And it won't be at least a few months before there is any sexual . . ." Participant 4 stated, "I can't see love as sex, so it makes it very hard for us to have a physically intimate relationship." "It's [sex] been difficult in my marriage, which is difficult" (P 2).

Some participants noted tendencies to be either sexually submissive, repressed or aggressive, or that sex was an inevitable obligation they owed to anyone and everyone. These issues often created problems in their couple relationships. "I would be friends with somebody and feel that they needed the same thing [sex]" (P 8). "I found out it's because of what happened to me, that I am not the aggressor. I'm not the one who's pushing having sex" (P 6).

Several had a perception that they didn't know how to be a competent partner in a committed relationship. This often led to insecurity and frustration in committed relationships. Participant 8 described it thusly, "And I had so much love inside to give, and I felt like a) I didn't know how to give it and b) no one really wanted it. So it's kind of like being alone in the world behind glass, watching everyone else live and you're not." Participant 7 explained, "I had to learn, I had to learn that sense of emotional and intimate connectedness with a female over and above or in addition to just the physical aspect. I think I pretty much objectified women, certainly in my first marriage, and did not have a sense of what it was that she might need."

A few participants noted a propensity to choose poor life partners, as explained by Participant 5; "I believe strongly that when we believe we are worthless and hopeless and nothings that we usually get involved in relationships that either tell us that, or are the same level themselves. She wasn't healthy. I picked her at an emotionally unhealthy time."

What Partners Do to Help Healing

As described above, each of the interviews included questions about what intimate partners do that helps facilitate healing for the CSA survivor. The results of the participants' responses are reported here in order of incidence and significance. Those themes and categories that appeared most frequently and were described as being the most important to the participants are listed first, with subsequent themes and categories presented in order of incidence and impact on the participants.

Safety and Trust.

The concept of safety and trust within the couple relationship was primary to participants feeling like the couple relationship was a place wherein they could find the space and opportunity to heal from the effects of CSA. All of the participants emphasized safety and trust as being imperative to healing. For example, Participant 1 stated,

> "What he brought to me was that I could be safe with him, that I didn't feel like he was going to take something from me that I didn't want to give. For me, not pushing me and allowing me to build that trust was something that allowed me to heal because it made me feel as if for myself, as if my body was mine. I've always been very aware of my body, due to the sexual abuse. And, those kinds of things allowed me to feel that my body was mine and if I wanted to share, I did. And if I didn't… you know. So getting me to the point where I feel that it's not about my body, that it's about me and I'm a person, I'm valuable. I'm more than just the physical female thing. That allows me to heal. That allows me to be safe in who I am, be me with you."

Several concepts figured into the perception of safety and trust within the couple relationship. The sense of safety that appeared most important to the survivors centered around a sense of emotional safety and trust. These included things like honesty, loyalty, open communication, and a feeling of commitment to the survivor and the relationship. Participant 4 explained how she knew that she could trust her partner: "By her commitment to not leave my side. She let me talk it out until I was done talking. She let me cry it out until I was done crying. So she really showed that she was paying attention

to me, that she really cared, that she was really there." Participant 8 noted, "He was on my side. It made me feel completely safe, like he was my safe place you know. I felt heard. I felt loved. I felt cared about. You know like, my feelings actually mattered, you know. I as a person matter to him, and that, nothing can replace that in someone's life." Participant 7 described how his partner engendered safety for him:

> "She's exceedingly open. Not in the sense of telling all, but she's open to any discussion. She is extremely kind. She's very, very generous with her time. She is probably one of the most forgiving women I've ever had the pleasure to be with. She's much more understanding and forgiving than I am. It's just a real safe place to be. It's a real safe place for me to bloom."

Respect for one's personhood was part of that sense of safety. This included an absence of shaming, blaming or criticism, and a respect for the survivor's wishes, that their needs were more important, or just as important, as their partner's needs. Also key was the idea that the participant could be sexually safe with their partner. Participant 2 expounded, "By having boundaries, even with my wife, and her respecting them, it allows me to become more, well, more intimate but more, kind of, some of the boundaries come down by her respecting them. I feel more free because I don't need the boundaries to feel safe." Participant 1 described her sense of safety with her partner:

> "Well, one thing is he was a person I could trust and he did that by showing me one; that I was number one in his life. He was not only concerned about his self. He was always there for me. Um, he was like, kind of protective of me. Being present and being protective of and being concerned about what was going on with me. And not so much about me being concerned so much about what was

going on with him. He would always make sure that I was on the inside and he was on the outside by the street. And this is just something that he did. If somebody was coming towards us or whatever, he would grab my hand. Especially if it seemed, I mean, we grew up in Chicago, in inner city. So it felt like if this person might be you know... He was just protective. I just didn't feel like anyone would do anything to me. I felt like probably our strength, that he could depend on me and I could depend on him. So it was kind of like, from his point, I got somebody that can be there for me and I can be there for them."

Besides a need for emotional safety, those things that brought a sense of physical safety also emerged in the participants' responses. This included their partner providing a sense of protection, and just the mere physical proximity of the partner engendered a feeling of safety. "We want to be together, just to be together. Even if I'm writing a paper and she's watching TV, being in proximity is much more comforting than being separated" (P 2). Another participant also described the sense of physical safety that came from her partner:

"Just his existence and having like, like having him close or watching TV, like sitting together. I loved that. He was my safe place. I felt safe with him going places. I felt safe with him when he would, he would sing to me a lot. Play the guitar and sing to me, and it was just a fairytale, you know every time I turned around he was making me feel safe. Um, I felt very secure and very safe with him. If I was going to be sexual with anyone, I would have chosen him" (P 8).

Acceptance and Validation.

The concepts of acceptance and validation were important to nearly all of the participants. These concepts are related to, but slightly different from, the perception of safety and trust. Often acceptance and validation had to do with the abuse story itself, and it's reflection upon the survivor. The partners' ability to validate the survivors' abuse experience and accept them in spite of it was crucial for all of the participants. Acceptance and validation were shown through belief in the abuse story without blaming, shaming or judgment. Partner interest, responsiveness and a sense of understanding and acceptance of both the abuse experience and the survivor as a person independent of the abuse were also seen as acceptance and validation.

Here are several examples given by the participants when asked how their partners responded to their disclosure of abuse. These messages of acceptance counter the shame and low self-esteem associated with the abuse: "She let me know that that [the abuse] didn't affect how she felt about me. I didn't expect that sort of reaction. I expected her to push me away. So I was very happy. I felt accepted" (P 2). "She listened. She cared. She believed me. She was very kind and very understanding about everything" (P 4). "Well, mostly he listened and then he understood, like… With him it just felt like it was okay that I had this event occur and that it was okay that he knew about it and that he was going to support me" (P 1). "I thought at first she'd be disgusted by it and would, might even just run away from me, but she didn't. When I finally felt comfortable enough to start sharing some of the, shall we say 'gory details,' the fact that she just took it in stride. You know, she didn't recoil and run away " (P 6). Respect for

the survivors' feelings, verbal affirmations of self, and a general attitude of forgiveness contributed to acceptance and validation.

> "I mean the fact that she listened to me about my anger and didn't cajole me, shame me, 'Oh you shouldn't feel that way.' I felt heard. I felt validated. I got comfort in her validation, you know, that there was no shaming involved. There was no, 'well why didn't you tell sooner' or 'why didn't you remember sooner' or 'how come you're remembering now' or, there was just this very forgiving, openness to it" (P 7).

Participant 3 expressed, "Her being able to understand those feelings that happen when you suffer from sexual abuse, she was very understanding, as understanding as she could be. It was non-judgmental." Participant 8 noted, "He didn't care if I cooked, and I brought home random animals all the time, like a bunny and two dogs… and he never yelled at me." Participant 2 explained, "If I'm able to express my feeling, and when she acknowledges it, respects it, and then returns to me and says, 'I love you, and when you are ready, I'm here for you.' That is very healing."

Open Communication.

100% of participants in the study talked about open, safe communication as being critically important to their healing, and to their being able to safely address topics surrounding their abuse within the context of the couple relationship. Participant 3 emphasized,

> "Like I said, open communication. I mean there's really not... But really there is just open communication. 'Just FYI, I'm having some self-esteem issues so, I'm having some issues with the sexuality thing. I know it has something to do with

this and that but I'm making you aware of it.' And she's very good at going, 'okay let's deal and talk about it.' Just being able to share that with somebody, full disclosure on everything was the biggest key. Informing the relationship and being able to nurse along what happened. Just speaking about, having open communication about the sexual abuse that happened in my life and hers has built that trust and I know there is nothing I can't tell her about my sexual abuse."

Open communication played a key role in establishing safety and trust, and yet safety and trust were necessary in order to have open communication, so they usually went hand in hand. Open communication rests on the idea that any topic is open and available for discussion. The safety necessary for open communication includes no shaming, blaming or harsh criticism, and a sense of understanding and acceptance. Participant 1 described how important open communication was for her: "Well, his response at the time, he was just very supportive. I think it was probably because we were friends and we talked about just about everything. He had had neglect and some things that I kind of helped him get through and so with that relationship I think it builds a cocoon for us to be open and talk about it. We had a lot of dialogue all the time." Participant 7 described the communication with his partner: "Open. Talks about, she'll be open to almost any discussion. Really helpful in creating emotional intimacy and trust." Participant 8 clarified how open communication helped her: "Yeah, he's helped me manage difficult emotions forever. Like, I would tell him stuff like, 'I'm attracted to girls' you know, and we'd talk about it. I would tell him, you know, like we could tell each other anything."

Aspects of open communication involve full disclosure, mutual disclosure, listening, negotiation of needs, and a significant amount of time and priority given to talking within the couple relationship. "We just did a lot of talking, and it was like, the trust was just there. You know, we'd talk about it [the abuse]. Actually, early in my relationship with her, we spent a lot of time talking about it" (P 6). Participant 2 explained the significance of open communication in his relationship:

> "However with my wife, I've previously described opening up to her, and her responding and encouraging me to open up to her. Trust in our relationship is not an issue. It's taken a lot of conversation and me telling her that I am not comfortable with it [various aspects of sexuality]. It's very difficult, but she is very respectful of it. So, honest conversation has been very helpful to establishing boundaries and developing trust and a sense of safety."

Emotional Intimacy – Perception of Being Loved.

Perceiving a real and legitimate emotional connection contributed to all of the participants' healing. If they felt such a connection was not there, or couldn't be trusted, it was very detrimental to healing. "I think I got, I'm sure I got comfort in connection" (P 7). These connections were often said to be felt and they necessitated a feeling of mutuality, but participants listed ways that their partners reinforced a perception of emotional intimacy and authentic love for them as a person. Stated Participant 3, "I could truly connect with her. If I need to be held, she holds me. Or if I need to hold her, I do."

Emotional intimacy was felt when partners were emotionally responsive and aware, as expressed by Participant 1: "I never met anyone else that was that supportive,

that friend that everything and had that same level of you know, love, respect and concern for the other person, which is me. He was aware. He was generous. He knew if there were something, like if I liked to go somewhere or do whatever. He was giving." It was reinforced through verbal expressions of love and closeness, thoughtful service, kindness, non-sexual physical touch, and a mutual perception of solid friendship. "He'd always bring me home flowers, he'd do the dishes. He was very considerate of me. It made me feel loved. Like real love, you know?" (P 8). Participant 5 relayed the affect that his partner's thoughtful expression of love had on him:

> "She wrote me 72 individual enveloped letters for the 72 days that I was gone, back before the days of cell phones and stuff. So she had somehow sneaked away and wrote 72 pretty extensive letters about what I might be doing that day on the tour and what she might be doing that day getting ready for the marriage, and she gave it to me, surprise, that day I got on the bus to go back on the tour. I had 72 letters, one for every single day of that tour. A very act like that of love, that made me feel like I was worth something."

Sexual intimacy could also serve to support emotional intimacy and "true love", but only when there was a sense of freedom of choice, openness, and real emotional connection associated with sexual intimacy. Participant 2 explained the affect that real intimacy had on him:

> "Which, being able to be intimate with my wife, and her being accepting, has really been healing to me, sexual intimacy. And I mean sexual intimacy as in actually being sexually intimate, with emotional closeness, because it's possible to be sexual and not be intimate, and that is not healing. I like to say my favorite

> part of sex is the cuddling afterwards, and that is very healing to me. Enjoying sex with my wife and not being ashamed of it and not feeling guilty about it. Not feeling like someone did something they didn't want to, but feeling like we both love each other and care for each other and want each other to be happy and want to please each other… That has been very healing."

Participant 1 explained what made a difference for her: "Well, one we were friends for about six to eight months before we even got to be at a different level and he was comfortable with that like, 'This is fine. I just want to be around you.' He helped me feel like it [sex] was about me." Participant 7 talked about how the sexual relationship influenced his ability to emotionally connect: "My partner is very open to the process of sexual behavior. Accepting, not rejecting, and that was refreshing. Her openness and healthy attitude toward the sexual relationship helped increase the intimacy a lot, the emotional connectedness."

Support.

Support is a concept that nearly all participants mentioned frequently as being very helpful to their healing. It overlaps somewhat with the perception of being loved and acceptance and validation, but it has attributes that are unique to the idea of the participant being both emotionally and physically supported during a difficult time. Actions by partners that contributed to a feeling of emotional support included listening, encouragement, understanding, reassurance, verbal affirmations of support and commitment, and quality time with their partner.

Participant 6 responded to what was helpful to him: "At first she was supportive. She said 'Okay, let's work with it. What happened? What do you want to do about it?'

Just the fact that she was willing to talk about it and she was willing to try and understand what happened to me and 'what affect this is having now?'" Participant 4 described her partner's support: "Just how supportive she was over everything. She understood that I was still very hurt and that I was still in a very bad spot. She was very good at calming me. She would just help relax me and calm me and tell me that it was ok. It made me feel soothed." Another example is from Participant 2: "Well, she tells me, literally, that she's there for me. She tells me she will go with me wherever I go and follow me wherever I take her, which lets me know that whatever path my career brings, she's there for me."

Physical support involved service, offers of financial support, non-sexual physical touch, and a perception of generosity and concern on the part of the partner. Participant 7 talked about his partner's response to his disclosure of abuse: "She was interested in was there anything I needed from her. You know, she said 'what do you need? If you need to go to therapy, we have the money, go. If you need this, do it. If you need that, go.' I mean, she's very compassionate, very understanding, just very supportive. I felt understood. It was nice to get that support." Participant 8 described the unique way that her partner was able to support her: "I had some really bad anger issues. He came home and I was throwing the "precious moments" he had given me, and they were shattering. And I was punching a mirror so hard, like I fractured my pinky. He would hold me from behind until… Like, there's only so much energy you can exert before you just crash. I felt he was supportive, because he would just hold me until I stopped." Participant 4 explained,

"She was just really there for me, and it really helped to have somebody listen, and help me find the solution. She would go with me to bookstores and I would start looking for stuff, and she would notice that I was looking for books on self-healing and self-help, and she would stand there with me and read through the backs of the covers and pick books out that she thought would help me or that I would like. I've had a lot of growth in the last few years, and it's really with her support and her insistence on not leaving my side. She has really not given up on me, and has continued to be there for me."

Empathy.

Empathy was found to be a significant emotional expression given by one's partner that helped participants to heal from the abuse. This was especially true when participants were queried as to their partners' response to disclosure and how their response affected them. Participant 2 gives a good example of the effect of his wife's empathy:

"She cried, and said 'I'm so sorry that happened to you.' I started to cry. I felt very… I didn't expect that sort of reaction. I expected her to push me away. So I was very happy. I felt accepted. It was, it was very healing. She has several times since then, cried just because of the… when she thinks about poor little 8 year-old me and what happened and how unfair it was. She's very empathetic… It makes me feel loved. Because I don't think it's a painful crying, it feels like she's sorrowful that bad things happened. And not mad at me, not sad at me, but crying because she's feeling pain because she cares for me, which I think bonds us."

Empathy included such things as expressions of sorrow, care and concern, sadness, tears and compassion. "She cried with me" (P 3). "He was very sorry and very sad that I'd gone through that" (P 8). "He hugged me afterwards and said I'm sorry, I wish I was there" (P 1). Empathy also included matching emotions, such as anger, indignation or outrage. "It was nice to hear that it hurt her and that it bothered her that it [the abuse] happened to me. She understood why the wounding was there" (P 5).

Freedom of Choice.

Having a sense that they have the freedom to have opinions and make choices that will be honored was very important for most of the participants. Having their thoughts, feelings and wishes recognized and honored was important in all areas of life within the couple relationship, but it was mostly keenly felt and needed within the context of sexual intimacy. It was of primary importance to most of the participants that they not be pressured for sex. Participant 1 stated, "When I was telling him 'Okay, well this isn't going to work for me, as far as you trying to push me too far when I'm not in the mood.' He understood it because he didn't push like that. If I said, I can't, or something like that then he knew that it was okay. He respected my boundaries. I met some people who didn't, but he did."

It was also uncomfortable for several of the participants to be pressured to think or feel differently on most any topic. Several said that they needed to have a sense of control, and it was helpful when their partners' respected their feelings, opinions, and personal boundaries. Patience on the part of the partner was often rewarded with increased trust and intimacy. An example of this is described by Participant 2:

> "Sometimes it's challenging for me to be intimate, sexually, with her, and she will just hug me. She makes it acceptable for me to have a boundary. At times when she just hugs me, I feel totally acceptable and I feel good. It feels healing. It makes me feel safe that I can have a boundary when I feel I need it. If I have a choice, I'm much more likely to be sexual, because I have a choice. When I'm trapped, I feel very… I get defensive and shut down. I feel like I need to be able to stop if that's what I feel, to stop or say no. Or also, to say, in any way of our relationship really, 'I like this, I don't like that.' To be able to express my likes and dislikes… It could be with what we eat, but also sexually, and that helps me feel like I haven't lost control."

Positive Growth.

A few participants referenced how helpful it was to have their partner grow and change with them. Their partner was interested in growing with them, and would model or inspire their own growth. For example, Participant 4 noted, "I think that she showed a different level of care that I had never before learned. I didn't know that people could be so caring, so nurturing, so loving. It made a big difference to have that kind of role model, almost, to be able to really enjoy life with." Participant 7 explained what his partner's example and encouragement meant to him:

> "I wasn't even sure I knew how to be with a woman. And then in the success, based on the continued happiness in my second marriage, I really thought, 'Hey maybe I can do this.' I mean, I once heard in a movie or a book or somewhere, 'you make me want to be a better person,' and I ALWAYS feel that way about my wife. There are sometimes where I will sort of say, 'Why would we want to

do that?' and her response will be 'Why not?' and so she sort of encourages me sometimes just to leap out there and do it. Take healthy risks..."

What Partners Do to Hinder Healing

Criticism and Rejection.

Criticism and a perception of personal rejection were extremely damaging to the participants' effort to heal. As all of the participants identified low self-worth, shame and guilt as being key results of childhood sexual abuse, criticism and rejection served to confirm those painful ideas and emotions, rather than alleviate them. This was sometimes first felt upon disclosure of the abuse. Any indication of blame, shame, judgment or a lack of empathy or responsiveness was often perceived as criticism and rejection. Participant 8 reported how her partner first responded to her disclosure: "He said 'why didn't you tell me sooner?' I felt like screwed up, and I always felt like that." Participant 4 explained how a lack of empathy and responsiveness affected her:

> "I thought she would respond more in a nurturing kind of way, perhaps maybe anger or frustration or, I think I was looking for a strong emotional response of any kind, and I didn't get it. I was looking for someone to say 'Let's go kill him,' or 'Let's go beat him up,' or "Let's do something about this situation.' I kind of felt like I was entitled to more of a response. I couldn't understand how somebody could take it so lightly, and I really wanted to be acknowledged that I was still traumatized. I felt very much that she wasn't there for me because I didn't get that strong emotional response I wanted, and because I didn't get the fight out of her, I thought that she didn't care."

It wasn't just what the partner said or did that was damaging. An absence of love and support was often seen as judgment and condemnation by the participants. A lack of understanding, or support, or affirmation of care or comfort through physical touch was seen as rejection. Participant 5 described his wife's response to disclosure: "My wife was not very understanding. She was very um …she didn't give you hugs about it. It was about you know, it was a very dangerous place to be in that place with her because if you weren't... It was just a dangerous place to be if there was something wrong or could be something wrong." Participant 3 described her first husband's reaction to her abuse: "He did not understand. He understood the part of me being sexually abused. He could not understand acting it out as an adolescent. As a matter of fact, in an argument he would use it against me. So, not a lot of healing there."

Outright criticism was very hard on some of the participants. So also was any implied message that they were somehow "not good enough," as that would compound the message of "badness" that they received during their abuse. Participant 5 explained,

> "It was always a set up to never be exactly perfect like she wanted me to be. I couldn't please her physically, sexually, financially, emotionally. I wasn't a good husband. I wasn't romantic enough. I didn't make enough money. I wasn't home enough. I worked two jobs so I could make more money. I wasn't a good father because I yell at the kids too much. I wasn't a good enough church person. I did things I shouldn't do. I shouldn't have been drinking. That list went on and on. It made it really hard to heal because that's what I needed; acceptance, approval. Because that's what they [the abusers] taught me, that I wasn't good enough. 'Your mom didn't care that you were here.' things like that."

Participant 8 noted, "I felt guilty if I didn't satisfy him [sexually]… like no 'that was wonderful I love you.' Like sometimes he would get up and be like 'wow, it's been the same for a couple of months now,' so I would feel worthless, you know. I wasn't up to par."

It was hard on the participants if their partner didn't take personal responsibility for problems in the marriage. An attitude of blame confirmed the idea that everything was their fault. For example, "I wasn't ever good enough for her. When we would have a problem and I'd say there's something wrong and she'd say, 'you know, I'm sorry you feel that way,' but she would never say 'I'm sorry'. It's just like there was always something wrong with me. Always my problem. I didn't do enough of this or that. Constant criticism. Hard on my healing process? Absolutely" (P 5). Participant 8 described,

> "We were really promiscuous before we got married and he has always put that on me. Like when we talk about it he is like 'I don't understand why you don't like sex now, like you were all over me before' and that kind of makes me sick because I was just trying to make him happy, and I wasn't the only one doing it, I wasn't the only one… What messes with me is the fact that there is no responsibility on his part for messing around."

Withholding of love and attention included sexual intimacy, when the survivor perceived sexual intimacy as a sign of love and acceptance. Participant 4 explained, "Right now we are currently experiencing problems with sex because I'm looking for that [validation]. I'm having difficulty waiting for the relationship to turn to a place of not

just emotional intimacy, but physical [sexual] intimacy. I think by physical [sexual] intimacy, I will become whole again." Participant 5 clarified,

> "We couldn't have sex because sex to her was not about joining in intimacy. Sex was beneath her. Couldn't be there romantically…she couldn't be that. Couldn't get what I needed so it affected it [healing] drastically. It made me feel worthless. It made me feel unloved. It made me feel uncared for. It made that it was something that I needed, and she didn't, so again you know, sex is then something dirty and something wrong. And there's something dirty and wrong with me because I want it. Most people who are sexually abused feel worthless, they feel they're bad, they feel they're not good enough. They just want to be loved, and I wasn't getting that at home… in a physical way, in a sexual way, in an emotional way."

Betrayal.

Betrayal involved various forms of disloyalty that caused a breach of confidence and trust in the relationship. They involved a breach of confidential communication, emotional or physical infidelities, disloyalty before friends or family, disingenuiness, pretense, or outright lies. It was severely negatively impactful on all the participants that experienced any form of betrayal. For instance, Participant 1 stated, "So once he did violate that trust eventually, I couldn't go back. It was shattered. For me when you violate my trust in you, you break it, so strongly. I feel like I have to back up off you and that means to separate myself and I, usually there's no way to repair it."

Acts of disloyalty, like putting friends or family before one's partner, was considered a breach of trust. Participant 8 gave an example:

> "There were times when he would talk to his family behind my back when he told me he wasn't. He would act like he was so upset that they treated me the way they did, and he would say 'we're not going to talk to them anymore'. But then I found out he was calling them when I wasn't around, and these small windows of inconsistency would make me just flip! Anger, that was the big one. I couldn't control myself. I would throw stuff, break stuff, and I think it's because I was breaking down inside."

Participant 3 confirmed the difficulty of a broken trust: "Emotional infidelities are the worst part of that healing because it's somebody that I shared completely everything with. Because the trust is, you have complete trust in somebody. You shared everything, even the deepest secrets that you're not so happy about. And when you can have that trust and share it with somebody, and they betray your trust, not in that way, but in any way, it becomes very hard to rebuild trust again."

Infidelity coupled with lies was especially harmful. Participant 8 described its effects:

> "I was snooping around the phone bill one time, you know because I was paranoid because I didn't want my perfect husband with anyone else. And I did, in fact find out that he was speaking to another girl for hours every day except weekends. And he met her on a trip and so, the lies, the inconsistency. The lies, because what I mean by inconsistencies are little lies that have led up to huge lies. It affected me horribly. My whole world has come crashing down again, like I don't trust men. I thought, I thought he was perfect and it turns out he's pretty much just like my abusers, just with a prettier face and kinder tone. Like no one

will ever, no one will ever love me. I, that's all I would think is that it's impossible for anyone to love me, unless I'm giving them something, and then it's not even love, it's just, 'thank you'. Because it's impossible to love me. I mean, he told me every day how much he loved me. He was my safe place. And then one day I find out that none of that was even true. And I find out all these lies; more and more and more, constantly. And, here I was being played a fool, that he could actually love me. It's like 'I am unlovable.'"

It wasn't just infidelities that hurt. A lack of trust in their partner's commitment to them was harmful to the participants' healing, as was any feeling of pretense or disengenuiness in the relationship. Participant 5 stated, "I couldn't trust her to be there to love me. I couldn't trust her to be there romantic with. I couldn't trust her to be there sexually. I couldn't trust her. I felt like I was begging for love, begging for attention, begging for relevance. I couldn't trust that I could get those things." Participant 8 explained,

> "He was considerate to keep me happy, only because he wanted to keep me pacified… He never wanted me to get upset or anything, and he'd just tell me what I wanted to hear, a lot. And the disingenuiness of that messed with me. Because then I, again, no one will ever just love me for me. Everyone's just gonna, you know, pacify me and use me. Like no one's actually going to look at me and care what I think or who I am…"

Participant 6 described the effects of a breach of confidential communication:

> "Instead of keeping my confidence she told her daughter, which meant I couldn't trust her any more. It tended to destroy what little self-esteem I had at the time. It

made me almost completely unable to trust any woman ever again, to say anything… I don't know if I ever got into a relationship again if I would even tell them. So basically she pretty much destroyed my ability to trust anybody ever again."

Disrespect of Personhood.

Disrespect of personhood is a category that exists in opposition to validation. It involves words or actions by the survivors' partners that made them feel as if they didn't matter, or mattered less than other things, or that minimized their thoughts, feelings or experiences.

"The [social, religious] expectations were all my partner cared about. Those expectations, that's what mattered. It made me feel that I must be bad and evil because I deep down don't really think I'm capable of doing those things. It just validated what the perpetrators taught me. That it's my fault, that something is wrong with me. It just validated what they said. It kept me in victim mode. Feeling like I had to live a life of pretense with my wife was very hard on my healing because if you're living in a lie, how can you be real with yourself? Let me say what I feel, free from the restraints of having to live, be, and say those things instead of saying what I am" (P 5).

Participant 4 sometimes felt her partner minimized her experience: "When she would say 'It's ok. You need to move on,' I would take 'you need to move on' as 'you need to forget it and just go on with life.'"

When partners put their needs and feelings before the survivors', it was perceived as harmful to healing. Participant 5 explained, "I had told her I was raped and then how

she said 'I felt so bad for you and that's all I could think about for nights is how you were raped.' I had no clue she was even going there in her head. She wasn't supporting me. It was all about taking healing herself that I told her a story about how I'd been raped that she would um...she had to deal with it." Participant 2 gave another example, "In some of our sexual encounters, experiences, I sometimes felt that she was selfish. It was very upsetting to me, because I felt like I was being used, just as a tool to please her, which kind of made me feel victimized." Participant 8 also described the harm of a partner's sexual insensitivity:

> "Second day into the honeymoon all the lights were out and we were having sex, and he could tell my body was all tense, and he was like 'What's wrong? Do you want me to stop?' and then I just said 'no, no, no go ahead finish' and he did and then we turned the light on and my face was swollen from tears and stuff. His feelings always meant more because I told him 'I'll never tell you to stop, because if you want to keep going, keep going.' and I guess in doing that I was always just waiting for him just to stop because he knew I wasn't comfortable. I really didn't know how to feel or process that. Because you know, part of me was 'you selfish ass-hole.' And then part of me was like, 'no, he wouldn't do that, he's not like them [the abusers]. He really loves me so it's my fault.' It made me wonder if he really wasn't who he was putting on that he was, because it felt like I was back, with the abusers. And so it was a big conflict in my head and in my heart."

It was noted that it was also harmful to have a partner take a survivor's boundaries personally.

"Well if she says… If she rolls her eyes when I resist or put up a boundary, or if she says 'you never want to have sex with me' or… She doesn't say 'you don't care about me,' but that's what I interpret. I can't remember the words that she says, but my interpretation of them is 'you don't care about me' or 'you're not physically attracted to me.' I feel she's hurt by my boundary. The effect is close to devastating. When she doesn't respond well to a boundary, then I feel like a bad husband. But it makes me even less… It reinforces that boundary even more" (P 2).

Lack of Choice.

Several participants indicated that situations in which they felt that they didn't really have a choice were quite distressing, often triggering feelings of victimization. The partners didn't need to force the participants in order for this to occur. Things like being pressured for sex, or pressured to change their thoughts, feelings or behaviors, or simply ignoring the participants' feelings or opinions, all contributed to the participant feeling unsafe with regards to the acceptability of them making their own decisions. Participant 1 explained, "I need to feel like I'm in control of myself. I don't want them trying to control me, 'cause number one, I've been controlled. Being pushed for sex, it makes me feel uncomfortable, especially when I'm not there. It makes me feel like you are trying to take something from me that I don't want to give and since I don't want to feel that anymore, I feel very unsafe." Participant 2 described what it's like for him to feel as if he doesn't have a choice:

"It's very difficult for me to not be in control. I think it goes to, if I'm not in control I feel trapped, which is very much how I felt when I was a victim, when I

was being abused. I felt trapped and felt like I needed to do, please, these people. And while I do want to please my wife, very much, I don't feel good when I feel trapped, or when I feel like the only acceptable choice is to, to be with her, to please her."

Guilt tripping by the partner, as well as being generally controlling, put the participant in an emotional quandary of not being able to say no and feeling like they didn't have control, which reminded them of their previous abuse. Participant 5 stated, "She would be overly concerned with her own needs and issues, would control the relationship, would control the money, would control everything." Participant 8 described the result that being pressed for sex had on her:

"And in our later years, I've told him that I didn't want to and then he has proceeded to convince me of it [sex]. Not necessarily in a bad way, but he didn't let it go and then we'd do it and then I'm back in that mindset. Depressed… really sad like I wanted to cry and nightmares for days after, sometimes weeks. He knew something went on. I usually wouldn't talk for a couple of days after but… so I think he just, he'd come home and give me a hug like 'how are you? Are you okay?' and I'd say 'yeah' and he's like 'good, give me a kiss and let's watch football'. But that's not what I needed or wanted. Like, I wanted for him to care enough to pull my head out of the pillow and say 'hey, check it out. You don't have to do this.'

Lack of Communication.

Lack of communication occurred when the partner was unwilling to discuss issues surrounding the abuse, or when the participant didn't feel safe enough in the relationship

to talk about it. Participant 8 didn't trust that her partner would keep her confidence. "So when I told him I was more in a state of 'Oh my gosh, I don't care' and after I told him I had really bad anxiety, because I was like…you can't…. this isn't something that can just come out, you know" (P 8).

Lack of communication was driven by a decreased responsiveness on the part of the partner and an active desire to avoid the subject. Participant 5 stated that he and his partner were unable to have open conversation about the abuse and its effects. "No. She didn't want to go there, she didn't want to hear that. She tried to avoid that so she didn't have to deal with it. When I told her about a hostile rape situation that happened to me later in life, she didn't react much at all. I saw no evidence of reaction… evidence of 'just don't talk about it'."

A lack of open communication within the relationship hindered the ability of the participant to be real with themselves. For example, "A couple times I just had to get in that mindset for him, you know. The mindset where I sexually satisfied him. Okay? And in return, pretended like I liked it. One time he asked me if I pretended, and I told him no. I did lie to him, that one time and it made me sick!" (P 8).

Partner Mistrust.

Though almost all the participants wrestled with feelings of mistrust, a few mentioned that it was difficult for them when they were not trusted. This was especially true when their partner was jealous or suspicious of them. Participant 1 stated, "One, I can't trust you if you feel like you can't trust me." Participant 2 explained, "I felt she didn't trust me. She was always grabbing my phone to check my text messages and see who I was texting and who I was calling and where I was going… And it was harmful to

our relationship and to developing an intimacy between us. And I also believe to my healing process, because I was not developing intimacy." Participant 6 described, "She told her daughter about what she knew, and that aroused a lot of suspicion… like most people, "Oh my God, you were molested so you're going to be a molester!" Well, guess what, that's not true. But that's what everybody thinks."

Lack of Growth.

Several of the participants indicated that it was problematic for them if their partner wasn't open to their change and growth, or didn't change and grow with them. Participant 1 explained,

> "I want someone of course who is smart, and that can teach me some things, but not try and change me. I wanted to be out, grow as a professional and he just wanted me to be his wife. And for me that wasn't enough for me, and that caused a problem. And it made me feel like 'you don't want me to grow. You just want me to depend on you.' If I'm with him, it's because I want him, not because I need him, because I don't want to be trapped."

Participant 5 noted, "If our partners don't change and grow with us, we will outgrow them. I would never go back in that situation."

Some of the participants noticed that their therapeutic change and healing caused a rift and separation between them and their partner. Participant 3 described, "If you are still holding on and you can't let go and you're not healing, you can't move forward. It is very frustrating to see somebody [her partner] that is still suffering who refuses to deal with it and to see how much that affects our current relationship because of the healing that I've gone through that she still hasn't." Participant 8 noted, "Up until a couple of

months ago I always felt like I had the perfect husband, you know. I think when I started therapy that was when, the first time that I realized that um, it was different."

Discussion

This study examined the experience of childhood abuse survivors (CSA) within the context of their couple relationship. They were asked specifically what their partners said or did that was helpful to their healing, and what their partners said or did that was a hindrance to their recovery from the effects of CSA. This made it necessary to understand if the participant had disclosed their abuse to their partner, and the amount and level of communication that was devoted to the abuse within the couple relationship. It was found that the decision to disclose the abuse to their partner was a significant one. While the decision to disclose was influenced by the participants' perceived level of safety within the relationship, it also affected the survivors' perceptions of safety in the relationship going forward, and whether they could enlist their partner as an ally when they were dealing with issues surrounding being a survivor of sexual abuse. It was also found that we could not pursue the question of what their partner did that was helpful or harmful without also understanding how the experience of childhood sexual abuse had uniquely affected the participant.

Participant Sequelae of Childhood Sexual Abuse

The analysis of participant data yielded themes previously identified in CSA literature as being frequent sequelae of childhood sexual abuse (Baima & Feldhousen, 2007; Cobia, et al., 2004; Goff, et al., 2008; Kochka & Carolan, 2002; MacIntosh & Johnson, 2008; Nadelson & Polonsky, 1991). There were four main themes of CSA sequelae given by the participants. The first was a very low and skewed self-concept. It

involved a relentlessly low self-esteem, with perceptions of worthlessness, unlovability, and self-blame. Concepts of "I am bad, flawed, broken, dirty, and/or disgusting" were common.

The second theme was that of severe emotional distress. Common emotions were anger, pain, shame, guilt, anxiety, fear, depression and general overwhelming emotional confusion. Emotional numbing and/or increased emotional reactivity were experienced by nearly all of the participants. Other emotions mentioned by the participants included hopelessness, powerlessness, shock, blame and rage. These themes are similar to those identified by previous researchers, particularly the themes of anger, shame, anxiety and guilt (Baima & Feldhousen, 2007; Cobia, et al., 2004; Goff, et al., 2008; Kochka & Carolan, 2002; MacIntosh & Johnson, 2008; Nadelson & Polonsky, 1991).

The third theme was confusion surrounding sexual identity, general individual identity, personal boundaries and body image. Overall sexual/emotional confusion was common for all participants. It involved ideas such as sex = pain, sex = badness, sex = victimization, sex = love, sex = power, sex = personal value/validation, "everyone wants sex from me", "I am my body", fear of sexuality, sexual and emotional disconnect, and even wholly repressed memories and emotions. Nearly all participants mentioned sexual promiscuity as a result of their abuse. These ideas and behaviors are also frequently found in CSA literature (Goff, et al., 2008; MacIntosh & Johnson, 2008; Cobia, et al., 2004; Miller & Sutherland, 1999; Harway & Faulk, 2005).

The fourth theme of CSA sequelae involved difficulties in interpersonal relationships. This extended to all relationships, not just romantic or sexual relationships. 100% of participants said that they felt they had a decreased ability to love and trust

others as a result of the abuse. Nearly all also identified a fear to love or trust others. Most admitted a fear of abandonment, fear of rejection, and an increased need for love and approval. Several mentioned a need for control within the relationship, and a fear of being trapped. Several also identified the feeling of fear that they didn't know how to be a good husband, wife, or partner. A few thought that they had made poor choices in life partners as a result of their abuse. Some participants also believed that they were more sexually submissive or aggressive than they otherwise might have been had they not been abused. These interpersonal difficulties have also been found in CSA literature (Baima & Feldhousen, 2007; Goff, et al., 2008; Harway & Faulk, 2005; Hughes,1994; Kachka & Carolan, 2002; Koedam, 2007; Oz, 2001).

These four themes of CSA sequelae became central as the participants discussed what was healing and what was hurtful within their couple relationships. What was helpful was organized around how they felt they had been hurt and what their partner did to soothe that hurt and meet their needs. For instance, a decreased ability to trust and low self-worth were two of the CSA sequelae that were identified as affecting the survivors the most deeply and profoundly. Therefore, words and actions that helped ensure a feeling of safety and trust within the relationship were deemed as being very helpful. By contrast, a breach of trust, in any form, was perceived as extremely damaging to both the relationship and the survivor. Because of the difficulties the participants experienced with self-esteem; acceptance, validation, and a perception of being truly loved for themselves (not for their body) were extremely helpful for the participants in their healing process. The corollary to this is that words and actions by partners that were

rejecting, de-valuing, judgmental or blameful were severely harmful to their ability to heal.

What Partners Do to Help Healing

A primary purpose of the study was to better understand what partners do that helps facilitate healing from CSA. Participants identified safety and trust within the couple relationship as the most significant thing that contributed to their being able to heal from the effects of CSA. Safety and trust included concepts such as open communication, honesty, loyalty, commitment, an absence of shaming or criticism, respect for participants' feelings and wishes, a sense of protection, physical proximity, and a sense that the survivor was valued as a person.

Acceptance and validation was related to a perception of safety and was also seen as very important for healing. Acceptance meant an absence of blaming, shaming, or judgment. It involved a sense of responsiveness and interest by the partner, belief in the abuse story, and verbal affirmations of validation and acceptance. Included in this category were participant perceptions of understanding and forgiveness on the part of the partner.

Open communication was noted by all participants as integral to their being able to trust their partner enough to disclose their abuse to them. It meant that participants felt that any topic was open for discussion, and that they would be safe talking about anything with their partner. Priority within the couple relationship was given to time spent talking, with the partner actively listening. It involved mutual disclosure and a negotiation of needs being met for the participant.

A perception of being loved by one's partner, along with a sense of emotional intimacy or emotional connection between the couple, constituted the third theme of helpfulness for the participants. It is a concept that the participants described as a feeling of mutuality, but it was supported by a sense of attentiveness by their partner. This meant that they were emotionally responsive and aware of the survivor, gave verbal and non-sexual physical expressions of love, thoughtful service, and kindness. They were perceived as being the participant's true friend.

Support followed close on the heels of emotional intimacy. It was a category specific to the participant feeling actively supported by their partner during times of difficulty or stress surrounding the sequelae of their sexual abuse. Emotional support was shown by listening, understanding, and spending quality time with the participant. Verbal affirmations of support and commitment were important, as was giving encouragement or reassurance. Physical support included service, generosity, non-sexual physical touch, and offers of financial support.

Empathy was especially significant when the participant first disclosed the abuse, or when the participant was experiencing emotional distress. Partners expressed sorrow, sadness, care or concern for their companion. It sometimes involved tears, but it always involved a sense of compassion for the survivor.

Freedom of choice was a concept that was extremely important to three or four of the participants. Feeling trapped or controlled put them back into an emotional place of victimhood, and it was of utmost importance that they have a sense of freedom within the relationship. Freedom of choice meant that their partner was patient, honored their boundaries and respected their opinions. They supported their sense of personal control

by never pushing them for sex, and refraining from pressuring them to change their feelings or behaviors in general.

Positive growth was mentioned by a few of the participants as being instrumental in their healing. It was helpful to both themselves and the couple relationship if their partners modeled and encouraged positive growth. The perception of being an equal participant in a successful intimate relationship was also helpful to the healing and growth of the survivor.

What Partners Do to Hinder Healing

What participants' perceived as being hindering to their healing existed in near opposition to that which they perceived as healing. One of the most significant hindrances to healing caused by their partners, was that of criticism and rejection of the survivor. It served to reinforce the negative self-concept inflicted by the childhood sexual abuse. This involved any perceived message of blame, shame, judgment, or not being "good enough." It also meant an absence of things ordinarily expected from an intimate partner, such as withholding love or attention, and a lack of emotional responsiveness, affirmation, understanding, support, touch, or empathy. Decreased personal responsibility by the partner, as well as unrealistic expectations, were seen as creating negative emotional environments in which it was difficult for the survivor to feel safe and accepted. For those participants who perceived sexual relations as a message of love and acceptance, sexual rejection was also perceived as very harmful to their healing.

Betrayal was equal to criticism and rejection in terms of its hindrance to the participants' process of healing. As the ability to trust was seen as one of the most deeply damaging results of CSA, a sense of betrayal by one's partner severely impacted the

participants in a profoundly negative way. Betrayal could involve an emotional or physical affair, a perception of general disloyalty, lies, pretense, disingenuiness, or a breach of confidence or trust on the part of the partner.

Disrespect of personhood stood in opposition to validation and acceptance. It included minimizing the impact of the abuse, disrespecting or taking participant boundaries as a personal offense, and conveying the general idea that other things matter more to the partner than the survivor. This might include an emphasis on outward appearances, or the partner putting their needs before the participants' needs. Engaging in sexual relations when the participant was anxious or distraught was seen as particularly harmful.

Lack of choice was the perception that it was not acceptable for the participant to maintain their own views, or make their own choices. It involved the partner ignoring their opinions, pressuring the participant to change their thoughts, feelings, or behaviors, guilt-tripping the survivor regarding any issue, and being generally controlling in the relationship. Pressure for sexual relations was perceived as particularly noxious to healing.

While open communication was seen as being very important to healing, and establishing trust within the couple relationship. Lack of communication was not seen as being as severely harmful as other things. Perhaps this exists because a reduction in communication kept the survivor safe from criticism or rejection. Participants listed decreased responsiveness and avoidance of certain topics by their partner as reasons for a lack of communication.

Partner mistrust was noted by a few of the clients as being harmful to their healing. This seemed to be for two reasons: One, mistrust by the participants' partners made it difficult to build real emotional intimacy within the relationship. The second reason was that it made it difficult for the participant to trust their partner.

Surprisingly, a lack of growth by the survivor's partner was seen by four of the participants as being hindering to their healing. It seemed that this was so because it caused friction within the coupleship, and led to their growing apart. Lack of growth included resistance to the participant's growth and change, and an unwillingness on the part of the partner to grow and change with them.

Limitations of the Study

The primary limitation of this study rests in its necessarily small and restricted sample size. Although there was a good representation of age, gender and sexual orientation among participants, racial and religious diversity was limited. The results will not necessarily be generalizable to all populations of survivors and their partners. Nevertheless, several of the participants provided rich detail as to their abuse sequelae and how their relationship with their partner influenced their perception of healing and growth with regards to being a CSA survivor. However, it became clear, even among only these 8 survivors, that it is difficult to generalize the experience of childhood sexual abuse and how any given person might be affected by it. Though participant responses to the results of childhood sexual abuse were reflective of what has been previously reported in the literature, how the participants experienced and dealt with these issues varied for each survivor.

The exact nature of each participant's CSA experience was neither explored nor controlled for in this study. An individual's sequelae is sharply influenced by their age at the time of the abuse, the exact nature and circumstances surrounding the abuse, it's severity and duration, who the perpetrators were, and what kind of response they received (or didn't receive) from their primary caregivers (Cobia, et al., 2004; Harway & Faulk, 2005). Participant responses were likely influenced by the unique circumstances of their abuse. The limited scope of this study didn't allow for these various influences to be taken into account. Whatever the participants' abuse experiences were, this study took at face value the participants' reports of the affects that CSA had on them and how those affects played out in their relationships with their partners.

The partners of the participants made a unique and palpable contribution to the survivors' experience of healing within the context of a couple relationship. If these participants had been partnered with someone else, it would have changed the emphasis and nature of some of their responses. It was noted that participant responses were likely influenced by the health, or lack thereof, of their current or most recent couple relationship.

It was also evident that participant responses were significantly influenced by where they were at in their own personal journey of healing. Some felt that they had dealt with their abuse and moved on, while some were still deeply affected by the pain and damage related to their abuse experiences. An example of this is seen in a comparison of two of the participants. Two of the participants were college educated white males in their 60's, both identifying as heterosexual. One was happily married and felt he had long ago healed from his abuse. One was divorced, living alone, and still

experiencing the return of new memories of childhood sexual abuse. Though they were demographically similar, their current life circumstances and stages of healing colored the emotional lens of their healing experience within the couple relationship. Though there were some similarities, these differing circumstances resulted in very different responses to the interview questions.

It should be noted that one member of the research team conducted five of the research interviews, while another member of the research team conducted the other three interviews. Although both interviewers used the same semi-structured interview guide, the interviewers had slightly differently interview styles, which likely affected the depth and breadth of participant responses. It is not thought that the interviewers affected the overall main content of participant responses.

During analysis of participant interviews, the team noted that it may be difficult to distinguish between what contributes to the healing of the CSA survivor and what generally helps intimacy develop in a couple relationship. Issues of trust, open communication and emotional connection could all be seen as merely elements of a successful couple relationship. It appears that there is quite a bit of overlap as to what constitutes a healthy couple relationship and what a CSA survivor finds particularly healing for them. The researchers made every effort to pay attention to and include only those elements of their couple relationship that the participants found healing or that addressed the sequelae of their sexual abuse. While the researchers suspect that there is a distinction between what makes for a happy intimate partnership and what is specifically healing to a CSA survivor, it is beyond the scope of this study to definitively make that determination.

Results as Compared to Existing Literature

The results of this study confirm and support existing literature with regards to the individual sequelae of childhood sexual abuse, its impact on a couple relationship, and the potential impact of the intimate partner on the healing process of the survivor (Baima & Feldhousen, 2007; Cobia, et al., 2004; Goff, et al., 2008; Kochka & Carolan, 2002; MacIntosh & Johnson, 2008; Nadelson & Polonsky, 1991). All of the survivors, save one, felt that their couple relationship had had a very significant impact on their healing process (Hecker, 2007; Kleinplatz, 2007). One participant felt that while he handled much of the healing process himself, the safety he felt with his wife allowed him the support and freedom to grow, change, address it, and talk about it.

From an attachment theory perspective, the results of the study confirm the interpersonal injury of childhood sexual abuse, and the resulting difficulty survivors have with the trust and intimacy necessary to form healthy, intimate attachments in adulthood (Conklin & Padykula, 2009; Hecker, 2007; Wallin, 2007). It is postulated that the safety and security of a secure attachment is a significantly helpful, if not necessary environment for a survivor to heal from an attachment injury (Potter-Efron, 2006; Wallin, 2007). This study provides significant support for the couple relationship as a context where healing from such an injury can take place (Chen & Carolan, 2010; Goff, et al., 2008; MacIntosh & Johnson, 2008; McCollum, 1991). In the words of participant 2: "Emotional closeness. Um, enjoying sex with my wife and not being ashamed of it and not feeling guilty about it, not feeling like someone did something they didn't want to, but feeling like we both love each other and care for each other and want each other to be happy and want to please each other… that has been very healing."

Trauma theory points to the need for survivors of trauma to share their experiences of the trauma and to feel like they've been heard, understood, believed and that the trauma experiences matter, and that they are still loved and accepted despite the trauma (Kleinplatz, 2007; McCarthy & Sypek, 2003; Miller & Sutherland, 1999). The participants confirmed the extreme helpfulness of being able to disclose their traumatic abuse to a significant attachment figure, and have them respond with empathy, understanding and acceptance. As relayed by participant 6:

> "I thought at first she'd be disgusted by it and would, might even just run away from me, but she didn't. When I finally felt comfortable enough to start sharing some of the, shall we say "gory details," the fact that she just took it in stride. I didn't, I thought there'd be at least a little subconscious (intake of breath, surprise or disgust). Like 'wow, I've never heard of that.' But, she did a good job. You know she didn't recoil and run away. That's probably the biggest thing that she did".

The results of this study brought out the helpfulness of mutuality within the relationship. It wasn't just about the partners making the survivors feel safe and loved within the relationship, although that was important. The concept of mutuality, that the survivor could also be a trusted place of love, support and intimacy for their partner, was found to be a significant contributor to the participants' perception of safety and intimacy within the relationship. Six of the eight participants talked about this concept of mutuality as being important to the trust and intimacy necessary for their healing.

A similar concept brought out by the participants, was the significance of mutual positive growth, both individually and as a partnership, within the couple relationship.

Four participants indicated frustration and difficulty when their partner did not grow and change with them on their path to healing. Two others commented on the extreme helpfulness of having their partner lead out, and grow with them.

Implications

The results of this study confirm and expand on previous literature that supports the concept of involving a CSA survivor's partner in the healing process. A successful intimate attachment, in and of itself, was confirmed by most of the participants as being very significant to their healing. Emphasis by the therapist on the couple relationship would be helpful when working with a CSA survivor. As mutuality and concurrent growth was found to be a significant issue in the participants' healing, focusing time and energy on the partners' needs and growth, and on the couple relationship itself, would be seen as time well spent in therapy. Couples and therapists could focus on strengthening those themes identified in this study; namely safety and trust, acceptance and validation, open communication, emotional intimacy and connectedness, empathy, support, freedom of choice, and unified positive growth.

Much of the most significant CSA sequelae were played out in the difficulties the participants experienced with sexual intimacy. Open communication within the couple relationship was very important in negotiating those difficulties. Several participants indicated that establishing boundaries and mutual expectations around sexual intimacy was one of the more challenging aspects of their relationship. It is evident that therapists could facilitate open dialogue for couples with regards to the CSA survivor's particular needs and difficulties with sexual intimacy.

One result that the author found particularly striking about this study, and yet obviously makes sense when given consideration, was the unique nature of each individual's CSA sequelae. How the participants' CSA experiences impacted them personally had the greatest influence on what it was that they exactly needed from their partner, and which words and actions either helped them the most, or hurt them the most. For example, for those participants who viewed low self-esteem as the most significant injury sustained as a result of their abuse, having their partner affirm their worth, competence, value and importance was the thing that was most impactful to their healing. For those participants whose abuse injury centered around the fear of being controlled or violated sexually, having their partners honor and respect their personal boundaries was what was most needful and healing for them. Those survivors whose greatest injury resulted in a decreased ability to trust could ask for increased reassurance and accountability from their partner until their ability to trust had strengthened. Other participants simply needed their sense of anger and outrage over such a profound injury validated as being legitimate. It mattered.

It seems to the author, that the one thing that would be most helpful for CSA therapists and their clients, is to help the survivor examine how their abuse has impacted them specifically. Analyzing that, accepting it, and sharing it with their partner (if the relationship is emotionally safe), would be profoundly helpful for both survivors and partners when negotiating how to be supportive and helpful in a CSA survivor's healing process. Knowing how one has been hurt will help inform the coupleship as to where the greatest needs are, and where sensitivities and hiccups in the relationship are likely to happen. Although informed couples could work this out themselves, the assistance of a

therapist may be very helpful in establishing a safe environment for this to occur. As noted in the study, the emotional fallout from childhood sexual abuse can be intense and overwhelming for both the survivor and the partner. Understanding how the survivor experiences that sequelae, and having an anticipatory plan in place for how the couple might be able to successfully negotiate that sequelae, could go a long way to preserving many marriages and helping a lot of survivors to fully heal in the process.

The author noted that the interview process had a significant emotional impact on several of the participants. At least six of the participants interviewed had a significant emotional response to the process of talking about their CSA sequelae and how that had influenced and been influenced by their couple relationship. Four people were moved to tears by the interview. Emotions observed by the interviewers included anger, frustration, shame, hurt and sadness. Perhaps in the future, the informed consent should be modified to read "possible moderate to high distress" rather than "mild distress" as one of the risks of participating in a study such as this. If the researcher or participant feels that significant distress is likely, they could arrange for some debriefing time with the participant or arrange to have their therapist available to them after the interview.

Despite this heightened emotional response, several of the participants indicated that they enjoyed talking about their experience. They were grateful for a venue in which they could tell their story and glad for the opportunity to possibly help other survivors of CSA. Several indicated pride in their struggle thus far, and hope in their continued growth. Four of the interviewees that were either coworkers or clients of the author, approached the author at a later date and indicated that their participation in the interview had opened up new insights and understanding in their marriage and in the systemic

process surrounding their abuse sequelae. Three said that they had been moved to have honest conversations with their partners that brought about increased understanding, sharing of emotions, and negotiation of needs. This caused the author to wonder if having the opportunity to examine their CSA issues within the context of their coupleship was therapeutic for the participants in and of itself. It may be that therapists could facilitate progress toward healing simply by conducting a thorough, open-ended exploratory interview with regards to a client's CSA sequelae and how it plays out in their relationship(s). This is an area that deserves further study. It may be that an interview guide could be standardized and generalized as an effective tool for therapists.

At the end of the first two interviews, both participants asked if they could say something else. The author agreed, and both participants talked more about their feelings about being a CSA survivor, what had personally helped them, and what they would want to say to any other survivors out there. One talked about how having the courage to talk about her abuse to family and friends had really helped her. The other talked about how his relationship with God, and his personal efforts to forgive his abusers, had been key elements in his healing journey. Based on these two early responses, the author added the question "Is there anything else you'd like to tell me?" to the end of the interview guide. All but one of the subsequent participants had some heartfelt comment or opinion to add at the end of the interview.

This is yet another area for possible therapeutic intervention for CSA survivors. Trauma theory postulates the need for trauma survivors to have a witness to their experience, and how being able to talk about what happened, and their experience of it, and what they learned from it, is extremely helpful in normalizing and integrating the

traumatic experience into their personal schema of themselves and the world around them. The participants took a risk and made a personal sacrifice to participate in this study. The interviewers could tell that in sharing their story, and the idea that their story mattered and might be the means of helping others survivors, the participants were significantly impacted. Most were uplifted. Their experience mattered. They mattered. Maybe the simple question, "If you could tell other CSA survivors one thing, what would it be?" would be a helpful intervention for therapists and their clients. Again, this idea deserves further study. It may be that having a researcher interview them, someone with potentially broader influence, is not the same as talking to their personal therapist.

Future Directions/Research

While much research has been done on the topic of childhood sexual abuse, it remains a significant problem in our society and in our health care system. Pursuing research that explores the use of secure attachments to facilitate healing is worthy of further research. Other topics to be explored include the use of the attachment relationship of the therapist with the survivor as a vehicle for healing, either with an individual survivor, in tandem with the couple, or as a secure figure when working with families and sexual abuse. Other research avenues would include qualitative studies that explore the experience of both the survivor and the partner together, looking at the impact of CSA on the survivor, the partner, and the relationship. Groups are also often used to facilitate the healing of CSA survivors. It would be helpful for future research to explore the question of whether groups function as an effective and safe attachment environment for healing to occur. The prospect of couple groups might also be explored as a possible safe environment for learning and support for both partners and survivors. While sexual

trauma remains a stigmatized and isolating issue within our society, it remains the moral obligation of concerned helping professionals to do more to bring this problem to light, and provide effective vehicles for those persons and families suffering from the effects of such a deep and violent personal injury.

Appendix A: Therapist Recruitment Letter

To Whom It May Concern:

As you know, childhood sexual abuse (CSA) is a traumatic experience that impacts people socially, emotionally and psychologically. Often these individuals present for psychotherapy as adults. As marriage and family therapists, we are interested what impact a couple relationship has on a survivor. We are specifically interested in what the survivor perceives as being healing within the context of the couple relationship. We are conducting a study that seeks to understand the individual's experience of their partner's influence on their healing process.

We are searching for individuals who are CSA survivors and have been in a committed relationship for at least one year. The study consists of a semi-structured interview with the participant at a location most convenient to them (i.e. their home, therapist's office, UNLV campus). Interview questions will focus on the participant's experience with how their partner's words and actions have helped or hindered their healing process. The study has been reviewed and approved by the University of Nevada, Las Vegas Institutional Review Board (see attached IRB letter). The research protocol includes steps to maintain confidentiality of research participants. No reference will be made in written materials that could link participants to this study, and all identifying information will be removed from the data.

Our ability to identify potential participants is dependent upon psychotherapists, such as you, in the Las Vegas area. We would be grateful if you would consider referring former and current clients for participation in this study. For current clients, please discuss their participation in this study in person if possible and provide them with the "Participant Information Letter" which explains the details and purpose of the research and how they can contact us if they desire to participate. For former clients, a phone call and email with the attached information letter may be the best option for recruiting. Please refrain from answering questions about the study past the information available in your Research Participant Information Letter.

Thank you for your consideration of our request, and thank you in advance for your time and effort helping recruit participants for our study. Our desire is that the outcome of this research will enhance our understanding of how the couple relationship affects healing for CSA survivors. We believe it will provide useful information for both therapists and their clients. If you have any questions or concerns about the study, you may contact Dr. Stephen Fife at 702-895-3117.

Respectfully,

Laura Smedley
Master's student of Marriage and Family Therapy
University of Nevada, Las Vegas

Stephen T. Fife, Ph.D.
Associate Professor and Graduate Coordinator
Marriage and Family Therapy Program
University of Nevada, Las Vegas
(702) 413-2465
stephen.fife@unlv.edu

Appendix B: Research Participant Information Letter

To Whom It May Concern:

Thank you for your consideration as a participant in this study. I am a graduate student in the Marriage and Family Therapy program at UNLV. I have been practicing therapy as a student intern for over a year, and have over 450 hours of therapy experience. I have noticed that childhood trauma, especially sexual trauma, has a profound effect on family relationships in the future. Childhood sexual abuse (CSA) is a traumatic experience that impacts people socially, emotionally and psychologically. Often these individuals present for psychotherapy as adults. As marriage and family therapists, we are interested in what impact the couple relationship has on a survivor. We are specifically interested in what the survivor perceives as being healing within the context of the couple relationship.

We are conducting a study that seeks to understand the survivor's experience of how their partner's words and actions have affected their healing process. We are interviewing individuals who are CSA survivors and have been in a committed relationship for at least one year. Our primary concern is confidentiality and to create an interview environment that is safe for all involved.

If you elect to participate in this study, you may choose the location of the interview. In the past, participants in similar studies have elected to be interviewed in their home or in the office of their therapist, with the therapist being present. You also have the option of being interviewed on UNLV campus or by telephone. The interview will take 30-60 minutes, and our conversation will be recorded with a digital recording device for later transcription.

Once the interview is complete, the interviews will be transcribed using aliases rather than your name to protect your identity, and all identifying information will be removed from the data. Then we'll analyze and compare your comments with those of other participants in order to identify common themes and processes regarding survivors' partner's influence on their healing.

Your personal experience may be a valuable resource for psychotherapists, other survivors and their partners in knowing how to help and support other CSA survivors.

TO PARTICIPATE:
Please contact Laura Smedley via phone or email
(702) 480-8814
SmedleyL@unlv.nevada.edu

We greatly appreciate your consideration. If you have any questions or concerns about the study, you may contact Dr. Stephen Fife at 702-895-3117.

Sincerely,

Laura Smedley
Student of Marriage and Family Therapy
University of Nevada, Las Vegas

Stephen T. Fife, Ph.D.

Appendix C: Summary of Results

RESULTS OF ABUSE	WHAT PARTNERS DO TO HELP HEALING	WHAT PARTNERS DO TO HINDER HEALING
Self-Concept - Skewed self-concept - Low self-esteem - Worthlessness - Unlovable - Self-blame - "I am bad" - Broken - Dirty - Disgusting **Emotional Distress** - Anger - Pain - Shame - Guilt - Fear - Depression - Emotional confusion - Emotional numbing - Emotional reactivity - Overwhelming emotions - Anxiety - Hopelessness - Powerlessness - Shock - Blame - Rage **Sexual and Identity Confusion** - Sexual confusion - Sex = pain - Sex = badness - Sex = victimization - Sex = love - Sex = power - Sex = personal value, validation - "everyone wants sex from me" - "I am my body" - Fear of sexuality - Sexual and emotional disconnect - Repressed memories and emotions - Sexual promiscuity	**Safety and Trust** - Open communication - Honesty - Loyalty - Commitment - No shaming - No criticism - Respect for feelings - Respect of wishes - Sense of protection - Physical proximity - Value personhood - My needs before their needs **Acceptance and Validation** - No blaming - No shaming - No judgment - Responsiveness - Interest - Belief in abuse story - Verbal affirmations of acceptance/validation - Understanding - Forgiveness - Respect for feelings **Open Communication** - Open discussion on any topic - Sense of safety and trust - Lots of time spent talking - Listening - Full disclosure - Mutual disclosure - Negotiation of needs **Emotional Connectedness/Intimacy – Perception of Being Loved** - Mutuality - Emotionally responsive and aware - Verbal expressions of love - Non-sexual physical touch - Thoughtful service - Kindness - Friendship	**Criticism and Rejection** - Blame - Shame - Judgment - "not good enough" - Withholding love/attention - Lack of responsiveness - Lack of affirmation - Lack of understanding - Lack of support - Lack of touch - Lack of empathy - Decreased personal responsibility - Unrealistic expectations - Sexual rejection **Betrayal** - Physical or emotional affairs - Disloyalty - Lies - Pretense - Disingenuiness - Breach of confidence/trust **Disrespect of Personhood** - Minimizing impact of abuse - Disrespecting boundaries - Taking boundaries as a personal offense - Other things matter more than me - Greater concern for outward appearances - Their needs take precedence - Sex when anxious or distraught **Lack of Choice** - Opinions ignored - Pressure to change thoughts/feelings/behaviors - Guilt-tripping - Controlling in the

Interpersonal Relations - Decreased ability to love - Decreased ability to trust - Fear to love - Fear to trust - Fear of abandonment - Fear of rejection - Increased need for love and approval - Need for control - Fear of being trapped - Bad wife/husband/partner - Poor partner choices - Sexually submissive - Sexually aggressive	- Sexual intimacy with emotional connectedness and perception of freedom **Support** - Listening - Understanding - Quality time - Verbal affirmations of support - Commitment - Encouragement - Reassurance - Service - Generosity - Non-sexual physical touch - Financial support **Empathy** - Expressions of sorrow, sadness - Expressions of care and concern for partner - Tears - Compassion - Indignation **Freedom of Choice** - Patience - Personal boundaries honored - Respect opinions/voice - Support sense of personal control - No pressure for sex - No pressure for change of feelings/behaviors **Positive Growth** - Modeling - Encouragement - Perception of a successful relationship	relationship - Pressure for sex **Lack of Communication** - Decreased responsiveness - Avoiding subjects - Lack of safety in the RxS **Partner Mistrust** - Jealousy - Suspicion **Lack of Growth** - Resistance to partner's growth and change - Unwillingness to change/grow with survivor

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