PRACTICUM

COUPLE THERAPY WITH SURVIVORS AND THEIR PARTNERS

By

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A Practicum Presented

to the Faculty of Social Work in Partial Fulfilment

of the Requirement for the Degree

Master of Social Work

University of Manitoba

Winnipeg, Manitoba

1996

THE UNIVERSITY OF MANITOBA

FACULTY OF GRADUATE STUDIES

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ABSTRACT

COUPLE THERAPY WITH SURVIVORS AND THEIR PARTNERS

This practicum involved the provision of therapy to couples where one partner is a survivor of childhood sexual abuse. Childhood sexual abuse can have a significant psychological impact on children that can continue to cause a range of difficulties for adult survivors. The effects of sexual abuse that adult survivors can experience may significantly impact their most intimate relationships, particularly their relationship with their life partners. The purpose of this practicum was to ascertain the usefulness of couple therapy with survivors and their partners. The evaluation instruments used to assess change were the Marital Satisfaction Inventory and the Beck Depression Scale. Two case examples are presented as an illustration of the themes and issues encountered in couple therapy with survivors and their partners.

ACKNOWLEDGEMENTS

I wish to thank my practicum committee, Dr. Barry Trute, my advisor, Dr. Diane Hiebert-Murphy and Ms. Doreen Draffin for their guidance, support and time throughout this practicum experience.

I wish to thank the Women's Post Treatment Centre for providing me the opportunity to work with female survivors and their partners. In addition to the referrals they provided, the Executive Director and clinicians shared their knowledge and time with me and I thank them for their support.

Finally, I would like to thank the staff at the Elizabeth Hill Counselling Centre for all their assistance during my clinical work.

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CHAPTER 1

INTRODUCTION

I graduated with my Bachelor of Social Work in 1983 and I have always worked in the field of psychiatry. When I graduated I never thought I would go back to school to complete a Master's Degree in Social Work. After about six years of practice I began to entertain the idea of graduate school and along with that came some very real questions about social work. These questions involved what some people might interpret as an "identity crisis". I questioned whether what "we" as social workers did helped? How did we know if we didn't follow clients longitudinally? Was what I did valuable? Was I really good at what I had chosen to do? I remember challenging social workers I knew and trusted to answer these questions as I struggled to find answers for myself. The journey to make the decision to go to graduate school was not a simple one and the strange thing is, the whole time I was thinking about this decision, I never once seriously thought about switching careers. After two summers of questioning myself and the field of social work, the decision was clear; I wanted to complete a Master's of Social Work Degree.

When I first applied to graduate school I thought I might do a practicum in family therapy, but when my advisor began talking about his interest in the area of sexual abuse and some practicum ideas, my curiosity was peaked. Even as an undergraduate student I had an interest in the area of sexual abuse. My employment at the Manitoba Adolescent Treatment Centre allowed me the opportunity to co-facilitate a sexual abuse survivors group for adolescent females for seven years. In fact, I reluctantly stopped doing this group so that I could focus on my practicum. A number of people along the way suggested that I use this sexual abuse group for my practicum but I wanted to expand my theoretical knowledge and clinical skills in other areas. It seemed natural that my practicum would involve something in the area of sexual abuse as long as the focus was different.

After two attempts at other sexual abuse related practicums my advisor approached me about the idea of doing couple work with survivors and their partners. The idea intrigued me because not only was it still in the area of sexual abuse but it also involved the chance to develop clinical skills in couple's therapy. As I began to research this topic and prepare my practicum proposal, the apparent gap in treatment information about couple work with survivors convinced me there was a lot I could learn about this work.

The learning objectives of this practicum were:

1) To increase my knowledge of adult survivors and the impact of child sexual abuse on the couple relationship.

2) To increase my knowledge of couple work specifically with survivors and their partners.

3) To develop my assessment and clinical skills in working with couples where one partner is a survivor.

4) To increase my understanding of the use of clinical measures in practice.

This practicum report is organized into five chapters. This chapter provided a brief overview of the practicum and learning objectives. Chapter two is a literature review which provides (1) an overview of the issue of child sexual abuse and its effects; (2) the implications for survivors and their partners; and (3) discussion of couple's therapy with survivors and their partners. Chapter three provides information about the practicum setting, procedures, supervision and evaluation. Chapter four describes five themes that arose in my work with two of the four couples with whom I worked during this practicum. As each theme is discussed process highlights are used to discuss the interventions utilized. Chapter five provides a summary of the practicum experience and conclusions reached during this practicum experience.

CHAPTER 2

LITERATURE REVIEW

Introduction

Although the problem of the sexual victimization of children has existed for generations, this issue didn't begin to receive long overdue attention until the seventies. In the early seventies child sexual abuse was thought to be a rare problem but today most professionals would consider it a critical social issue. In fact, the sexual abuse of children has emerged as one of the major forms of child abuse in our society today.

Prohibitions have existed against child sexual abuse in the form of incest since ancient times. Primitive and modern cultures have provided penalties as severe as death for breaking the incest taboo (Haugaard & Reppucci, 1988). Incest is forbidden in most cultures and the discovery of it usually provokes shock, horror and consequences. However, despite the well documented prohibitions against incest, researchers have traced evidence of its existence back to Biblical times (Courtois, 1988). It is impossible to know the true historical extent of child sexual abuse . However, evidence does suggest that incest has been "embedded in and covertly allowed in most cultures while being overtly and publicly decried and denied" (Courtois, 1988, p.7). Historically, this led to

victims not disclosing their own victimization due to the lack of acknowledgement and validation regarding sexual abuse.

Initial requests from the public to stop child sexual abuse were largely ignored by professionals due to the perception that child abuse of any form was a rarity. However, once the problem of physical child abuse gained attention in the 1960's and child abuse laws were instituted, it was possible for attention to be drawn to child sexual abuse. In fact, with the advent of child abuse reporting laws the reality of sexual abuse within and outside of families could no longer be ignored.

Initially, child sexual abuse entered the public arena because advocates from the women's movement and children's movement banded together to draw attention to the issue (Finkelhor, 1984; Haugaard & Reppucci, 1988). Both these groups had an active voice with the public and policy makers, so when they joined forces they were able to draw serious attention to the issue of child sexual abuse.

There has been an explosion of interest in the area of sexual abuse since the seventies. The initial attention tended to focus on prevention, reporting, investigation and the legal aspects of abuse. However limited the initial focus seemed to be it did begin to facilitate the societal legitimization of sexual abuse as a real social problem. This in turn validated the reality of the sexual abuse for the victims which empowered them to begin to disclose the secrets of their own victimization. It was not only children who began to disclose their victimization but adult women who had survived being sexually abused as children but harbored or buried the secret for years or even decades.

Definition and Prevalence

Sgroi (1982) provides a clear and comprehensive clinical definition of child sexual abuse:

> Child sexual abuse is a sexual act imposed on a child who lacks emotional, maturational and cognitive development. The ability to lure a child into a sexual relationship is based upon the all powerful and dominant position of the adult or older adolescent perpetration, which is in sharp contrast to the child's age, dependency and subordinate position. Authority and power enable the perpetrator, implicitly or directly to coerce the child into sexual compliance. (p.9)

The definition would cover extra familial or third party sexual abuse which involves a perpetrator without family ties and not in a pseudo parent role but from whom a child should expect safety and protection.

In the narrow legal definition of incest, a blood relationship must exist between the victim and the offender and intercourse must have taken place. However, clinicians have moved to a broader definition of incest that recognizes a spectrum of sexual behaviours and emphasizes the psychosocial relationship between the victim and the offender. As defined by Sgroi (1984):

> Incestuous child sexual abuse encompasses any form of sexual activity between a child and parent or step parent or extended family member (ie: grandparent, aunt or uncle) or

surrogate parent figure (ie: common law spouse or foster parent), (p.10).

What is important is the emotional bond and trust in the relationship not simply a blood relationship.

Prevalence rates for sexual abuse have varied considerably in studies and there is a lack of knowledge about the true prevalence of the phenomenon (Haugaard & Reppucci, 1988). Estimates of sexual abuse have varied depending on the data used, the type of sample and the definition used in the research (Tierney & Corwin, 1983). However, estimates of the problem of sexual abuse have risen over the years from one to five in a million in the 1950's to one in every three children in the 1980's (Barrett & Trepper, 1992). The 1984 Badgley Report on Sexual Offenders Against Children (Baker, 1990) which focused on a sample of adult Canadians estimated that "1 in 2 females and 1 in 3 men had been victims of unwanted sexual acts" (p.4). Regardless of the problem establishing true prevalence rates it is known that sexual abuse is not uncommon.

Despite the difficulties estimating incidence the literature strongly suggests that: (a) the rate of sexual abuse is much higher than it was initially believed to be; (b) females are victimized more than males during childhood; (c) a significant portion of child abuse occurs within the family; and (d) fathers or surrogate fathers make up the largest category of perpetrators (three fourths) (Berliner, 1982, Courtois, 1988, Tierney & Corwin, 1983). This is not to say that males are not victimized and that other family members do not offend.

Impact of Sexual Abuse

As survivors began to tell their stories researchers and clinicians began to look at the impact of the abuse experience on the victims. Clinicians and researchers working in the field generally believe that child sexual abuse is a mental health problem that can have serious short-term and long-term effects (Briere, 1992; Browne & Finkelhor, 1985). Browne and Finkelhor (1986) provide an imperial review of the clinical literature regarding the short-term and long-term effects of child sexual abuse. They delineate long-term effects from short-term or initial effects by defining initial effects as those that occur within two years of the termination of the abuse. Browne and Finkelhor (1986) conclude that the:

> Imperial literature does suggest the presence - in some portion of the victim population - of many of the initial effects reported in the clinical literature, especially reactions of fear, anxiety, depression, anger and hostility and inappropriate sexual behaviour. (p.69)

They do warn that the studies reviewed were empirically weak and the findings should not be considered conclusive.

Browne and Finkelhor (1986) also concluded that many of the long term effects described in the clinical literature are empirically supported:

> Adult women victimized as children are more likely to manifest depression, self destructive behaviour, anxiety, feelings of isolation and stigma, poor self-esteem, a tendency

> toward re-victimization and substance abuse. Difficulty in trusting others and sexual maladjustment such as sexual dysphoria, sexual dysfunction, impaired sexual self-esteem and avoidance or abstention from sexual activity has also been reported by empirical researchers, although agreement among studies is less consistent for variable on sexual functioning. (p.72)

Haugaard and Reppucci (1988) also review clinical reports and suggest that victims suffer a variety of negative consequences that can last for many years. They describe emotional consequences such as feelings of guilt, anger, depression and helplessness that play a major role in the development of adverse behaviours. Some victims internalize this distress which leads to somatic complaints, sleep pattern disturbances, nightmares and self-destructive behaviours. Those victims who externalize their distress might exhibit aggressive behaviours, acting out and sexual activity with younger and older individuals (Haugaard & Reppucci, 1988). Haugaard and Reppucci (1988) also conclude that previous sexual abuse experiences appear to have detrimental effects on the sexuality of older adolescents and adults.

Browne and Finkelhor (1986) also examined contributing factors associated with worst prognosis and conclude that there is no one causal factor on which all studies agree but that there are trends. These trends include; (a) that abuse by fathers or step fathers have more negative impact than abuse by other perpetrators; (b) experiences involving genital contact seem more serious; (c) presence of force seems to result in more trauma

for the victim; (d) when the perpetrators are men rather than women, and adults rather than teenagers the effects of are more disturbing and; (e) when families are unsupportive of the victim and/or the victims are removed from their homes the prognosis is worse (Browne & Finkelhor, 1986). Similarly, Haugaard and Reppucci (1988) conclude that there are few unequivocal results in attempts to find causes in the different levels of impact reported by victims. They conclude that overt use of force by the perpetrator and negative parental response contribute to more negative consequences. Good emotional health prior to victimization results in the victim experiencing fewer negative consequences (Haugaard & Reppucci, 1988).

Finkelhor and Browne (1985) have developed a useful framework for understanding the effects of child sexual abuse. They describe four traumagenic (trauma causing) dynamics they identify as the core of the psychological injury inflicted by the abuse: (a) traumatic sexualization; (b) betrayal; (c) powerlessness; and (d) stigmatization. Each dynamic has its own resulting psychological consequences and behavioural manifestations.

Finkelhor and Browne (1985) define traumatic sexualization as "a process in which the child's sexuality (including both feelings and sexual attitudes) is shaped in a developmentally inappropriate and interpersonally, dysfunctional fashion as a result of the abuse" (p.53). This can happen in a number of ways over the course of the abuse experience. For example, the child might be repeatedly rewarded for sexual behaviour that is inappropriate to his or her development. The perpetrator/offender exchanges attention and affection for sex and the child then learns to use sexual behaviour to get

their needs met. The perpetrators will communicate confusing messages about sexualized behaviour and morality to the child. Traumatic sexualization also occurs when parts of the victim's anatomy are given distorted importance and meaning by the offender. Some victims associate frightening memories and experiences with sexual activity and the connection can persist into adulthood. The degree of traumatic sexualization can vary, however the child that has been traumatically sexualized can emerge with an inappropriate repertoire of sexual behaviour, confusion and misconception about their sexual identity and with negative or unusual associations to sexual activities (Finkelhor & Browne, 1985). The behavioural manifestation Finkelhor and Browne (1985) attribute to this dynamic include sexual preoccupation and compulsive sexual behaviour (masturbation), precocious sexual activity, aggressive sexual behaviours, promiscuity sexual dysfunctions and avoidance or phobia of intimacy.

Finkelhor and Browne (1985) define betrayal, the second factor, as "the dynamic by which children discover that someone on whom they were virtually dependent has caused them harm" (p.531). Children can experience betrayal not only by the offender but also by other family members who didn't abuse them but may have been unwilling or unable to protect them or who did not believe them. Sexual abuse experiences that are perpetrated by family members or a trusted person have more potential for betrayal than stranger abuse. However, the sense of betrayal may be mitigated if the child was suspicious of the offenders behaviour from the onset of the abuse, and did not experience the contact as nurturing and loving. The degree of betrayal is also related to how believed the victim feels; children who are blamed, ostracized and not believed

experience greater betrayal than those who are supported. The psychological impact of this betrayal can include guilt, depression, dependency, mistrust, impaired ability to judge trustworthiness in others and anger and hostility. The behavioural manifestations might include clinging, vulnerability to re-victimization, isolation, discomfort with intimacy, aggressive behaviour and delinquency (Finkelhor, 1986).

Powerlessness or disempowerment refers to "the process in which the child's will, desires and sense of efficacy are continually contravened" (Finkelhor & Browne, 1985). Many aspects of the abuse experience contribute to this dynamic and a basic powerlessness occurs when a child's territory and body space are violated and invaded against the child's will. This powerlessness is exacerbated when coercion and manipulation are used by the offender. The experience of powerlessness is further internalized when the child experiences an inability to stop the abuse, is not believed when they disclose, feel fear, or realize their dependency entraps them. Finkelhor and Browne (1986) believe this powerlessness psychologically impacts the victim and can result in fear, poor self-confidence, victim identity, and a need to control. The behavioural manifestations might include nightmares, phobias, somatic complaints, depression, disassociation, running, truancy, re-victimization, aggressive behaviour and potential to victimize others (Finkelhor, 1986).

The final dynamic described by Finkelhor and Browne (1985) is stigmatization which refers to "the negative connotations, such as badness, shame and guilt, that are communicated to the child around the experiences and that then become incorporated into the child's self image" (p.532). These negative messages can be communicated by

the abuser directly through blaming and demeaning the victim or through pressure to keep the secret which can increase the feelings of guilt and shame. However, stigmatization is also reinforced by messages the victim receives directly or indirectly from non-supportive family members, the community or society at large. This stigmatization is further internalized by reactions of shock and disgust, or messages that blame the victim for the abuse or label them as "easy" or "damaged goods". Victims can feel guilt, shame, low self-esteem, isolation and a sense of differentness (Finkelhor & Browne, 1985; Sgroi, 1984). They may gravitate towards drug or alcohol abuse, criminal activity, or become involved in self destructive behaviours (mutilation) or suicide attempts.

There are a number of factors which can have a protective influence on a survivor's development and ability to cope. These factors include that age of the child at the time of the abuse, the chronicity, the severity, the relationship to the offender, the levels of threats to the child, the emotional climate of the child's family prior to the abuse; the child's mental and emotional health prior to the abuse, the amount of guilt the child feels, the sex of the victim, and the parental response to the child's victimization (Gil, 1991). It is believed the sexual abuse is nearly always a disruptive and destructive experience although the degree of impact may vary (Finkelhor & Browne, 1985; Sgroi, 1984). The dynamics of abuse described alter the survivor's cognitive and emotional orientation to the world and distort the survivor's self concept, world view and affective capabilities (Finkelhor & Browne, 1985). The survivor's attempts to cope with this may result in some of the psychological and behavioural manifestations that are associated

with these traumagenic dynamics. Without an understanding of the dynamics and some form of intervention these manifestations can persist into adulthood and affect survivor's individual functioning and their relationships with those around them.

Long Term Effects and Adult Survivors

Herman (1992) suggests that "repeated trauma in adult life erodes the structure of the personality already formed, but repeated trauma in childhood forms and deforms the personality"(p.96).

The children who are unable to care for or protect themselves must cope with the failures of the adult caregivers by the only means available, a system of defences that is not fully developed (Herman, 1992). The abusive environment forces the child to develop both creative and destructive capacities (Herman, 1992). These capacities often become some of the effects or symptoms experienced by victims of childhood abuse and these effects often continue into adulthood.

The sexually abused child may grow up hoping that becoming an adult will bring relief or freedom from the effects of the abuse. However, Herman (1992) suggests that "the personality formed in an environment of abuse is not well adapted to adult life" (p.10). The survivor is left with problems in basic trust, autonomy, initiative, self-esteem, and coping (Herman, 1992; Bass & Davis, 1988).

Depression is one of the effects of sexual abuse believed to be common. Briere (1992) cites a number of empirical studies that suggest a greater depressive symptomology in adolescents and adults with sexual abuse histories. Eliana Gil (1988),

in a study on the consequences of abuse, reports that the most common problem was depression from which 75 percent of the sample suffered. The survivor may exhibit symptoms of depression periodically, or continually, through childhood into adulthood. Courtois (1988) states the symptoms of depression a survivor might exhibit include: "low self-esteem, feelings of worthlessness and hopelessness, passivity, lethargy, eating disturbances resulting in weight loss or weight gain, helplessness and lack of personal efficacy, inability to concentrate, withdrawal and isolation, anhedonia, and self injurious behaviour including self-mutilation and suicide ideation and gestures" (p.98).

Most of the research on the relationship between childhood mistreatment and suicidal behaviour has been in the area of sexual abuse and suggests that adolescents and adults molested as children have more frequent suicidal behaviour or ideation than non-abused samples (Briere, 1992). Courtois (1988) states that a higher rate of suicide attempts, suicidal behaviour and self-destructive wishes exists in sexually abused survivors compared to those without a history of abuse. Survivors may also exhibit self-mutilating behaviour which involves deliberately inflicting some sort of injury to the body (Courtois, 1988). This may include cutting or carving, burning, gouging, pinching, hitting and sometimes genital mutilation. Briere (1992) suggests that most of these forms of self-injury have been shown to occur among survivors of severe child abuse. The reasons documented for why survivors self-mutilate vary. Briere (1992) refers to researchers who believe that this behaviour serves as temporary relief from the stress associated with extremely negative affect, self-loathing, guilt and other psychological states.

The research links a history of sexual abuse to later substance abuse or addictions (Briere, 1992). Blume (1990) suggests that "women experience addictions differently than do men; their `substance of choice' and course of their addiction are correlated to their social political life experiences, as well as their physical differences" (p.157). Addictions are considered by some to be a common way of coping and can become a way of coping with the pain of child sexual abuse (Bass & Davis, 1988). The addiction seen in survivors may include, but is not limited to, alcohol, street or prescription drugs, food and sex (Bass & Davis, 1988; Blume, 1990).

The connection between chemical dependency and abuse is well documented (Briere, 1992; Courtois, 1988). Courtois (1988) suggests that there are two patterns in evidence regarding chemical dependency; the first is the survivor with a family history of chemical dependency and who was dependent before and after the abuse; the second is the survivor who begins to use alcohol and drugs to cope with the after effects and self-medicate. In the latter group, the chemical becomes a means to cope with the distressing symptoms of the abuse history (Courtois, 1988). The chemical can serve to block the memories, numb the feelings to push the pain down, and to deny the truth (Bass & Davis, 1988; Blume, 1990). What initially is a coping or survival strategy can become destructive and self-defeating (Bass & Davis, 1988). Bass and Davis (1988) believe the addiction must be curbed before the survivor can heal. Courtois (1988) suggests that when the chemical use is secondary to severe symptoms of abuse, the therapist should monitor the chemical use to assess whether there is a decrease as the symptoms decrease. If not, then primary treatment for the chemical dependency is necessary (Courtois, 1988).

Most child abuse takes place in the context of relationships or intimacy (Briere, 1992). The child's trust is often betrayed by an adult they thought would protect them and at a critical point in the child's emotional development. As adult survivors, they may have difficulty with trust, interpersonal relationship and intimacy (Courtois, 1988). The survivors difficulty with trust includes trust of others, but also trust of themselves, their own perceptions, decisions and judgements. Learning to experience and tolerate intimacy and feel safe with sharing is a challenge of survivors (Bass & Davis, 1988).

Clinical experience strongly suggest that adults who were sexually abused as children are likely to report difficulties in the sexual area (Maltz & Holman, 1987). Maltz (1988) suggests that there is a strong relationship between sexual abuse and some disruption in sexual functioning. Maltz (1988) goes on to identify the most frequent sexual problem for survivors as some form of sexual withdrawal. However, some survivors can become hypersexual with periods where there are numerous sexual partners and sexual contacts (Bass & Davis, 1988; Blume, 1990).

Survivors usually have their first sexual experiences in a non-consenting and premature way. Sexual abuse takes away the survivors right to experience sexual contact as a consenting choice within their control. Many survivors learn to connect sexuality with feelings of mistrust, guilt, anger, betrayal, fear, helplessness and shame (Bass & Davis, 1988; Maltz, 1988). The feelings experienced at the time of the abuse can become conditioned responses to sexual arousal and stimulation, even for an adult survivor in a caring and loving relationship (Maltz, 1988).

Some sexual abuse survivors may struggle with what is referred to as dissociation or depersonalization (Blume, 1990). Sometimes, when children are unable to remove themselves from the abusive situation, they will find other ways to leave emotionally. Often this leaving becomes a form of separation from self, which survivors may refer to as splitting (Blume, 1990). At the time of the trauma, survivors consciously separate themselves from what is happening to their bodies and will describe these experiences as if "they left their body" or "floated into a corner and watched as if it was a movie or happening to someone else". In adult survivors, dissociation manifests itself in symptoms such as nightmares, trances, perceptual distortions, memory difficulties, feelings of depersonalization, fainting spells, headaches and in extreme forms, Multiple Personality Disorder (Courtois, 1988).

Adult survivors may also experience symptoms of anxiety including unrealistic fears (phobias), panic attacks and flashbacks (Briere, 1992; Courtois, 1988). Survivors may also experience physical symptoms, real or psychosomatic.

This discussion of the long term effects on survivors was an overview of some of the impacts of the sexual abuse, but is not an exhaustive description of the traumatic effects of the sexual abuse experience. It is also important to note that the effects of sexual abuse can be complex and multifaceted and while some survivors may have extreme difficulties, other survivors grow up and develop healthy coping strategies and maintain intimate, close relationships.

Survivors and Their Partners

Many sexual abuse survivors will enter "intimate" relationships as adults. The survivor is bound to play out the psychological and behavioural manifestations of the abuse within the context of an intimate relationship. In fact, partners and children of survivors are sometimes referred to as "secondary victims"because the destructive effects of sexual abuse extend beyond the person abused (Courtois, 1988). Whether the after effects of the abuse are acute, chronic or delayed they may all have significant impact on partners.

It has only been in the last ten years that clinicians have looked at the impact of childhood sexual abuse on the relationships of female survivors and their partners and the focus of this work has been on helping the survivor (Chauncey, 1994, Engel, 1991, Gil 1992). The partner was viewed as a conjunctive support and the focus was on helping the partner to be patient, understanding, and compassionate in order to assist the survivor's recovery process. Very little attention has been given in the literature to the emotional experiences of the partners, what it means for them to be involved with a survivor and their specific needs in therapy.

Just as the recovery process for the survivor can be difficult, being the partner of a survivor can be a challenge. Survivors generally have difficulty with trust, intimacy and sex. All of these elements can have a direct impact on the couple relationship (Bass & Davis, 1988; Gil 1992). As the survivor struggles with the issues of recovery, she may be angry, depressed, preoccupied, self destructive, suicidal or may need to feel in total control of her life and therefore the relationship (Bass & Davis, 1988; Graber 1991). The

partner may not understand what is causing the difficulties for the survivor and how the difficulties are connected to the past experience of sexual abuse. If the survivor's partner has an understanding of the impact of the abuse, the recovery process and what to expect, this may not only help him to be supportive to the survivor but might help him to put the difficulties in perspective as they relate to the sexual abuse experience and the past. Without this understanding, the tendency might be for the partner to blame the relationship, blame the survivor or take responsibility for the difficulties not directly connected to the relationship.

The abuse often occurs at an early age when survivors have not learned to cope with strong feelings (Gil, 1992). Consequently, many survivors cope with these feelings by developing defence mechanisms that help them emotionally distance themselves from the abuse. The coping strategies can become unhealthy as they become adults and form intimate relationships. Defence mechanisms can include but are not limited to: denial, minimization, suppression, and numbing. Survivors need to unlearn familiar patterns of communication and learn new coping skills to allow for a healthy expression of their feelings, desires and needs in a relationship.

Anger is a particularly complicated and confusing emotion for survivors. The survivor usually has made negative connections between anger and frightening feelings (Gil, 1992). The feelings of anger also get connected with the survivor's experience of powerlessness and the perpetrator's control over the survivor. As the survivor begins to allow herself to experience the angry feelings, and learns not to suppress or stifle the anger, the expression of the anger may be projected towards the male partner. The

survivor may not only need to learn that expressing the anger is healthy but may also need to learn constructive approaches to dealing with anger. The partner will also need to learn to recognize when the anger is being misdirected at him and to not take this personally.

Sexuality and sexual functioning are often the most sensitive areas for a survivor to verbalize. The partners of survivors may be significantly impacted by the effects of the sexual abuse in this area. The survivor learns to connect sexuality with feelings of mistrust, guilt, anger, betrayal, helplessness and shame. Maltz (1988) identifies a strong connection between sexual abuse and some disruption in sexual functioning. The impact of the abuse on the survivor's sexual experience will likely have implications in how they are sexually with their intimate partners.

Couple Therapy with Survivors and their Partners

Follette and Pistorello (1995) report that "clinical and scientific research suggests that survivors tend to experience an inordinate amount of distress and dissatisfaction in their couple relationships" (p.132). The survivors' difficulty with trust can impair their ability to develop and maintain intimate relationships. Further, Follette and Pistorello (1995) state that "when compared to controls, survivors are more likely to be separated or divorced, demonstrate higher rates of conflict and fear of their partners and report lower relationship and sexual satisfaction" (p.132).

There has tended to be a focus on group treatment for survivors due to the nature of the impact of the abuse such as shame, isolation and self-blame. Follette and

Pistorello (1995), although acknowledging the general success of group therapy for survivors, refer to one study that concluded that married survivors did not benefit as much from group treatment as those without partners. Follette and Pistorelli (1995) draw further attention to the importance of the couple relationship in recovery, by referring to the findings of studies where rape survivors in stable intimate relationships had speedier recoveries than those who were not in relationships and a group therapy study where the few survivors who deteriorated after treatment were the ones experiencing severe marital distress.

Follette and Pistorelli (1995) believe that the interpersonal relationship plays an important role in the treatment of survivors and that the survivor's "social network has the power to influence the outcome of the trauma"(p.133). Follette and Pistorelli (1995) further assert that "what follows is that the greatest treatment gains would be felt on the women's primary intimate relationship" (p.133).

Little is written about couple's work with survivors. Sue Blume (1990) in her book Secret Survivors devotes one paragraph to couples therapy, sex therapy and assertiveness training. She writes:

> Although these therapies can be extremely helpful, an incest survivor should not begin any of them if she is so internally demolished that she can't deal with her life or her past. Some inner rebuilding may be a good idea before these refinements are addressed. The survivor in couple's therapy for instance, needs to be strong enough not to take all the

> blame for the problems in the relationship and not to allow herself to be persuaded that her needs are invalid and she should change to meet her partner's needs.(p.275)

Considering the recovery process can take three to five years or more (Graber, 1991) and often adult survivors are in an intimate relationship as they begin the work of recovery, the idea of waiting has implications for the couple. If the partner is not included in some form of education or therapy, he may not be able to understand the recovery process, the survivor's needs and how to be supportive and patient. One could assume this might limit the partner's ability to support the recovery process and increase the risk for marital distress, separation or even divorce.

Follette and Pistorelli (1995) suggest several rationales for using couples therapy with this population. They believe that because sexual abuse frequently occurs in the context of an intimate relationship, a couple relationship can be a particularly powerful working context (Follette & Pistorelli, 1995). Additionally, Pistorelli and Follette (1995) believe that "areas such as communication, partner abuse and sexual abuse are best addressed with both partners present" (p.133). As well, they believe the inclusion of the partner may also prevent the recovery therapy from having a negative impact on the couple relationship (Follette & Pistorelli, 1995).

Maltz (1988) believes couple's treatment is recommended especially when addressing trust issues, strengthening intimacy and more specifically in dealing with sexual concerns. Including the partner in some of the survivor's work on the sexual abuse issues can help strengthen the relationship. The survivor can begin to experience

the partner as supportive and understanding (Maltz, 1988). The couple's therapy can focus on educating the survivor and partner about the dynamics and impact of sexual abuse and how the past is influencing their current relationship. The educational aspect will help to normalize some of the couple's experiences especially in the area of sexual difficulty. Couple work can help the couple to work on open communication of issues, feelings and needs so that the survivor learns to share in a healthy manner and the partner does not feel in the dark or helpless. Chaucey (1994) believes that in couple therapy, the partner and survivor can be helped to talk more directly to one another and to negotiate their needs more directly. Further, she believes improved communication and understanding may help the couple to find more comfortable and satisfying ways to relate (Chaucey, 1994).

Couples therapy can help the survivor to disclose the abuse experience to her partner. Although the concept of disclosure may be distressing to the survivor it is believed to be an important step in healing (Courtois, 1988). The disclosure breaks down the secret of the abuse and helps the survivor be more open about her past. Again, disclosure with the partner present can help the survivor experience the partner as nonjudgemental, safe, supportive and trusting. The detailed disclosure also helps the partner to be aware of the sexual activities that might trigger uncomfortable feelings or symptoms in the survivor (Maltz, 1988).

Although couples therapy may be helpful, sexual abuse survivors are not always ready or able to participate in this form of therapy. The therapy must be a patient process

and at all times the survivor's readiness or lack of readiness must be respected by both the partner and the therapist.

CHAPTER 3

THE PRACTICUM

Setting

The setting for this practicum was the Elizabeth Hill Counselling Centre (EHCC) located at 301 - 321 McDermot Avenue, Winnipeg, Manitoba. The EHCC is a training facility for students from the Department of Social Work and the Department of Psychology at the University of Manitoba.

Client Referral

The couples for this practicum were referred by clinicians from The Women's Post Treatment Centre Incorporated. The Women's Post Treatment Centre is located at 62 Sherbrook Street in Winnipeg, Manitoba and provides individual and group therapy to any woman who has received help for problems related to chemical dependency and who is experiencing the traumatic effects of childhood sexual abuse.

The survivors in the couple relationship referred to me for treatment were currently receiving services at The Women's Post Treatment Centre, or had received services from that agency in the past. The individual clinicians from the Women's Post

Treatment Centre would assess if the survivor were ready for and interested in couple work. When appropriate, consent of the clients was obtained and their names and phone numbers were given to me. I would then phone the couples directly. All the couples were offered the choice of having the initial session at the Women's Post Treatment Centre as it was felt this offered some safety for the women. Although there was an awareness that the partner in the relationship might be more comfortable with a neutral agency setting, the choice was offered to all couples with the understanding that the subsequent sessions would occur at the Elizabeth Hill Counselling Centre. Of the four couples involved in this practicum, two couples chose to have the initial session at the Women's Post Treatment Centre. Neither of these couples appeared to have any difficulty with the transition to the Elizabeth Hill Counselling Centre following the initial session.

Practicum Committee and Supervision

The practicum committee consisted of Dr. Barry Trute of the Faculty of Social Work, Dr. Diane Hiebert-Murphy of the Faculty of Social Work and Ms. Doreen Draffin of the Addictions Foundation of Manitoba.

Clinical supervision was provided primarily by Dr. Trute. In the brief absence of Dr. Trute during part of the practicum, Dr. Hiebert-Murphy provided clinical supervision. Clinical supervision was provided on a regular weekly basis. Of the two couples discussed in this practicum, one allowed videotaping to occur the other did not consent to videotaping.

Evaluation

The clinical evaluation of this practicum involved using two tests on a pre and post intervention basis. The instruments were The Marital Satisfaction Inventory (MSI) (Snyder, 1981) and the Beck Depression Inventory (BDI) (Beck, 1978).

Given the potential impact of child sexual abuse on the overall mental health of survivors the Beck Depression Inventory was used. The BDI is one of the most widely used measures of depression. The scales can be self administered or interviewer administered. It is a short questionnaire consisting of twenty-one multiple choice questions. Each question assesses a specific symptom of depression. The scale is fairly quick and relatively easy to complete. Keyser and Sweetland (1986) report a test retest reliability of above .90. Internal consistency studies resulted in a correlation coefficient of .86 for the test items (Keyser & Sweetland, 1986). Content validity is thought to be quite high and concurrent validity comparing the BDI with other measures of depression resulted in correlations of .66 to .75 (Keyser & Sweetland, 1986). Overall, the BDI is thought to be a valid and reliable measure of depression for adolescents and adults.

The Marital Satisfaction Inventory provides an objective self report technique for assessing partner's attitudes and beliefs regarding areas of the marital relationship (Sabatelli, 1988). The MSI contains 280 true/false questions covering 10 different dimensions (subscales) in the relationship. The dimensions are: global distress, affective communication, problem-solving communication, time together, disagreement about finances; sexual dissatisfaction, role orientation, family history of distress, dissatisfaction with children and conflict over child rearing. Although the MSI is a fairly lengthy

measure, it was chosen because it provides an overall assessment of satisfaction within the couple's relationship (global distress scale) as well as a series of sub-scales that assess more specific and pertinent areas in a couple's relationship.

Studies of the internal consistency of the individual scales resulted in coefficients ranging from .80 to .97 with a mean of .88 (Keyser & Sweetland, 1986). The test retest reliability coefficients for the scales ranged from .84 to .96 with a mean of .89 (Keyser & Sweetland, 1986). Keyser and Sweetland (1986) described the MSI as "an important addition to the selection of instruments available to assess factors associated with marital satisfaction (p.48). In addition, it is relationship specific and focuses on elements related to couple interaction that are in contrast to previous scales that focused on individual partner's personality characteristics (Keyser & Sweetland, 1986).

The MSI and the BDI were to be administered as pre-tests following the first session with each couple. Unfortunately, due to various circumstances this was not always the case. The length of the MSI, the timing of the sessions (evenings) and the couple's availability to complete the questionnaires resulted in the questionnaires being completed after the second session. Having the MSI questionnaire available for the couples to complete at home seemed to facilitate this process. This also assisted with the post-test procedure as well. Following the last session with couples, both the BDI and MSI were mailed to the couples with a stamped return envelope. This process was discussed with each couple during the last session and the couples returned the questionnaires in a relatively short period of time.

CHAPTER 4

THE COUPLE THERAPY

Introduction

During this practicum experience I was able to work with four couples for varying numbers of sessions. In this chapter I will present the background information on two of the four couples. These two couples were chosen for discussion because they were seen weekly or bi-weekly for the duration of the practicum. The first couple Steve and Marlene were seen approximately bi-weekly for sixteen sessions over a period of eight months. The second couple Joe and Karen were generally seen weekly for sixteen sessions over five months. The work with these couples was intense, and I believe, allowed me to fully engage in the treatment process.

I will then discuss six themes that are identified in the literature as clinical issues that are relevant for survivors and their partners, and relate points in the couple treatment that highlight these clinical themes. As each clinical theme is identified and discussed the treatment interventions will also be reviewed.

Background Information

Couple One

Marlene and Steve were referred to me by Marlene's therapist at the Women's Post Treatment Centre. Marlene had been involved on and off with the Women's Post Treatment Centre. At the time of the referral, Marlene had recently re-engaged in individual therapy at the Women's Post Treatment Centre. Marlene continued to see her individual therapist from the centre regularly for the duration of my involvement with this couple.

Marlene (37) and Steve (38) have been married for fourteen years and have two children; Cathy (4) and Bill (9). Steve worked full-time shift work and Marlene worked part-time in a day care setting. Marlene had a history of alcohol problems and had been sober for ten years. Marlene attended AA meetings on a regular basis and had a small support network through this association. Steve attended Alanon meetings regularly and credits this organization for some of his own individual growth over the previous several years.

Marlene had a history of diagnosed depression and saw a psychiatrist on a regular basis. Marlene's depression had been treated with prescription medications for several years and she was on anti-depressant medication at the time of the referral. Marlene had one suicide attempt which was several years prior to my involvement with this couple.

Marlene was sexually abused from age five to eight and a half by an adult male neighbour who she considered a family friend. The abuse ranged from fondling to

intercourse. Marlene did not disclose the abuse to anyone other than Steve until she was 25 years of age.

I spent several sessions exploring family of origin histories with Steve and Marlene, having them share their stories with one another. Highlights from the histories included Steve's identification of his father's drinking, that seemed to increase over the years. Steve recalled his family being isolated and his parents' marriage as not very communicative. Steve appeared to identify with his memories of his father providing the basic necessities (food and shelter) for the family. Marlene described her parents as distant and felt that they didn't care about her growing up. Marlene described her parents as not being affectionate or emotionally demonstrative with one another or with the children. Marlene recalled that her parents did not communicate much, and never openly talked about feelings. Marlene had particular memories about how anger was or wasn't dealt with in the home. Marlene recalled needing to stifle feelings, including physical pain as this was seen as a "weakness" when she was growing up.

Couple Two

Karen and Joe were referred to me by a therapist from the Women's Post Treatment Centre. Karen had some previous involvement in individual and group treatment at the centre but was not actively involved with the centre at the time of the referral.

Joe (36) and Karen (30) had known each other for nine years and lived in a common law relationship for seven years. They first met in another province and moved

back to Manitoba in the early stages of their relationship. At the time of the referral Joe and Karen were receiving financial assistance from the city.

Throughout the duration of couple therapy Joe was involved in individual therapy at another agency and had previously taken part in a men's group there. Karen stated during the first session that she felt she was "agoraphobic and depressed" and was scheduled for a psychiatric consultation shortly after the first session.

Karen had used marijuana on a daily basis. Karen had received treatment at the Alcohol Foundation of Manitoba and was no longer using drugs. Karen was sexually abused by her mother's common law husband over several years. Karen's father was her caregiver after her parents separated and the abuse occurred when Karen would go to visit her mother. Karen said she felt she "put up with abuse so I could get attention from my mother." The sexual abuse continued until Karen's parents reconciled when she was 12 years old.

Karen is an only child from her parents' relationship. Karen's father was hospitalized as a young adult for mental health concerns and her mother has a history of major mental illness. Karen's mother left the marriage to be with another man (the perpetrator) when Karen was five. Karen was placed outside the home briefly but returned to live with her father who she describes as non-affectionate and emotionally abusive. Karen recalled her mother going back and forth between her father and the other relationship until her parents reconciled. Karen recalled her father being emotionally and verbally abusive towards her mother in their relationship. Karen said her mother was not abusive towards her but looking back felt her mother was

"neglectful" and unable to meet her basic care needs due to her own difficulties. Karen was emotionally cut off from her parents when I met her.

Joe's parents separated when he was five and his mother remarried a number of years later. Joe described his biological father as an alcoholic with whom he had sporadic contact over the years. Joe discussed his stepfather as someone who drank a lot and who was physically violent towards his mother for years. The stepfather would get physical with Joe and his siblings if they attempted to intervene to protect their mother. Although Joe initially asked if he had to answer my question about any history of sexual abuse in his family, with Karen's support and encouragement, he did disclose painful memories of his stepfather in his sister's bedroom and his belief that she was sexually abused.

Progress in Therapy: Pre and Post Measures

Couple One - Marlene and Steve

Beck Depression Inventory

Steve's pre-test score on the BDI was 8. The normal, or non-depressed range is 0 to 9. Steve's post-test score on the BDI was 5, a slight decrease and still within the normal range. The results on the measures are consistent with Steve's presentation in the sessions. Steve did not appear depressed nor report any symptoms consistent with depression.

Marlene's BDI pre-test score was 45. Twenty-four to 63 is the range for severely depressed on the BDI. Marlene's post-test score on the BDI was 33. The score represents a decrease in twelve points but is still within the severely depressed range.

These scores are consistent with Marlene's history of diagnosed depression and ongoing struggle with symptomology. The decrease in score might represent a couple of things. Just prior to termination, Marlene's psychiatric medication had been changed to reflect her psychiatrist's new clinical impressions. The decreased score might represent a response to the new medication regime. As the sessions with the couple progressed, Marlene was able to express some hope for herself and the marital relationship. This increased hope could be a result of the combination of individual treatment and psychiatric treatment as well as the couple's treatment where a large focus was trying to help Marlene recognize some hope, improvement and positive aspects in the relationship. If Marlene was feeling more hopeful about herself and relationship, then the hopelessness related to depression may have decreased.

The Marital Satisfaction Inventory

The Marital Satisfaction Inventory Pre and Post Test Profiles for Marlene and Steve may be found in Appendices A and B.

For both Marlene and Steve, their scores on the Global Satisfaction Scale on the MSI came down representing an increase in the overall satisfaction in their relationship. Marlene's score came down only slightly whereas Steve's score came down closer to the normal range. However, both pre and post test scores on this scale remain in the problematic range. These results appear consistent with the couple's clinical presentation. Although I felt there were some improvements in Steve and Marlene's ability to communicate and share, there was still a fair degree of distress in this

relationship. On the problem-solving and communication sub-scale, Marlene's pre-test score was 25 and her post-test score was 24. On this same scale, Steve's pre-test score was 18 and his post-test score was 12. Although the couple both felt Marlene was expressing more in the relationship, this remained an uncomfortable, anxiety provoking area for Marlene which might explain the minimal change in her score. Steve, on the other hand, had been used to feeling Marlene totally shut him out in this area so any increase in sharing by Marlene might have represented real improvement for him. On the Sexual Dissatisfaction Scale, this couple's pre and post scores remained almost unchanged. Again, this is consistent with the work that was done with this couple. The sexual difficulties were an issue for this couple, particularly Steve. The fact these scale scores remained the same represents the reality that this aspect of the relationship was not directly focused on a great deal, in the couple work.

Couple Two - Karen and Joe

Beck Depression Inventory

Joe's pre-test score on the BDI was 5 (normal range) and his post-test score was 12 (mildly depressed). I am not sure why Joe's scores on the BDI may have gone from normal to mildly depressed. Joe's presentation in sessions did not seem to change or reflect a change in his mood. Some of the work this couple did involved Karen and Joe discussing their current status and future goals. Karen would sometimes present as very critical of Joe and state her perceptions of his short-comings. Joe would discuss his desire to have a job, provide a better living for them and his wish to be in a position to

have children. Perhaps some of this discussion of the future left Joe examining his life in an introspective way. Some of the questions where his answers changed were those that reflected self-esteem.

Karen's pre-test score was 39, her post-test score was 29. These are both within the severely depressed range. Karen felt she was "depressed" that she and had a number of other clinical syndromes at the time I first met her. Karen's pre-test score certainly reflected her stated mood. Although her post-score was still in the severely depressed range, the ten point decrease might reflect some of the couple work. The focus on trying to help Karen identify positive aspects of the relationship and to feel hope for themselves might be reflected in the score. The couple's self-reported decrease in conflict may also be reflected in Karen's decreased score. I believe the fact the score remains in the severely depressed range reflects the amount of internal damage from which Karen still suffers.

Marital Satisfaction Inventory

The Marital Satisfaction Inventory Pre and Post Test Profiles for Karen and Joe can be found in Appendices C and D.

Joe and Karen's scores on the Global Satisfaction Scale also showed improvement indicating some increase in their overall satisfaction with their relationship. This improvement is positive and provides some hope for Karen and Joe, who planned to continue couple therapy. However, their scores still remained in the problematic range

which was consistent with their clinical presentation at the time of termination. There were still a number of significant issues that needed to be addressed.

On the Affective Communication Scale Karen's score dropped from 24 to 18 which represents a slight improvement in satisfaction in that area. This could reflect the work that Karen did on her own communication style with Joe. Karen had worked to express her strong emotions and dissatisfaction with Joe more productively and also learned to prioritize which issues she brought up with Joe. Karen felt this helped her not to escalate to the point of extreme anger as much. In sessions, Karen reported this as a positive change that helped her feel more in control and led to less conflict. This might explain the improvement reported by Karen. Joe's score on the Affective Communication Scale remained the same. I believe this reflects the fact that Joe's affective expression did not appear to change in his interaction with Karen. Joe did report he engaged in less conflict likely in response to changes Karen had made in her interactive style. Joe felt he was connected and close to Karen through the therapy.

Clinical Themes in the Couple Work

Trust

When children are sexually abused it can shatter or significantly damage their ability to trust. Usually the survivors' trust was betrayed by an adult perpetrator whom they expected to protect them and whom they felt they could trust. The sexual abuse experience can damage the survivor's ability to trust at a most basic level and most survivors are emotionally impacted by this issue (Graber, 1991).

Generally, in the process of therapy, the therapist has to join with the client and establish some level of trust to begin to do the therapeutic work. With survivors this stage can be more complicated and trust can take some time to develop. As well, one can expect survivors who tend to test out trust in extremes, to test out interpersonal trust in the therapeutic relationship.

I had two initial sessions with Marlene and Steve. For the most part the focus of these sessions was probing and exploration to get a sense of the relationship and what the couple identified as issues they would like to work on in therapy. Although some sensitive issues for survivors were identified in these first sessions (i.e., sexual intimacy) I tried to explore these in a gentle manner. The early sessions were also used to begin the process of joining with the couple. After the second session I received a call from Marlene's individual therapist at the Women's Post Treatment Centre. Marlene was aware that her therapist was calling and had given her permission. The therapist provided some background information and then shared with me that Marlene was feeling "very blamed" in sessions. The therapist had also encouraged Marlene to speak to me directly about these feelings. By this time I had assessed that Marlene had self-esteem issues and I felt she tended to perceive things negatively. I had already begun to use the metaphor of Marlene's own "internal tape recorder" giving negative messages the previous session. The therapist validated my perception and offered a helpful hint from her work with Marlene. The individual therapist regularly checked with Marlene about what Marlene heard and perceived in sessions; checking Marlene's internal dialogue or interpretation of what was said with the intended message. I felt this phone call from the

therapist was helpful. I did not feel I was blaming Marlene. Steve tended to be more verbal in the early sessions because Marlene was presenting as quiet, guarded and a person with whom it was difficult to engage. I wondered if I was taking the easy way out and focusing too much on Steve, rather than being creative and trying various ways to engage Marlene. I was glad Marlene felt she could trust her individual therapist enough to talk about her concerns and allow them to be shared with me. I saw this as a definite trust issue. It did not play out as a splitting between the two therapists, which could have been negative and counter productive. I felt it was important to address the issue directly and to create an environment in therapy where Marlene could test out her perceptions and express her concerns in session.

At the beginning of the next session I mentioned the phone call from the individual therapist. In checking it out with the couple, it was apparent Steve was unaware of what was going on. I had Marlene attempt to explain this situation, with me adding some details. In exploring the concern of feeling blamed, Marlene could not identify anything specific I had said or done. I validated Marlene's feelings and indicated my intent was not to blame anyone. I suggested, as an intervention, that I might need to check in with Marlene at the beginning and end of the sessions to see if Marlene had any concerns or if there was anything that needed to be clarified. I felt this would give Marlene an opening to express any issues, as it was too soon to think Marlene could bring up issues on her own. Marlene agreed to this idea. I made sure to use this intervention formally for the next several sessions and Marlene never chose to or needed to clarify anything. Throughout my work with Marlene and Steve I continually checked

in with Marlene about her perception of the session and things that were said, to try to ensure that Marlene's perceptions of the sessions were not perpetuating her damaged self-esteem, negative world view, or self blame. After about three months of treatment I felt Marlene tentatively begin to trust herself enough, and the therapist and her husband a little, as she began to openly share feelings after a particularly emotional time without actively needing to be asked.

Another issue of trust became apparent following a crisis Marlene experienced. In short, Marlene had been admitted to a Crisis Stabilization Unit (CSU) as a result of suicidal ideation. In discussing fears about Marlene's safety and his feelings of powerlessness to help, Steve talked about the pain of not being trusted enough by Marlene for her to share her feelings with him before the crisis. Steve spoke about how hard it was for him and agreed with my sense that he felt like an "outsider." Steve seemed particularly hurt by the fact that Marlene told her individual therapist about her feelings and suicidal ideation and couldn't tell him. I validated Steve's feelings and explained to him that it was not uncommon for partners of survivors to experience feelings of resentment or jealousy about the survivor's relationship with her individual therapist. I explained to Steve how the sexual abuse experience can damage basic trust for survivors and how this lack of trust can even involve the survivor's intimate partner. I felt it was important for Steve to see Marlene's trust in her individual therapist as a hopeful sign that she had the ability to trust and heal and not see it as an exclusion of him.

Marlene's trust of her own parents was discussed in one of our conjoint sessions several months after her admission to the Crisis Stabilization Unit. Steve wanted to know why Marlene would not tell her parents about her depression and difficulties, especially the crisis admission. Marlene said she was fearful that they would respond the way they always had and let her down by not understanding or caring. Steve felt that Marlene needed to give her parents a chance and suggested she didn't know how they would respond. I labelled this as a "trust issue" in the session in two respects. One was Marlene not trusting her parents to be supportive and caring based on past experiences. I validated her feelings of not wanting to be hurt or let down. The other was Steve not trusting that Marlene knew what was best for herself. I asked Marlene to try to explain her feelings to Steve and suggested to Steve that he needed to respect that Marlene wasn't ready to trust her parents. I attempted to help Steve understand that survivors need to deal with, or not deal with, their family of origin in a way that is protective to them. Often, partners either want the survivor to deal with the family of origin differently or want to approach the family of origin themselves. I needed to help Steve respect Marlene's feelings and choices with regards to her own family.

By having Marlene share her feelings with Steve directly, she also took a risk (six months into treatment) to say she didn't trust that Steve's motives were all based on a concern for her well-being. Marlene was able to share that she felt Steve wanted her parents to know so they would come down to help with the kids when she was hospitalized. Steve acknowledged that such assistance would be helpful, but assured Marlene that his main intention was to be caring and supportive of her. In the end, Steve

could agree that Marlene needed to be empowered to make the decisions as to how and why to inform her parents of situations in their immediate family.

Another situation that highlights the trust issues for this couple occurred in their last and second last session. The issue of sexual intimacy was evident throughout my work with this couple and discussed in varying degrees over the course of treatment. I had attempted to discuss intimacy over several sessions and felt the couple had avoided this issue. In the second last session, after several attempts to discuss physical intimacy, this couple was able to talk directly about sex. Marlene expressed her feelings, or rather lack of feelings, about sex and her past sexual abuse experience. Marlene talked about not liking sex and the connection to the abuse. Marlene blamed herself for this and was able to tell Steve she felt responsible for this problem in their relationship. Marlene cried as she talked about this, something she rarely allowed herself to do in sessions. Steve started to speak to me about his feelings and was encouraged to speak directly to Marlene. Steve told Marlene how sad he felt that she had to be in so much pain and that she had to go through so much. Steve became openly tearful as he explained this to Marlene. When this discussion started I encouraged this couple to put their chairs together and hold hands, after it was verified that Marlene was safe with the physical contact. This type of direct intervention had been used in the last several sessions in an attempt to promote emotional safety, and physical intimacy in the controlled setting of the office. The couple briefly shared what the experience was like for them before the session ended.

In the last session, I chose to go back and talk about this previous session in the hopes of consolidating some of the emotional closeness and empathy that I felt had occurred. With this issue opened up, Marlene stated she had thought about it and later felt that Steve was not sad but frustrated and disappointed. I suggested that Marlene did not trust the genuineness of Steve's feelings. Marlene then suggested he might have been half sad and half frustrated. I invited Steve to respond to this and he chose to directly say to Marlene again, that it hurt him to see the pain she was in and what she has to go through. Steve explained he was not frustrated for himself but because Marlene's healing was so hard for her. I then asked Marlene if she realized how patient and caring Steve seemed to be and she was able to acknowledge Steve "likes me a lot." Marlene said that "the thought that Steve loves me is too hard for me because the abuser used those words and told me this (the abuse) was how he wanted to show it". My intention was to highlight what I felt was an open, positive communication between Marlene and Steve in the previous session. Instead, this intervention highlighted Marlene's ongoing distrust of Steve is caring and his feelings for her. I felt it was important to highlight Steve's caring and patience because my assessment was that his gestures were genuine and I felt Marlene needed to find a way to trust Steve. I believed it was important to challenge what I felt was Marlene's cognitive distortion about Steve's honesty and presentation in both of these sessions.

It is important to note that several times throughout my work with this couple, Marlene would bring up the issue of why Steve would still be with her after everything that had happened to her. She also felt that if she showed her true emotions he might

leave. I thought the underlying issues were Marlene's self worth and trust. Each time this came up, I challenged Marlene by either praising Steve for how patient he had been, or cognitively challenging Marlene by asking her what more could possibly occur that would make Steve choose to leave, considering what they'd been through. On one occasion I asked Steve to tell Marlene why he chose to stay in the relationship. All these interventions were attempts to cognitively challenge what I believed were Marlene's irrational thoughts about the marriage and Steve, and to help her begin to trust that Steve was committed to the relationship despite the difficulties and Marlene's interpersonal struggles.

In my work with Karen and Joe the issue of trust presented itself differently. The one similarity I noted was that Karen also came back after each of the first couple of sessions and asked about some perception or interpretation she had about something I had said or she had thought I said. As with Marlene, Karen had identified self esteem as an issue during the first session. Karen also presented as self deprecating at times and seemed to have a negative filter about how she saw the world. This is not to say that as a therapist I did not unintentionally say something or ask a question that sounded as if I was blaming Karen. Each time Karen asked for clarification I validated her feelings and praised her for her assertiveness and trust in discussing the concerns with me. I took a one-down stance suggesting that if I sounded negative or like I was blaming, that was not my intent, but I was sorry it had come across that way. In some ways I felt this might have been some testing of the therapist on Karen's part which was reasonable. After the first few sessions Karen continued to ask questions and clarify things, however her

presentation changed. The questions and clarifying became a part of the regular therapeutic process rather than her appearing to start each session in a way that seemed to be testing the trust.

In my work with Karen and Joe it is harder to choose specific process highlights because I felt the issue of trust permeated almost every session with this couple. Although I believe it was always an underlying theme with Marlene and Steve, it seemed much more overt with this couple. In at least seven of 16 sessions (three of which were solely devoted to family of origin issues), Karen brought up issues related to her apparent distrust of Joe. Most of the information centred around Karen's experience with Joe "leering" at other women on the street and her perception of Joe as a male. Joe would respond by acknowledging glancing, but not leering. Karen would also accuse Joe of watching pornography late at night. In several sessions Karen discussed an incident that had occurred a few years earlier. Joe had gone for a bike ride with a male friend who brought along a female friend. Joe insisted he did not know his friend was bringing a female. Karen discussed this event with such intense feelings it was as if it happened recently. Joe insisted the situation was innocent, but Karen was not able to believe him. Karen stated several times she did not believe Joe has been unfaithful to her physically but felt he had "mental affairs". In fact, Karen clearly said she did not think Joe would actually physically have an affair. Karen also spoke on several occasions about her strong feelings about the sexual objectification of women in society. I labelled these trust issues for Karen and attempted to help her separate what might be related to a generalized distrust response to all males and connected to her victimization (which can

be common with some survivors) and what specifically related to her current relationship with Joe. In response, Karen would usually refocus on Joe and her distrust of him. I questioned Karen about what Joe would need to do for her to trust him or what would be different if she trusted him - "solution focused questions" (see Werner-Davis, 1992). Karen would respond by saying things like "Joe is the way he is" or "he's a write-off". On one occasion Karen described them as a "sick co-dependent couple" and said that was all that kept them together. Joe did not agree with this diagnosis of their relationship.

Karen, more than once, spoke of Joe's insecurity and distrust. Joe clearly stated he felt he could trust Karen. Karen spoke of Joe's previous marriage and his ex-wife's flirtatiousness as the reason for Joe's insecurity. Joe said insecurity was not an issue for him currently, but did say it had been in the past. Joe believed his individual work had helped him grow in this area. Joe did not appear threatened, jealous or insecure in sessions. Attempts to focus on the positives with Karen (i.e., Joe's individual work and descriptions of change and his attempts to help Karen see the apparent genuineness of his feelings) were usually met with resistance and commitment to her distrust of Joe.

When Karen would speak of these issues the content would be interspersed with very self-deprecating remarks such as, "I'm too ugly", "undesirable", or "I'm a loser anyway". I tried several interventions regarding this issue. On two occasions I had Karen and Joe talk about what initially attracted them to each other and what they felt kept them together. Joe was able to provide some positive thoughts on this, whereas Karen's responses seemed coloured by her negative self-image. I then attempted to help Karen see that she might be projecting some of her own feelings onto Joe (mistrust and

insecurity) as they did not seem to be issues for Joe. Also, I tried to help Karen identify what might be her own individual issues and to separate those from the relationship issues. At this point I even attempted to externalize the problem by asking Karen how long she was going to let her feelings (of insecurity) push her around. Again, these interventions seemed to have little impact on Karen's perceptions of Joe and the relationship. I felt very struck with this couple when it came to this trust issue.

I still believe a large part of this distrust came from Karen's individual problems in the present and were related to how intra-psychically damaged she was from her past. However, I also believe I missed something here. Despite interventions, Karen remained ambivalent or negative about the relationship while at the same time saying she was caring and committed to the relationship. In hindsight, as I reviewed my notes, I wondered if my focus was too narrow in that Karen's distrust of Joe was about her past sexual abuse and her projecting those feelings onto Joe. Karen may have been having "mental or physical affairs" or fantasies which I never explored, and she may have been displacing those feelings onto Joe. Karen had an affair in her prior marriage. I also may have not pursued the idea of Karen misplacing her angry feelings about her victimization and the abuser onto Joe enough. This can be a critical issue for survivors and their partners and perhaps I let Karen's "resistance" or my feelings of her emotional fragility stop me from pursuing this more in therapy.

Communication and Intimacy

Communication is often considered the cornerstone of a healthy relationship. Communication can be considered the basis for understanding, compassion and creative problem solving (Bass & Davis, 1988). Communication in a relationship involves both partners being able to openly and honestly express their feelings, thoughts, concerns, wants and desires. Ellen and Davis (1988) describe intimacy as a bonding between two people based on trust, respect, love and the ability to share deeply.

I have already discussed the problem of trust for survivors. The coping mechanisms (i.e., denial, suppression, minimization) a child may have used to survive the abuse may make it difficult later to access or identify feelings. Survivors have often learned to cut off their emotions and then function on a rational or intellectual basis. With support and encouragement the survivor can learn to recognize and label feelings and begin to express them safely. Given how connected communication and emotional intimacy are, it is not surprising that these issues were predominant in my work with both couples.

In the first session with the couples, where exploration of issues occurred, both couples identified communication as something they wanted to work on in therapy. Steve identified communication as an issue for him and Marlene. Marlene revealed how difficult it was to talk about her feelings. Steve raised the issue of physical and/or sexual intimacy in the first session. Marlene indicated she felt emotional intimacy affected everything. Marlene spoke about safety, fear of losing control and her sense that any

feelings she might have would turn into anger. This presentation was consistent for a survivor.

I believe the sessions where Marlene and Steve told their family of origin histories in the early stages of therapy helped them identify communication patterns in their families of origin and how this may affect their current relationship. I believe this also served to broaden the focus beyond Marlene's sexual abuse experience at a point where she was struggling to trust the therapist and felt "blamed" for the issues in the relationship because she'd been abused. I think this was helpful because of my sense of Marlene's fragility and the need not to encourage her self-blame. It was also important to establish that marital issues are interactional and not allow Marlene to blame herself. Follette and Pistorello (1995) discuss the importance of balancing the focus of couple's treatment between the survivor and partner's histories and issues, in order to give the message that both histories are important and contribute to the current marital difficulties. Marlene had learned to suppress all emotions in her family or origin, where she learned crying was a sign of weakness and anger was either a non-verbal, repressed emotion that everyone could feel (her mother) or shown by her father "blowing up". Steve came from a family where there was also very little communication between his parents and the focus was on meeting the fundamental needs of the family. Marlene also offered some information about her sexual abuse experience but seemed to have difficulty talking about her feelings past and present regarding the abuse. I thought a hopeful sign was that she had discussed her abuse history with Steve when they met and felt perhaps this was a sign of minimal trust and safety. Helping Marlene to identify and discuss her feelings

was a identified as a goal. This family of origin exercise was also an opportunity to provide some education for Steve regarding the emotional issues for survivors and how they can be brought into current relationships.

In therapy, there is the belief that crisis can promote change. There were two crisis situations that came up in my work with Marlene and Steve that I feel were helpful in promoting communication and emotional intimacy. The first occurred in the fourth session with this couple. I asked Marlene and Steve how things had been going. Marlene appeared more sad than usual and said it had been a difficult week. Marlene explained that a friend from Alcohol Anonymous had committed suicide. At the time of the incident, Steve had taken a risk and asked Marlene if she was okay and Marlene was able to say yes. Steve told Marlene in this session how helpful he found this, because he felt he could put his fears about her emotional well-being to rest. I praised Steve for putting his fears to rest and not pressuring Marlene to discuss her feelings if she wasn't ready. I also praised Marlene for taking the risk to respond to Steve's question of concern. In this session I used a metaphor and encouraged Steve to continue "leaving the door open" for Marlene to express her feelings by continuing to check in with her and suggested that someday she might surprise him and "go over the threshold". Marlene wondered how long Steve would leave the door open if she didn't cross the threshold. With encouragement, Marlene directed this question to Steve who reassured her he could keep the door open until she was ready. I wondered out loud if Steve meant until she felt safe. Marlene then proceeded to discuss her feelings about the suicide. She spoke about her anxiety of going to the first Alcoholics Anonymous meeting after and her fear that

she would have to share her feelings about the death at the meeting. Marlene talked about what she said at Alcoholics Anonymous and what that experience was like for her. Steve told Marlene he was glad she told someone what was going on for her. Marlene also spoke of her guilt about not doing more to help this person because she had talked to him the day before and should have known. I normalized Marlene's guilty feelings and spoke about suicide patterns in the hope that it would alleviate some of Marlene's guilt. Marlene then took a risk and said that Steve had been telling her how to work her Alcohol Anonymous program recently and that made her feel sad and angry. Marlene and Steve were briefly able to discuss this issue with one another. At the end of the session I highlighted what I felt were positive things that had occurred for this couple: the communication exchange outside the session and Marlene's expression of difficult painful feelings in the session today. Marlene had previously spoken about her fear that if she shared her feelings with others they would know the real her, not like her or she'd lose control. I pointed out to Marlene that she had talked in her Alcoholics Anonymous meeting and in session today and she had not lost control. Attempting to challenge Marlene's cognitive distortions would be an ongoing part of my work with this couple. Marlene agreed that some small changes were happening. Given Marlene's negativity, self blaming and hopelessness to date, I found this acknowledgement by her a hopeful sign.

The next session started with Steve discussing how difficult things had been over the past two weeks and how terrified he had been. Steve and Marlene explained that Marlene had been admitted to the Crisis Stabilization Unit for five days due to suicidal

ideation. Marlene's individual therapist had arranged this admission. Marlene talked about not letting Steve come to see her because she was afraid she wouldn't want to let him go or would want to leave the crisis unit with him. I wondered out loud if Marlene was afraid Steve would see "the real her" and not the mask she had spoken of wearing to prevent this. Marlene responded with a slight smile which I took as a positive response to my question.

During her admission, Steve and Marlene had talked on the phone and both been tearful. Steve told Marlene how much closer he felt to her at those moments and why. Again, I chose to highlight the emotional closeness of this moment and Steve's commitment to Marlene no matter what the problem. Marlene spoke of her belief that crying was a "weakness and wimpy". I pointed out to Marlene that this belief was a learned response from her family of origin and the abuser and that although it may have been helpful to her as a child, it was probably not helpful now. We talked about crying being a necessary part of healing and not a weakness. Again, I was trying to challenge Marlene's thinking. Marlene stated that she felt embarrassed and ashamed that she had talked so much with her therapist and Steve at the time of the crisis. This didn't make total sense to me because although Marlene was very guarded, it sounded as if she was quite open with her individual therapist. I explored this further and believe a more salient issue came out, and it was Marlene's fear that this would be the last straw for Steve and he would leave. I directly questioned Marlene about why she thought Steve was still in the relationship. Marlene was able to acknowledge that Steve cared for her. I highlighted Steve's patience and support and pointed out that as difficult as it has gotten

for Marlene, especially recently, Steve was still there. I directly challenged her belief system, by pointing out that the recent crisis and her expression of feelings had not led to Steve leaving. I also pointed out to Marlene that she expressed all these feelings and had not lost control, and her world had not caved in. On more than one occasion Marlene had spoken about such fears and I felt it was important to continue to challenge her irrational beliefs about expressing her feelings. The pattern of Marlene questioning why Steve stayed with her would be repeated several times throughout therapy. In one of my last few sessions with this couple, Steve spoke about his fears about how Marlene was coping because of several stressors in her life. Steve was worried Marlene would have another crisis. Marlene talked about her fear of allowing herself to feel, about being vulnerable, overwhelmed and losing control emotionally. I reminded Marlene of past sessions where she had expressed feelings and she had not lost control. As we continued to talk about Marlene's fears, she went to say something and stopped in mid sentence. I encouraged her to continue the thought. Marlene said something had just popped into her head and she dismissed it as unimportant. I pointed out that sometimes those ideas are the most helpful and insightful. Although Marlene said she was embarrassed, she did say her fear was that if she was to totally open emotionally, she would be "unlovable". Marlene wondered if "worthy" was a better word; that she wouldn't be worthy of Steve's love if she was honest with her feelings. In the next session I tried to connect Marlene's fears of being unlovable to intimacy (physical) but Marlene brought it back to emotional intimacy and questioned why Steve loved her. Again, Steve offered reassurance that he was staying and told her nothing she could go through would shock him or make him leave.

Attempts to ask Marlene what she would need to believe Steve had not elicited much in previous sessions. So in supervision it had been suggested that I try to ask Marlene what percentage of her believed Steve. Marlene was able to say 99% of her believed Steve would stay and I pointed out that she needed to listen more to the 99 percent of her that believed him than the doubting 1 percent. This was an attempt to highlight and help Marlene believe Steve was genuine and cared for her.

Marlene continued to talk about her need to be strong and not let Steve know if she was upset. I questioned whether Marlene thought that Steve actually didn't know she was struggling emotionally. Marlene would often answer questions about how she was doing with "fine", said in a guarded and restricted tone. I labelled this "fine" as a myth for Marlene and suggested that she probably wasn't fooling the therapist or Steve. Marlene was able to state that she felt her feelings "were off the wall" and not normal when things weren't going well. Again, I chose to challenge what I believed was an irrational thought, by pointing out to Marlene that in the time we had been together she had been through some very difficult things and the feelings she shared were normal and valid not "crazy" or "off the wall".

The sessions with Marlene and Steve seemed to continuously focus on helping them to communicate in sessions with the hope that they would begin to carry this outside sessions. Often sessions focused on helping the couple develop communication skills such as speaking directly to each other and not through the therapist. A lot of work was done helping Marlene express her feelings in sessions and challenging the cognitive distortions I believe she had developed because she was a survivor. Marlene's coping

mechanisms had helped her to survive as a child but she needed to move beyond them in order to develop healthier communication and trust in the marital relationship. I believe Marlene's fear of abandonment and her belief that she was damaged were significantly impacting her ability to allow herself to get close to Steve and begin to trust him.

Joe and Karen also identified communication as an issue for them in the first session. They felt that poor communication led to misunderstandings and resulted in a lot of conflict (fighting). A lot of the work done with Joe and Karen focused on basic communication skills, like helping them to listen and to clarify the meaning of what they heard. This became particularly important for Karen who, due to her low self esteem, had a tendency to hear or interpret things negatively. This work often involved basic teaching about communication skills and helping Karen and Joe speak to each other not through the therapist.

In one session early on in the work we were discussing Karen's family of origin history having completed Joe's history in a previous session. Part way through the session Joe asked to leave to go get some more tea. I hesitated when asked this and looked at Karen as if to see if it was okay with her. Karen told Joe to do what he wanted. While I was left in the room with Karen it was obvious her mood had changed. I asked her how she felt and initially she did not seem to want to answer, but said it "hurt" and "made me feel unimportant like he didn't care." Karen was reluctant to share those feelings with Joe when he returned and seemed to minimize the importance of her feelings. However, with my encouragement Karen was able to share clearly with Joe how she felt without the angry tone that has permeated most of Karen's interaction with

Joe in the sessions up to that point. Joe tried to reassure Karen that was not what he intended but needed coaching from me to pay attention to Karen's feelings rather than be dismissive of them. I spoke about non-verbal communication and the idea of intended messages and perceptions (how messages are received). Joe was able to say he needed to think about what he said or did and Karen was able to say that she needed to take a step back and not be as reactive. Karen went on to say she recognized how helpful it would be to let Joe know how she felt, how she perceived the information and then check her perception out with Joe. I also felt it was important to point out that due to her poor self esteem and confidence, she tended to hear and interpret things through a negative filter and that would make clarifying the intended message extremely helpful. The next step would be for Karen to develop trust in Joe so that when he clarified his intended message she could believe him. In hindsight, I should have been more direct with Joe, asked him what he thought Karen's reaction would be to his request to leave the room. Perhaps, Joe would have been able to be sensitive to Karen's needs with some prompting by the therapist. I should not have deferred the decision to Karen who I knew struggled with self-esteem and minimized her own importance. I clearly should have taken control as the therapist and been aware of the impact of Joe leaving the room at that point in time.

Often with Joe and Karen we talked about communication and interactional patterns in discussions about what had happened between sessions and often by debriefing a particular conflict. By the last two sessions with this couple they were saying things were going better and reporting less conflict. They reported a month without "incident", meaning a verbal fight. I felt this was hopeful and I needed to focus

on it to help them see that positive change was occurring. I tried to help them identify what had been different in the month so that I could use this information to build on the positive change. Joe felt that he had been more accommodating and asked Karen if she had noticed. Joe seemed to need validation from Karen and Karen was able to give it to him. Karen had also tried something different by using non-verbal messages to give him hints as to what she wanted him to do. For example, rather than constantly remind Joe to take care of his fish tanks, Karen began to leave Joe's cleaning pails in the front hall as a visual reminder that he needed to take care of the fish. I asked Karen to talk about what was helpful about this and she said she didn't get as caught up in her feelings about what he needed to do and was able to walk away. She also said she got less agitated with him if it took him a couple of days to do something, where as before, continuous "nagging got nowhere" and often led to conflict. It had always been very difficult in my work with this couple to find something positive to build on because often Karen would quickly retreat into her negative, hopeless world view of the relationship with Joe. In this session she quickly retreated to this stance and I needed to work hard to keep the positive focus by asking questions I hoped would help them to do more of the same and move forward.

Often positive type questions elicited a barrage of negative responses from Karen. In one session I asked Karen how she would know things were getting better in the relationship. Her first response was to say "she would have left". I consciously chose not to respond to this as it was negative and then she was then able to identify things she and Joe could do differently that would help. Joe's response to the same question was very similar. Again, I highlighted the strength I saw here; that what each of them felt

were things they could do differently in the relationship were similar and that there had already been improvement because they seemed to be communicating better and learning to compromise. In the last session with this couple it was important to continue to discuss these positive changes and help the couple to consolidate them. We reviewed what had changed and Joe and Karen said being more accommodating and compromising had helped decrease conflict. Joe felt if they didn't compromise "they'd hit a brick wall and fight about everything". Karen said she "couldn't be bothered because fighting wasn't worth it". I felt Karen was stepping into a negative view with this comment and it was important not to let that happen. Karen explained an incident in which she was angry, had yelled at Joe, and called him names, but it didn't escalate into a big conflict. I believe I needed to capitalize on what was different in this situation because it hadn't escalated into a fight. Joe felt it didn't escalate because Karen didn't "push it" and he said he usually didn't escalate situations. I chose to positively reframe this as Karen learning to prioritize what issues were worth fighting about and letting other "less important" things go. I felt this had a more positive sound then the hopelessness of Karen's statement "fighting is not worth it". I praised Karen for having learned this valuable skill. I suggested something must be working because they both agreed there had been less conflict over the past six sessions. Again, I had them try to talk about what was different to help them recognize what was contributing to the positive change in their communication. My hope was that if they could recognize what had contributed to the decrease in conflict to them, they could continue to make positive changes in this aspect of their relationship.

Physical Intimacy

As previously discussed in the literature review, the sexual abuse experience can significantly impact the sexuality and sexual functioning of a survivor (Maltz & Holman, 1987). This can have significant impact on the survivor and her partner and it would be remiss not to discuss this as a theme in couple work with survivors.

This area was a most significant theme for Marlene and Steve. Their lack of sexual intimacy was identified by Steve as an issue in the first session. When this issue was identified by Steve, Marlene suggested she did not feel in control during sexual contact and would "leave emotionally". Trust and safety were issues in this area for Marlene; she felt any kindness shown or contribution made by Steve meant Steve wanted sex (i.e., if he did the dishes). This couple had previously negotiated a "commitment" where they had not had sex for two years so that Marlene could work on her issues in individual therapy. This is a common intervention for survivors to use at a certain point in the recovery process. At the time I met this couple, the commitment had been over for approximately four months. In the first session, Marlene said she did not like sexual contact and that "anything beyond hugging was gross". Marlene spoke about feeling out of control in any sexually intimate situation. She also felt if she said no to Steve, he wouldn't stop. Although Steve had stopped sexual advances when Marlene said no in the past, it was clear Marlene did not trust Steve. The feelings and concerns Marlene shared about physical intimacy are commonly encountered in work with adult survivors of sexual abuse (Maltz and Holman, 1987).

In another session early in treatment we explored sexuality further. Marlene talked about how sexual intimacy had been easier for her when she used to drink because the alcohol numbed all her feelings. I attempted to do a brief sexual history with them and asked some questions to ensure it wasn't a medical difficulty (i.e., was it physically painful). I gently asked very direct questions using appropriate language. Marlene cringed with obvious discomfort at these few questions. She suggested that it was embarrassing and bad to talk about these things. Although I tried to explain that this type of discussion was healthy, I could feel her shame, embarrassment and feelings of guilt. These feelings are common for survivors to experience in relation to physical intimacy.

My sensitivity to Marlene's discomfort may have given me an excuse not to actively pursue this area and allowed me to cope with some of my uncertainty and inexperience in this area of couple work. I believe I may have rationalized my pulling back as being sensitive to Marlene's feelings, and as a result, this issue did not come up again for four months. When checking in at the beginning of a session, Marlene and Steve both agreed Marlene's mood had been brighter except for the last couple of days when Marlene had been "antsy". Steve assumed it was because of a wedding they were to attend and I asked him to check this assumption out with Marlene. She agreed that the wedding was an issue because (1) a friend who had recently lost a daughter would be there and (2) they would be staying in a motel and the last time they had stayed in a motel Steve wanted "intimacy" (sex). Steve said he knew this was why Marlene had been antsy. Marlene felt that the last time they had stayed in a motel she had to say "no" more than once, they both were mad afterward, and it was never talked about again.

Steve tried to assure her he had changed, that he knew no meant no, and that he could respect the first no. I spent some time helping Marlene and Steve talk about this and to negotiate some rules about choice and respect and helping Marlene to trust Steve. The next session they both reported the trip went well but things had been "tense since". Apparently, Steve had made a sexual advance and both agreed he respected Marlene's "no". However, Marlene thought that in the previous session they had agreed there would be no sexual advances at all. She said Steve rolled over after she said no and was still angry the next day. When I asked more about this, I discovered that they had not talked about the weekend since it had occurred. I asked Steve about Marlene's assumption that he was angry and he said it was not about being angry or frustrated. He told her he felt more hurt for her and that "sex wasn't worth it if it put her in so much pain". He told Marlene how painful it was to him to see what she had to go through. I commented on what I thought was Steve's sensitivity and empathy and asked Marlene if she could hear the sensitivity in his words. In working with survivors it is important to help them see their partners as sensitive and supportive. She could see Steve was being sensitive but "she felt guilty and didn't know why he stayed". I then asked them to talk about what they think keeps Steve in the relationship in an attempt to have Steve reassure Marlene, challenge her devaluation of herself and to help them to see hope. I also felt it was important to draw attention to the fact that despite the misunderstanding, when Marlene did say "no", Steve respected that choice. It would be important for Marlene to begin to trust that Steve would respect her especially in this area where she needed to feel in control and safe.

In the last few sessions with Marlene and Steve the issue of physically intimacy was explored again. I had tried to discuss how this couple demonstrated affection in these last sessions and each time the couple shifted to issues around verbal communication. After this happened a couple of times, I pointed it out and wondered why. Marlene talked about her belief that the intimacy and safety needed to come first before physical intimacy. She also spoke about the past, when she and Steve wouldn't get along all day, and her feeling that Steve would expect sex at bedtime. She was able to tell Steve she resented these experiences. When they were asked how they expressed affection to each other they both said they kissed (peck on cheek) in the morning and at bedtime. I suggested this seemed safe for Marlene and she responded jokingly that "in the morning one of the cars is running and at bedtime she could always do laundry until he slept" and she laughed . I felt Marlene's attempt at humour and her laughter were indicative of how anxious she felt talking about sexual intimacy. I suggested that Marlene seemed to like this ritual. She said "it was neat". I suggested perhaps it was safe because these were situations she knew wouldn't go any further and situations where she felt she had some control. I believed that situations where this couple expressed closeness, but where Marlene still felt safe, were important and needed to be highlighted for them. If Marlene and Steve could experience these gestures of intimacy positively, then they could build on these experiences.

In supervision my advisor suggested a simple intervention that I used in the next two sessions. The suggestion was to ask Marlene if it would be okay if Steve moved his chair over and touched her (arm around her or holding hands) while they talked. This

intervention was used to help them demonstrate affection in the safety of the therapy setting. In the next two session I continued to talk about emotional and physical intimacy with this couple. Marlene acknowledged that at this point the only part of physical intimacy she liked was cuddling because she felt she wasn't alone and she felt close to Steve. I asked Steve to talk about how it felt for him to hear Marlene say that and he said it felt "good and hopeful". Steve was also able to tell Marlene that he enjoyed cuddling and felt close to her at those moments as well. I felt this was important for this couple as it was a way they could both feel positively about physical intimacy while at the same time Marlene could feel safe and in control.

In our last session, I continued to explore intimacy, and asked Marlene to talk about safe ways Steve showed her that he loved her. Marlene was able to name a couple of things including backrubs and cuddling. I wondered how Marlene experienced backrubs as safe and she said she would initiate them herself and would do so the day after sex because this gave her a sense of control. I wondered what Marlene would need in order to ask for a backrub anytime and to be able to tell Steve she didn't want sexual contact. Marlene couldn't image herself ever saying those words. Steve spontaneously tried to reassure Marlene that every time he kissed her or touched her he didn't mean he wanted sex. He explained to Marlene that he enjoyed the closeness of other forms of affection and didn't need the sex. They had both clearly stated, more than once, that they enjoyed cuddling and affection without sex. I reminded them of this and the positive feelings they had both shared about this type of contact. I then wondered if this was so positive for them what would need to happen for them to do more of it? Marlene

suggested that if cuddling and touching occurred outside the bedroom this wouldn't lead to sex. Steve could agree to this alternative approach. It was a big step for Marlene to suggest this and gave her a sense of control over this situation. It still left the bedroom as an emotionally unsafe place for Marlene but I felt it was a hopeful sign that Marlene offered a safe way to have more physical contact. I felt this was a very productive session for Marlene and Steve. This couple clearly felt close and connected and wanted and needed more physical contact. If I focused on this issue earlier in the therapy perhaps I would have been more helpful to this couple. Although it took quite a while for Marlene to be ready to have this type of discussion, I should have tested this out sooner.

In the final session with this couple one of the last things Marlene asked me was "what is good healthy lovemaking and how do I get to the point where I enjoy it". This question caught me somewhat off guard because it was quite direct for Marlene. I think I answered it well, but I felt sad for Marlene and Steve. My sadness came from sensing how much it must have taken for Marlene to ask that question and what it must be like for an adult to need to ask such a question. At the same time I was sad that this caring couple couldn't experience this part of a healthy relationship. I also took it as a sign of hope that Marlene asked the question because it meant, I believed, it was where she wanted to get to in her healing. This sadness was probably mixed in with my feelings about terminating with this couple because I liked them and felt that their journey of healing together had just begun. Although my restricted time involvement with this couple limited my ability to do extensive work in the area of physical intimacy, I believe my own anxiety may have contributed to me not pursuing this issue to the fullest. At the

time, I believed I was being sensitive to Marlene's issues and how emotionally damaged she was by her experiences, but I may have protected her too much. I don't believe I contributed to any further damage in this couple's relationship, but I may have limited the potential effectiveness of the therapy by not pursuing this issue more actively in therapy. Generally, I believe it is hard to have a healthy, demonstrative, physical relationship when basic trust, communication and emotional intimacy are so difficult for a couple, especially when one partner is a survivor of child sexual abuse.

Joe and Karen did not identify physical intimacy as a present issue for them as a couple. Karen often spoke about how the initial chemical attraction was what drew her to Joe. Karen also talked about her trust issues with Joe "leering", watching "pornos" and having mental affairs. In the second last session, after consultation with my supervisor, I brought up the issue of sexual intimacy. We had talked all around the issue but not directly about it until this session.

Karen said she had sex because she felt she should and said that Joe was aware of those feelings. Karen was taught in her individual therapy to not have sex if she didn't want to in order to help her to heal. She suggested she had sex "once a year to keep up appearances". I asked Joe if he knew what Karen meant by "her healing" and Joe indicated this had been discussed. Joe said he would like sex more but was "okay with where Karen is at this point in time". I asked Karen if she knew Joe was trying to be patient and sensitive to her needs to help Karen see this as positive and to help her begin to see Joe as an alley. Karen said she could see this, she trusted Joe and knew he would never force her to have sex. As a couple Joe and Karen were both able to initiate sexual

contact. Karen said the sexual experience was better for her when she initiated but she didn't really ever enjoy sex. Karen explained that she would sometimes shut down emotionally and physically during sex. I spent some time connecting this to Karen's sexual abuse experiences and the coping mechanisms that helped her as a child. This was more to help Joe make those connections as Karen had an awareness of survivor issues. Karen was able to tell Joe that if actual intercourse happens too soon in the sexual exchange she is more inclined to shut down.

Both couples had issues in their sexual relationships that I feel were significantly influenced by the survivor's sexual abuse experience. Joe and Karen, though impacted by the abuse, seemed to have some strengths to build on (she could initiate, she could recognize when she shuts down and why there were parts she enjoyed). Karen was probably at a different place in her healing than Marlene. Knowing how significant the impact of sexual intimacy can be for survivors, I should have explored this aspect of Joe and Karen's relationship earlier in the treatment process.

Anger

Anger is a natural response to victimization (Gil, 1992). The emotion of anger can be a particularly complicated emotion with which survivors have to cope. Sexual abuse survivors often fear anger because they may have never seen anger dealt with constructively (Graber, 1991). Their anger often gets mixed in with the feelings of helplessness, powerlessness and loss of control associated with sexual abuse victimization. Often survivors were not able to act out, experience or express their anger

when they were abused. Even as adults, the risk of dealing with the anger directly may be so great that they continue to displace that anger onto those around them, including their intimate partners.

The theme of anger was apparent in my work with Karen and Joe. In the first session Karen acknowledged that she experienced "rages". Karen felt she was disconnected from her anger and often "pinned" it on Joe when it had nothing to do with him. Karen felt that this might be contributing to the amount of fighting in their relationship which was identified as a presenting problem.

After the first couple of sessions, Karen entered the next several sessions angry. She would question the value of the couple treatment and state "I can't talk to Joe so what is the point". She said she "couldn't talk to him because he minimized, rationalized and denied". Karen would say "I hate Joe and it felt good to say that". She would also call Joe names and put him down. Karen would start the sessions this way and the information was often presented in an aggressive manner. Karen always seemed to be in control and her tone of voice didn't escalate but her words were quite striking. I found it very difficult to use this anger productively in sessions as Karen didn't seem to move beyond the words. My attempts to explore the origins of the anger or question if it was related to past experiences tended to result in more anger being directed at Joe. Joe would sit and not respond, even when encouraged to do so. Joe did not seem to get angry or upset.

Several interventions were needed to deal with this situation. First, in one session I needed to label Karen's behaviour as verbally abusive. I told her I could not condone

name calling and put downs as they were abusive and that was not acceptable. Karen seemed to accept this and although the anger continued, the name calling subsided. The next intervention was to state that the week between sessions seemed to stir up issues for Karen and perhaps she needed 5 or 10 minutes at the beginning of each session to vent. It was felt that this would give Karen the message she could control her anger. Also, this intervention was anchored in information Karen had given me the first session about her "rages". She had said she had anger that she pinned on Joe but maybe didn't have anything to do with him. I suggested to her I had been thinking about that information and how insightful she had been. I suggested that she really understood herself and perhaps I should have attended to this sooner but felt this intervention might be helpful now. I further suggested that if she took this time to vent it might be easier to focus on the couple issues. Karen agreed to this intervention but said she didn't need the time that session. In subsequent sessions, Karen didn't present with the initial anger, so time for venting was never used.

Even now, I am not sure what Karen's presentation was about. It could have been Karen putting her feelings about her abuser or her father onto Joe, but early exploration of this didn't confirm this hypothesis and seemed unproductive. Karen described a history of mood lability where her moods could change within minutes. Karen also described a history of depression. Both these mood difficulties could have contributed to her irritable presentation in these situations. On one occasion, Karen attributed the presentation to nicotine withdrawal because she was trying to quit smoking. Regardless of the reason for her presentation I did feel I had to draw clear boundaries around what

was acceptable and non-acceptable behaviour in session. It would not be helpful to allow Karen to take on the role of aggressor.

On several occasions, Karen did present with what I felt was projection of her anger. In our first session, Karen said Joe was "hillbilly". This statement did not seem to have a context and was part of Karen's angry presentation, so I chose not to explore it that day. It was not until Karen shared her family of origin history that this statement began to make sense to me. Karen's mother had left her father to live with "a mountain man in a run down shack". This man was also the person who abused Karen. In several subsequent sessions, Karen talked about Joe as a hillbilly, who lived like a bum, never threw anything out and kept an old non-working van (eye sore) in the parking lot. These themes came up in various sessions and the energy Karen put into the content seemed out of proportion to what the present issues were each time. It took me several sessions to make a connection and wonder out loud whether Karen was more angry at her abuser than Joe. Karen thought about it but did not respond. I pointed out the parallels I saw, the mountain man and hillbilly, the run down shack and Karen's fears about Joe's laissez faire attitude about their home and the van. A small light bulb seemed to go on for Karen and she agreed this might be an issue. Over time, Karen agreed more strongly with this and I told her she would need to separate out her feelings for Joe from the abuser, and to place the anger where it belonged, with the abuser. I also talked about early trauma and projection as a defence mechanism and told Karen and Joe that it was a normal coping strategy but still needed to be addressed. I stressed for Joe how important it was to not take the anger personally and blame himself when Karen's feelings seemed unrelated to

him. Graber (1991) suggests the partner can be directed to encourage the survivor to find constructive ways to deal with her anger. Although we talked about constructive expression of anger in session, I felt this situation was too volatile to direct Joe to prompt Karen at home in the heat of the moment.

Towards the end of treatment with this couple Karen talked about issues she had with Joe and each time slipped into talking about her father. Karen had described her father as verbally abusive and as someone who put her down. It was important to help Karen sort out what issues were related to her father and what was really about Joe. I also explored with Karen triggers for her (things Joe might say or do that perhaps triggered feelings about her father). Karen was able to say that when she felt Joe was insensitive to her and did not validate her feelings, this would trigger emotions connected to her past. I did a very concrete exercise with Karen and Joe asking them to go through one of these trigger situations. I coached Karen on how to clearly express her feelings and needs and how to separate current issues from the past. I coached Joe on how to use sensitive and validating statements. This was an exercise I had used with them before and it was helpful. It was important to help Karen sort out her feelings about her past and her current relationship with Joe. It would be important for Karen to resolve her issues about her childhood abuse but my focus in sessions was to help Joe and Karen understand this process. A goal was to separate the couple issues from the past and work on their relationship.

When I began to work with Marlene and Steve, Marlene spoke about how she was angry all the time and how every emotion she had "turned into anger". Marlene said the

anger was there all the time and if she let the anger out she was afraid she would lose control. However, Marlene spoke about the anger in an emotionally removed, intellectual way and she did not look or sound angry. Marlene appeared more anxious and sad than angry in sessions. Steve didn't describe Marlene as angry at home but did experience Marlene as unhappy. I wasn't sure what to make of this; maybe Marlene was so well defended against her anger that she presented it in an emotionally removed way. I also wondered if her identification with the anger was a protective shield that kept everyone at a distance. Marlene agreed that being angry could serve this purpose because "if you got too close to people you would care and that hurt". I shared with Marlene and Steve that anger was a normal response and perhaps the anger had served a purpose for Marlene as a child because it had protected her and helped her survive the abuse. I felt that in order for Marlene to move forward, it was important for her to learn to let down her guard emotionally in ways she could still feel safe.

Over the next several sessions Marlene described situations where the predominant feeling didn't appear to be anger. Each time a situation came up I would ask Marlene about her feelings, often actually suggesting what she might be feeling based on her presentation. Hopefully, this introduced her to the idea that she had other feelings besides anger. As with many survivors, Marlene did not appear to have a vocabulary for a range of feelings and perhaps this was why she felt she only experienced "anger". Over time, Marlene gradually began to use other feeling words when she discussed situations in her life.

Marlene had mentioned her fear of losing control if she got angry several times in the early sessions. She felt this fear was connected to how she had handled anger earlier in her life (physically on two occasions as a child) and to her fear of going "crazy" if she expressed her anger. After a situation in session where I felt Marlene had been angry with Steve and directly expressed that anger to him I pointed out that she'd been angry and had not lost control or gone "crazy". I thought this was a beginning step in helping to change what I felt were Marlene's cognitive distortions about her anger. At this point, it was obvious that anger was not the only emotion Marlene felt and that she could express in a productive manner without "losing control".

There seemed to be less talk of anger over time as Marlene talked about other feelings. About four months into our work, Marlene talked about the anger as an "edginess". In discussion with my supervisor we talked about helping Marlene not give so much power to the anger. In an attempt to do that I reframed the anger which that day was described as "edginess", as "agitation or irritability" . Irritability is a common symptom of depression and Marlene was being treated for depression. I hoped this might take some of the power out of the emotion of anger for Marlene. I also suggested that partners of survivors have a tendency to blame themselves for the confusing moods of survivors and that it was important that Steve not take Marlene's change in moods personally. I wanted Steve to learn to be more of an ally to Marlene and therefore ask her what Steve could do to help her at these times. Marlene suggested that Steve could not feel responsible, accept her limited response and not pressure her to talk. Although Steve continued to struggle with his feelings of helplessness he could agree with

Marlene's suggestions. However, Steve also asked Marlene to tell him when her mood had something to do with him. I believed this was a reasonable request and Marlene agreed "to try".

Towards the end of treatment with this couple, Marlene spoke of losing control emotionally. At this point in treatment it was not in reference to anger, but to crying which she saw was a sign of weakness. I felt this was a significant shift for Marlene. By then she had cried in sessions and not "lost control", but she still struggled with her need to be strong. I believe this shift signified that Marlene no longer needed anger to feel safe and was allowing herself to be more vulnerable.

Power, Control and Safety

A well documented impact of child sexual abuse is the sense of powerlessness and lack of control that victims feel (Bass & Davis, 1988; Gil, 1992). The perpetrator usually is stronger and more dominant than a child victim. Often the abuse occurs before the child had learned about his or her own sense of power and control and therefore can damage the survivor's ability to establish healthy exchanges of power and control (Gil, 1992). Gil (1992) defines "personal power as a broad concept that includes the ability to speak, ask, negotiate, invite, demand, develop feelings of safety, adequacy, self control and self-esteem" (p.73). Survivors often have difficulty with balancing power and control. They may respond by needing absolute control over every aspect of their lives, including the marriage and children, in order to feel safe. On the other hand, they may continue to feel powerless and passively relinquish all control by not

participating in decisions, future planning and developing goals in the relationship (Bass & Davis, 1988). Both of these coping strategies can have a significant impact on the balance of power in the couple relationship.

It is difficult to choose specific moments in my work with Marlene and Steve to illustrate this theme because I believe for Marlene, the feelings of powerlessness, fear of losing control and personal safety permeated virtually every session. I felt I was continuously working in ways to help empower Marlene and to help her feel emotionally safe in sessions, while at the same time encouraging her to take risks. Marlene presented almost every thought she had as unimportant or stupid. It was very difficult to help Marlene talk about her needs in the relationship because I believe her poor self esteem and sense powerlessness coloured her perception of her contribution to the relationship. To this end, it was important that Marlene had control over whether she talked or not, what she said, or didn't say, and that she could stop talking about any issue at any time. It was important to educate Steve about Marlene's sense of powerlessness so that he could learn to be more patient and understanding. This is not to say that Marlene wasn't gently pushed to express herself and say more each week. Marlene's feelings were validated continuously and Steve was encouraged to give her messages that were encouraging and respectful. Towards the end of therapy, Marlene was able to tell Steve the things in his style of communication (i.e., sarcasm) that she felt reinforced her internal tape recorder or poor self-esteem. It was an important step for Marlene to look beyond her sense of self and self-blame, and to connect that to current patterns in her marital relationship.

Marlene talked in sessions about how she felt Steve dominated her and controlled her by his moods and decisions. Marlene felt Steve made her mind up for her and I believe this was connected to her sense of powerlessness. In our first session, Steve acknowledged he had been more domineering in the past but had worked hard to change that and to change his expectations of Marlene and their children. He said he could deal with anger more constructively. As I spent more time with Marlene and Steve, Marlene's initial description of Steve became more and more confusing for me. Steve presented as patient, caring, and sensitive, Steve tried or seemed to say the right things. I can't say I wasn't worried, at times, that I was missing something in my assessment of this couple. Even Marlene's individual therapist thought there was something "serious going on in the relationship". This couple denied any history of physical violence and nothing in sessions led me to have concerns about this as a therapist. On several occasions I began to question my assessment of the couple and had to discuss this in clinical supervision. The clinical supervision helped reinforce my assessment, but I could still not make sense of Marlene's perception of Steve's control issues.

The more time I spent with this couple the more I hypothesized that Marlene was giving away her power and control and then getting angry at herself and putting those feelings back onto Steve. Over time, it became apparent that Marlene allowed Steve to make most of the decisions and when she did have to make a decision she always questioned herself and felt her decisions were wrong. Marlene talked about her own "internal tape recorder" telling her what she had to say to Steve wasn't worth it. I began to challenge Marlene, by suggesting every time she listened to that inner tape recorder

she was giving away the power not to Steve but to the tape recorder. It was the tape recorder that stopped her from telling Steve her ideas, and contributing to decision making because it seemed like the tape recorder doubted her, not Steve. We had used the metaphor of the negative messages on the internal tape recorder many times before. Marlene was able to say she needed to stop listening to those messages and she agreed she might be giving away her power and control. Over time, Marlene was able to share her opinions, decisions and thoughts with Steve in session. However, this would occur in debriefing a situation in sessions. Marlene still needed to be direct with Steve as each situation arose in their lives.

I have already discussed Karen's anger at length, however it is important to point out that the name calling and verbal battering is a misuse of power and control. For Karen it may have been the only sense of power and control she felt in her life, but it was still not productive or acceptable for her to treat Joe in such a manner. It would be important for Karen to experience a healthy sense of personal power and control.

The theme of safety and power came up in my work with Joe and Karen between the third and fourth session. Although it could be related to Karen's early sexual abuse victimization, I believe this issue was more connected to Karen and Joe's family of origin experiences with conflict resolution, verbal and physical violence. The night before the fourth session Karen and Joe had a fight. The fight was about a similar theme that I had heard before, Karen trying to sleep and Joe staying up late at night. This verbal fight escalated and physical aggression was used by both Joe and Karen. Their versions of the events were slightly different, which is not unusual in these circumstances, but they

agreed they had both been physical. Joe presented for the session with a black eye that he said resulted from Karen punching him. She said she had been defending herself. I separated them, spoke to each of them about the incident and safety. I told them violence was not acceptable and discussed safety plans with each of them individually. Karen had chosen not to charge Joe the night before and she did not want to go to a shelter but was aware of this resource. I met with them together to go over both sides of the safety plan to which they agreed. I also told them I was not sure I would be continuing couple work in light of the violence and I would need to consult with my supervisor about this. We scheduled an appointment for the next week because no matter what the clinical decision I wanted to tell them in person.

This was a dilemma for me. Most of what I'd ever read about domestic violence recommended against working with violent couples. It was confusing because my previous experience with domestic violence seemed clearer; the women had not responded physically not even to defend themselves. I met with my supervisor prior to the next couple session. We discussed the history of violence in this relationship. Both Karen and Joe agreed the violence had been worse earlier in the relationship. Prior to this violence there had been an incident three months earlier and then not one for over a year before that one. My supervisor and I agreed that in the next session I would separate them again and assess the safety they felt in the current relationship. I needed to assess Joe's sense of whether he could control himself or not and assess the degree of his denial and minimization about the violence. It was felt that this assessment would help me make a decision about whether to continue couple work or not.

When I met with Joe individually, I felt he took responsibility for his aggression and was aware that he could be charged for the violence. He seemed to understand some of the dynamics and was able to say that if he feels his buttons are being "pushed" it's his responsibility to stay in control no matter what. I felt he showed genuine remorse for the violence. Joe was aware of some of the physical signs that he might be getting tense or agitated and could agree to leave the situation should this be the case. Karen said she felt safe with Joe most of the time. I was concerned that Karen was blaming herself because of statements such as, "I caused it because I was at him" or "it only happens when I'm in a rage". Karen said she didn't feel in control if she was in a rage. Karen said that "if I spit or hit him first he would hit me back".

My supervisor and I discussed this incident and the decision to continue couple work or not. I wondered if I was feeling I wanted to continue to work with them for the right reasons. After the initial incident they said the didn't want to end and start over with someone new. Was I responding to their need? I also liked this couple and felt I'd joined with them. After much discussion we decided that I would continue the work. In the next session I told Karen and Joe that I would continue to work with them and clearly laid out that violence was not acceptable and if it happened again it was a sign I couldn't work with them anymore. I also told them any person who hits is 100% responsible no matter what. They also had to follow the safety plan to separate when Karen is in a rage or a fight was escalating. Karen and Joe agreed to all of this and I continued to check in with them each session regarding any violence that may have occurred. I can't say I

didn't question whether I'd made the right decision especially in the next several sessions, but there were no further incidents of physical violence reported by the couple.

Intrapsychic Issues

I have discussed the types of intra-psychic damage that can occur as the result of the trauma of early childhood sexual abuse in the literature review. It is difficult to separate out specific session highlights that illustrate this because I believe that intrapsychic issues influenced every session with these couples.

Despite the degree of long term effect, I believe that to have survived the abuse at all demonstrates strength in all survivors. Of course, the survivors do not always believe that themselves. Both Marlene and Karen presented with what I believe were a lot of intrapsychic issues. Both described and exhibited little or no self esteem throughout my work with them. I believe that this lack of self-esteem and their self-blame strongly influenced the way they received and interpreted any information. An initial goal with them was to decrease some of their presenting anxiety and help them see hope about themselves or the relationship by continually drawing attention to anything positive. It was fascinating to see how "skilled" they were at taking even the simplest positive message and filtering it in through their negative self image so that perceived messages became an affirmation of their self worth. This occurred whether it was me or their partners who had given a positive message. I had worked with a lot of adolescents and adults with poor self-esteem, so I was familiar enough with the pattern not to continually question what I'd said or intended in my work with these women. However, this doesn't

mean that I was not sensitive to their needs and didn't review my choice of questions or phrases as I worked with these women. Early on with both couples I used the metaphor of an internal tape recorder that filtered all these messages in a negative way and also played negative messages for the survivor. Both Karen and Marlene accepted this metaphor and each time I believed they misperceived a message, I reminded them of the tape recorder and I restated clearly the intended message. I also had the partners clarify and repeat their messages. I am not surprised that a lot of my work with these couples was around communication patterns, given Marlene and Karen's pattern of negatively interpreting information and their belief that they couldn't contribute to the relationship because they were "unimportant" and "damaged". I would like to say I felt their self esteem significantly changed over the course of therapy but I don't think it did. In the end, they could identify when they were misinterpreting something and would refer to the negative messages, often before I did. I saw this as a slight cognitive shift for each of them.

A lot of energy in each session seemed to go to decreasing the survivor's anxiety in the room and trying to help her feel better about herself. I felt with the male partners there was a continuity of joining each session whereas with the survivors in the first six sessions it felt like I was starting from the beginning. With Marlene I found this particularly difficult. I think her issues with trust and fear of emotional sharing influenced her ability to join more initially. The partners seemed easier to join with and I often had to watch myself so I didn't focus too much on the survivor in sessions and

alienate the partners. Conversely, I had to be careful not to rely too much on the partners just because they were more verbal and open.

Of the two survivors, Marlene seemed more obviously damaged. As stated previously, Marlene was under the care of a psychiatrist and had been on several different types of antidepressants. Despite the medication Marlene still struggled with depressive symptoms and felt the medications weren't having the desired effect. Part way through my work with this couple Marlene's medications were changed to a prescription medication commonly used for manic depression. Marlene experienced suicidal ideation, did not eat properly, did not sleep well and on one occasion had what appeared to be self inflicted burns on her arms during the course of my work with her and Steve. Steve would bring up his concerns for Marlene's self care and healing and would talk about his feelings of powerlessness and helplessness related to her recovery. I hypothesized that Steve might be angry with Marlene for not taking care of herself (eating, taking medications) and perhaps, because of that, had some resentment that she wasn't healing as quickly as he wanted. I asked Steve about this and Steve confirmed that this was what he was feeling. It frustrated Steve that Marlene wasn't doing what she could do to heal. In response, Marlene felt Steve was like a "father - watching over her". I talked to this couple about the idea that sometimes it seems likes survivors sabotage treatment but that generally it happens because of the intensity of the feelings at certain stages of recovery and their need to control the recovery process. I felt it was important to help Steve remove himself from feeling responsible for Marlene's mental health and individual healing. I told Steve directly that Marlene alone was responsible for her life,

healing and mental health. I validate Steve's feelings of helplessness but told him ultimately Marlene was responsible for her own individual healing. I suggested to Steve that if he allowed Marlene the necessary control over her healing and was patient, in time he might see the benefits of her improved self care. Although I realize that an individual's mental health influences the family, ultimately I believe the individual has to be responsible for getting better and other family members can only be responsible for their own reactions to the situation.

I struggled with the couple therapy process because at time I felt I was doing more individual survivor treatment than couple work. I believe this was related to the needs of the survivors, but wonder if this may have occurred because I was more experienced with survivors work than couple work. I don't believe this was necessarily detrimental to my work because it was important for the partners to understand the impact of the abuse and the process of recovery. I also believe that I was modelling to the partners how to be nonjudgemental and supportive of the survivor. I did work to keep a balance between focusing on the survivor's issues, the partner's issues, and how marriage is interactional. However, at times, this was a difficult balance to maintain.

In this chapter I have discussed five themes which I experienced in my work with both these couples. I have discussed process highlights from sessions to illustrate these themes and discuss the interventions I used. I do not believe that these themes are the only themes a clinician will encounter in working with couples where one partner is a survivor and I believe that clinical work should be influenced by the issues each couple presents in therapy and not necessarily by their individual histories.

CHAPTER 5

CONCLUSIONS

Common Themes in Theory and Practice

Many survivors show a marked impairment in their ability to trust others, due to the betrayal they suffered as childhood victims of sexual abuse (Courtois, 1988). The ability to trust is essential and necessary in order to establish interpersonal relationships (McCann, Pearlman, Sakheim & Abrahamson, 1988). This betrayal of trust may manifest itself in a number of ways, including intense fear of betrayal or abandonment, anger and rage towards past or potential betrayers, lack of trust in self, isolation, and withdrawal (Courtois, 1988; McCann et. al., 1988). This difficulty can become generalized to include all people and the feelings of distrust may be more intense in the survivor's closest relationships (McCann et. al., 1988).

I believe that for the couples I described in this practicum report, the difficulty with trust was an issue in the couple relationship and in the survivor's relationship with the therapist. The difficulty with trust that Marlene experienced manifested itself in the length of time it took her to begin to trust the therapist and to trust herself enough to begin to express her thoughts and feelings in session. I believe Marlene's constant questioning of her husband's commitment to her may have reflected her need for

reassurance that he would not abandon her or betray her, especially if he knew how "damaged" she really was as a person. Karen presented in a similar manner. Karen often questioned her relationship with Joe and would also bring up issues of trust that I believe reflected her own fears of betrayal and abandonment. Karen's focus on Joe's "leering", treatment of women and how she mixed her views on Joe in with her views on men and the objectification of women could be interpreted as a general distrust of all males in response to her early childhood betrayal. I found that in my work with both these couples it was important to help the women experience their husbands as trustworthy and believe that they were allies in their recovery process. It was important to pay attention to what I felt were the positive qualities these men portrayed and the strengths in the relationship, to help these women begin to trust their husbands. I chose the words *begin to trust* purposefully because I believe my work with these couples represented only the beginning stages of the women beginning to trust their partners.

Bass and Davis (1988) define intimacy as "a bonding between two people based on trust, respect, love and the ability to share deeply" (p.324). For many survivors intimacy is scary, and learning to tolerate intimacy and caring is a challenge. Communication, or the sharing of thoughts and feelings, provides the foundation for developing an environment of trust, safety and intimacy (Bass & Davis, 1988). Sexual abused children are traumatized at a point when they have not learned to cope with strong feelings (Gil, 1992). Consequently, as adults survivors, they may be unable to identify strong feelings or cope with them in a healthy and productive manner. The difficulty

survivors have with intense feelings, communication, and intimacy can impact their relationship with their partners.

One of the intense emotions that survivors sometimes have difficulty dealing with is anger. Gil (1992) suggests that anger can be "one of the most frightening, confusing, paralyzing and uncomfortable feelings" for survivors (p.7). Graber (1991) explains that "sexual abuse survivors often fear anger because they have repeatedly been victims and have never seen anger used constructively" (p.52). When the risk of expressing the anger or acting upon it is too great, the survivor may learn to deny it, suppress it, displace it onto something or someone else, or turn it inward (Graber, 1991; Bass & Davis, 1988). Survivors need to learn to identify and express their anger and direct it where it belongs, usually with the abuser and those who didn't protect them as children.

Both of the couples described in this report identified communication as one of the presenting problems in their relationship. For Marlene and Steve, the problem was a lack of sharing and openness in the relationship. Initially, it was very difficult for Marlene to identify her feelings, never mind express them. Marlene could say she felt angry, although it quickly became evident to the therapist that her stated anger did not match her presentation in session. I believe Marlene's strong identification with anger helped her to feel safe and allow her to think she was keeping people at a distance. Marlene didn't get too close to anyone that would hurt or betray her. An important part of the work with this couple was helping Marlene to identify and express other feelings and let go of her identification with anger. It was also necessary to change Marlene's cognition that if she expressed her feelings she would go "crazy" or "Steve would leave

her". The next step was helping Marlene to begin to talk to Steve directly about her thoughts and feelings. In turn, this allowed Steve to be supportive and not feel left out. Like some partners of survivors, Steve seemed to resent the fact that Marlene could talk to her individual therapist but not to him. As a therapist, I had to point out to Marlene when Steve was being sensitive and supportive so that she could experience her husband in that way herself. The themes of communication and emotional intimacy were at the forefront of all my sessions with Marlene and Steve. I believe the fact that Marlene and Steve were able to discuss intense feelings in sessions was a hopeful sign that they could communicate outside the context of therapy. Although Joe and Karen also identified communication as an issue, the difficulty presented itself differently with this couple. They described how their communication difficulties led to misunderstandings which became open conflict. Both Joe and Karen were distressed by the amount of fighting they were experiencing at the time I met them. Karen and Joe needed to learn a healthy, constructive and safe way to deal with the conflict in their relationship. Karen's tendency to displace her anger about her past abuse and the offender onto Joe needed to be identified for her. Karen was then helped to separate out feelings related to the abuse from her feelings about her current relationship with Joe. The work could then focus on helping this couple develop basic communication skills and conflict resolution.

Often when children are sexually abused, the abuse can become connected with the child's need for nurturance and affection (Bass & Davis, 1988). The survivor may have difficulty sorting out the need for affection from the fear and strong feelings that may have become associated with sex. Survivors may experience a wide range of

difficulties with physical intimacy and sex that are natural and reasonable responses to the abuse (Bass & Davis, 1988). The survivor's work to recover their sexuality may be long and painful, and the partners need to be helped to understand the impact the abuse may have had on the survivor, and how that affects their current relationship.

As I previously discussed in the process chapter, sexual intimacy was an issue for both of these couples. Marlene and Steve identified it as a presenting problem whereas Joe and Karen discussed this aspect of their relationship when I began to explore the topic late in the therapeutic process. Before I began this practicum I had an understanding of the long term impact of sexual abuse and issues for adult survivors in the area of sexuality. Given this knowledge, I should have asked about sexual intimacy sooner with Joe and Karen, as this would have allowed more time in therapy to explore the issues and help this couple in this area. Sexual intimacy was an ongoing theme for Steve and Marlene and came up at various points throughout therapy. Again, I could have taken a more direct role as a therapist and addressed this issue more in sessions. I do believe the focus on emotional intimacy and safety with Marlene and Steve was valuable as it can build the emotional foundation for increasing emotional intimacy and the safety for sexual intimacy.

One after-effect of childhood sexual abuse can be the survivor's feelings of powerlessness. At the time of the abuse, the child victim has not usually had the opportunity to learn about personal power or been allowed to experience a healthy balance of power in relationships (Gil, 1992). Survivors may have difficulty coping with the feelings of powerlessness and lack of control. Some survivors may need to control

everything in their lives while others may give away all the power and control in their significant relationships (Bass & Davis, 1988). What was once a means of survival can become an unhealthy coping strategy or as Bass and Davis (1988) say, "an entrenched habit" (p.331). These survival techniques are maintained because they have given the survivor a sense of power and control and safety in their lives, but can contribute to difficult, destructive patterns in intimate relationships.

These themes of powerlessness, control and safety were present in my work with both couples. I believe Marlene's sense of powerlessness, coupled with her poor self-image, contributed to her experience of Steve "being in control". I do not want to minimize the fact that Steve acknowledged being emotionally controlling in the past, but in my work with them, I did not experience Steve as controlling. I did feel that Marlene often gave away the power by listening to her negative self talk. Marlene needed to value what she could contribute to the relationship, offer her opinions to Steve and experience Steve as supportive of her input. The theme of control and safety was also evident in how Marlene handled situations where Steve would make sexual overtures. Marlene felt safe in the situations in which she felt in control. For Marlene, this meant situations where a goodby kiss or backrub couldn't proceed any further sexually. Marlene's feelings of safety and control in these situations were used constructively to have the couple identify what they liked about the closeness in these situations and by encouraging them to participate more in the safe type of intimacy.

The themes of power, control and safety with Karen and Joe were discussed in the process chapter in relation to the incident of physical violence that had occurred. I

believe this pattern of violence was connected to both Karen's sexual abuse victimization and both Karen and Joe's family of origin. These themes were also addressed when some of Karen's verbal behaviour in the initial sessions was labelled as abusive. Karen felt powerless when she was abused and felt powerless even in her current relationship with Joe. Perhaps the verbal abuse gave her a sense of power. However, this behaviour could not be condoned by the therapist and Karen needed to experience healthy personal power in her life

The feelings of guilt, shame, embarrassment, powerlessness, helplessness, distrust, and betrayal that survivors often struggle with as adults, can manifest themselves in unhealthy coping mechanisms and psychological sequela. This psychological sequela can include depression, anxiety, poor self-esteem, suicidal ideation and attempts, self-destructive behaviour, addictions, and dissociative symptoms (Briere, 1992; Courtois, 1988).

I believe that Karen and Marlene both experienced psychological difficulties that could be attributed to their early childhood trauma. In the initial sessions, Karen's mood fluctuation would often set the tone for how the sessions would proceed. One week she could present as angry, hopeless, and self-deprecating, the next bright, hopeful and positive, but always self-deprecating. Both Karen and Marlene's poor self-esteem made it difficult for them to see their own value and to believe that they had anything they could bring to the couple relationship. Their self image influenced the way they saw their partners and interpreted information. Initially, the focus in therapy needed to be on ensuring they were not negatively interpreting information from the therapist or the

partners, perpetuating their own need to self-blame. Throughout my time with Steve and Marlene, Marlene struggled with depression, episodes of suicidal ideation and self-destruction. The challenge was helping Marlene and Steve see the strength and hope in their couple relationship, despite Marlene's individual difficulties. Another goal was to help Steve let go of his need to "fix" Marlene and his resentment that she wasn't taking better care of herself. Steve needed to understand that Marlene was responsible for her own individual recovery, and that recovering is a slow process. Although the women had significant individual issues to cope with, I do not feel these individual issues precluded the use of couple therapy.

Learning Benefits

This practicum experience has broadened my theoretical and clinical understanding of survivors and couple therapy with survivors and their partners. Given the well documented information about the long term impact of childhood sexual abuse, I was quite surprised about the lack of information written about couple work with survivors. Most of the information written has focused on helping the partner understand the recovery process and how to support the survivor. Though helpful to partners, I found this information rather limited when it came to understanding how to work with couples.

I learned that it is very important to balance the focus of the couple work between the survivor's issues and couple issues so as not to further stigmatize the survivor. I also learned maintaining this balance is a challenge because it is easy to get drawn into

focusing too much on recovery work with the survivor. Initially, the language and work of recovery was much more comfortable for me because I had more experience in that area. It was necessary for me not to get stuck where I was comfortable and to focus on the couple dynamics, not just the survivor issues.

In working with couples where one partner is a survivor the therapist needs to be aware of the risk of attributing too many or all of the difficulties to the child abuse experience. Although early sexual abuse may significantly impact a survivor, the couple may present with issues that are common for all couples and not necessarily related to the abuse experience. If the therapist keeps an open mind to what issues may be related to the current marital dynamics it may help prevent them from focusing too much on the survivor.

I found both Marlene and Karen significantly impacted by their experiences. Though both were survivors, I believe they each carried many issues with them from abuse. I learned is that despite these significant individual issues, it was possible to do couple's therapy. Previously I might have thought these women were too "intrapsychically damaged" to cope with or benefit from couple's therapy. However, I believe that this couple work was valuable, and provided these women with hope that things could change.

This practicum experience also gave me the opportunity to learn some things about myself as a therapist. I learned that not only can I do couple's therapy, but I enjoyed the challenge of this type of therapy. I also learned that my own clinical belief system changes over time. As I mentioned previously, perhaps my background in

psychiatry led me to believe that psychologically traumatized people benefited more from individual therapy and could not cope with, nor benefit from, couple therapy or family therapy before the individual issues were addressed.. While I believe that individual therapy is important in the recovery process, I now see that there is a role for adjunctive couple's therapy with some survivors and their partners. Even if couples aren't ready for ongoing therapy, then I believe at the very least, the partners could benefit from some form of therapy and education about sexual abuse and the impact on survivors. I would need to work with more couples to truly understand what the criteria might be for deciding when the couples could benefit from couple therapy. I do know that couples I might have screened out because the women were too "damaged" I would now be more inclined to include in couple treatment.

I had co-facilitated a survivor's group for adolescent females for seven years. My co-therapist was always a male and I felt comfortable with any aspect of the sexual abuse experience that these adolescents discussed. I found that working with adult survivors and their partners was a different experience for me emotionally. I still had the intellectual understanding of the impact of the abuse, but I found that the adult survivors impacted me more emotionally. Perhaps, like some survivors, I wanted to believe that with adult survivors the pain and impact would lessen over time. I felt myself experiencing their pain and feeling sad that the survivor's experiences were preventing them from enjoying healthy, happy, intimate relationships. I learned that I could feel their pain and still be a good therapist. I learned I could be hopeful, despite the

difficulties these couples were experiencing and despite how hopeless these survivors felt about themselves and their situation.

I also learned that being comfortable talking about sexuality with adolescents and with parents in the context of adolescent doesn't necessarily mean I was as comfortable talking about sexuality in the context of couple therapy. I believe that this anxiety will dissipate as I gain more experience in this area. However, I would also need to learn to balance my need to be protective of the survivor and her comfort level in this area, with the need to focus on this as an important aspect of couple work with survivors. I don't believe couple therapy would be complete without some exploration in this area to assess whether there are difficulties. The limited reading I did in the area of sexuality and couple's therapy made me realize I have a lot to learn theoretically and clinically in this aspect of couples therapy.

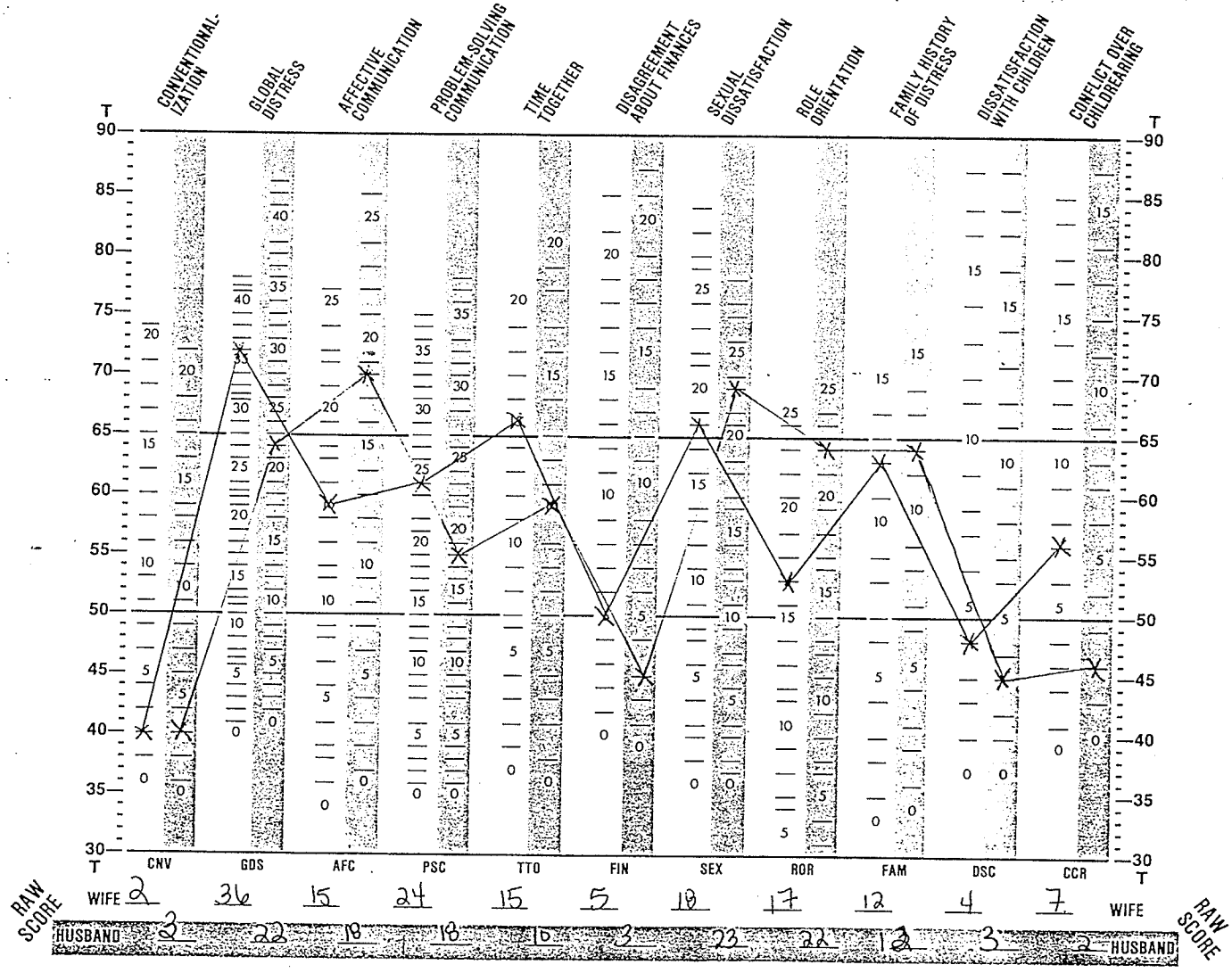
Overall, I believe this practicum experience met my learning objectives. I believe that I increased my theoretical and clinical knowledge of adult survivors and the impact of the sexual abuse on the couple relationship. In addition, I learned about some of the clinical differences in working with adolescent survivors and adult survivors of child sexual abuse. I believe I increased my knowledge of couple work in general and specifically where one partner is a survivor. I also believe I developed assessment and clinical skills in the area of couple's therapy with survivors and their partner. I believe that using pre and post clinical measures has provided me with an introduction to the use of measures in clinical practice. The number of couples I worked with limited my exposure, particularly in the area of scoring and interpretation. I do believe in the

importance of measures in clinical practice and I hope I have the opportunity to build on the experience gained during this practicum.

APPENDIX A

THE MARITAL SATISFACTION - PRE-TEST PROFILE COUPLE ONE

Marital Satisfactory Inventory - Pre-Test Profile Couple One



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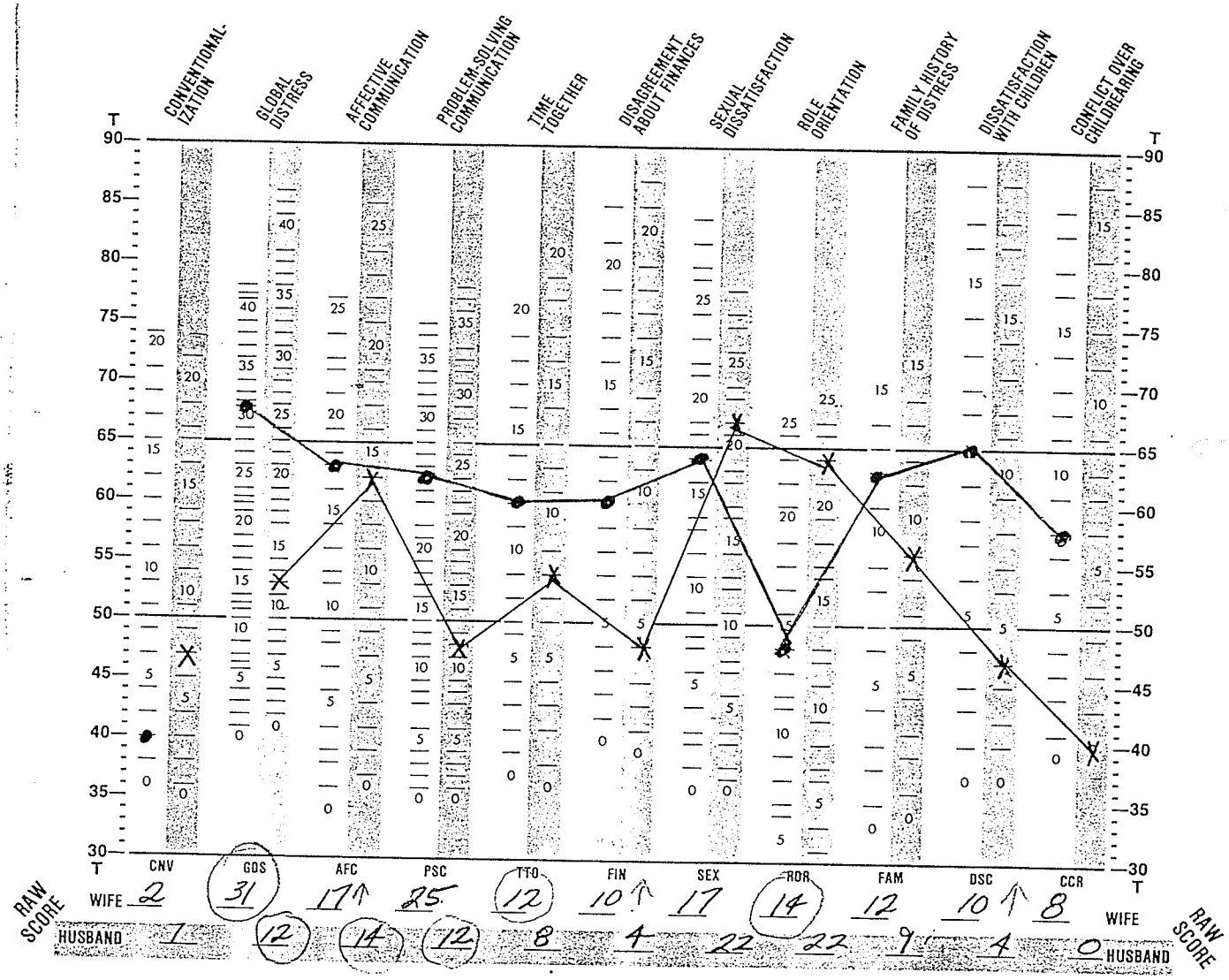
APPENDIX B

THE MARITAL SATISFACTION - POST TEST PROFILE COUPLE ONE

Marital Satisfactory Inventory - Post Test Profile Couple One



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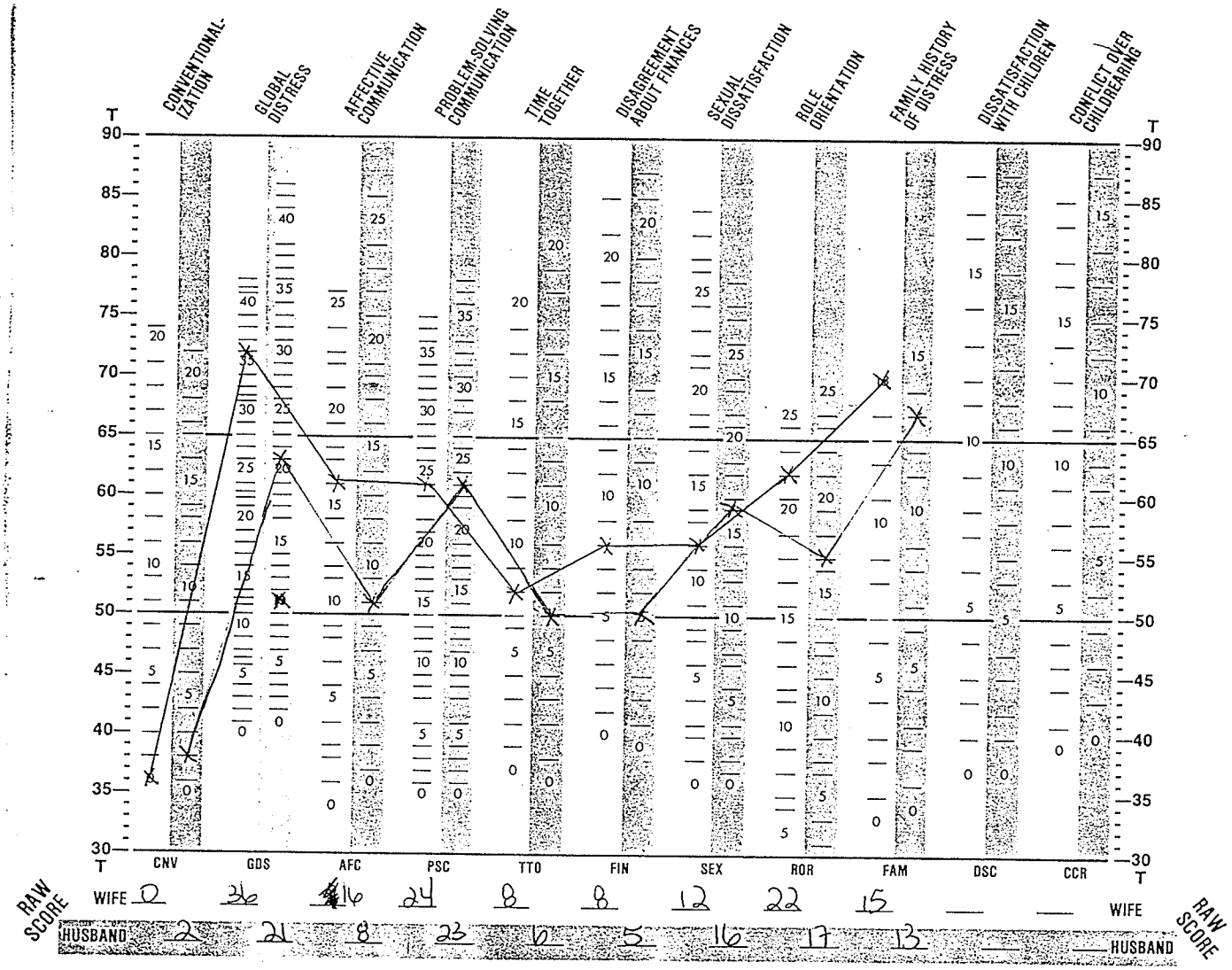
APPENDIX C

THE MARITAL SATISFACTION - PRE TEST PROFILE COUPLE TWO

Marital Satisfactory Inventory - Pre-Test Profile Couple Two



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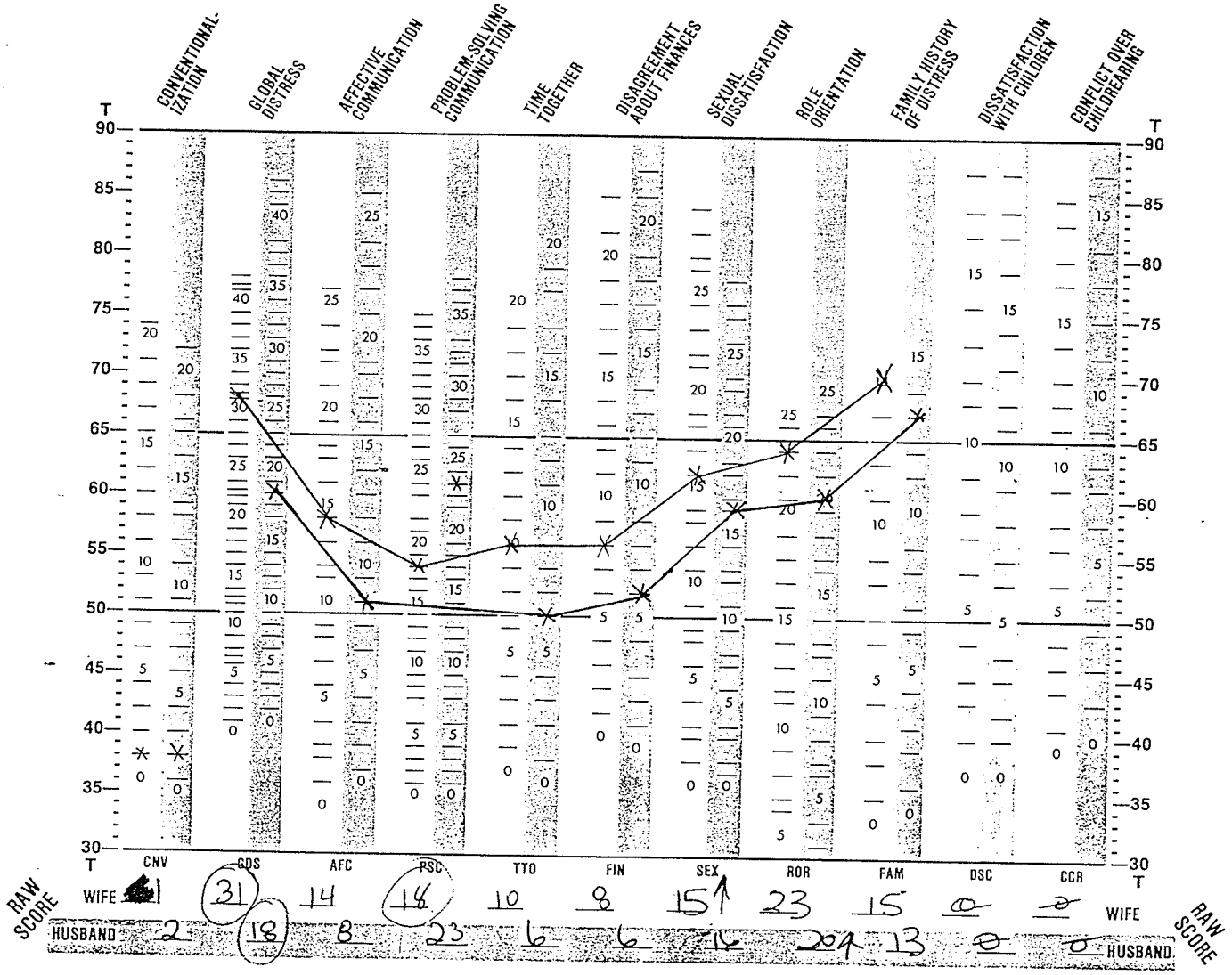
APPENDIX D

THE MARITAL SATISFACTION - POST TEST PROFILE COUPLE TWO

Marital Satisfactory Inventory - Post Test Profile Couple Two



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