

Strategies for Addressing Childhood Sexual Abuse in the Hope Approach

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There are multiple factors that influence couples to seek marital therapy. Past traumatic experiences can negatively impact marital satisfaction and motivate them to seek help (Nelson-Goff, Crow, Reisbig, & Hamilton, 2007). Childhood Sexual Abuse (CSA) is a very common form of sexual trauma that can significantly impact marital functioning. In fact, couples perceive CSA to be a significant contributor to the etiology and continuation of their distress.

Research identifies a host of negative long-term sequelae for CSA survivors including decreased emotional intimacy, sexual dysfunction and dissatisfaction, lack of trust, feelings of betrayal, low self-esteem, depression, anxiety, and fear of re-traumatization (Anderson-Jacob & McCarthy-Veach, 2005; Whisman, 2006). In particular, flashbacks and intrusive memories of sexual abuse may interfere with the survivor's quality of sexual intimacy or even deter the survivor from engaging in sexual activity with a partner (Bacon & Lein, 1996; Davis, Petretic-Jackson, & Ting, 2001; Nelson-Goff et al., 2006). In contrast, some survivors report experiencing sexual promiscuity and preoccupation with sexual encounters following CSA (Anderson-Jacob & McCarthy-Veach, 2005).

Gottman and Silver (1999) assert that a crucial goal of marriage and dating relationships is to create an atmosphere where each person feels safe to talk honestly about his/her convictions. Often times, these essentials of a healthy relationship are damaged or lacking within the couple relationship when one partner has experienced sexual trauma. However, it is important to realize individual differences; survivors or couples may experience differing degrees of symptomatology. For example, a supportive social system may lessen the impact of the traumatic event whereas negative support or lack of support may compound symptoms (Herman, 1997).

Case Vignette:

Delilah and Mark presented for couple therapy with constant conflict being the chief complaint. They reported engaging in sexual activity approximately twice a month and attributed this infrequency to marital conflict. Delilah (21) and Mark (23) had been married for three months. Both Delilah and Mark said that they did not notice any problems until they were married. Both of them self-identified as Christians and said that they had waited until their wedding night to engage in sexual activity.

During the individual interview with Mark, he explained that immediately following their "first time," Delilah just turned away from him and began to cry. When he asked her what was wrong, she told him that she didn't like sex, but refused to talk about it any further. He reported that he initially thought her aversion was a normal reaction and that they would need to make new accommodations for comfort. He also attributed her remarks to the extreme stress of planning the wedding. However, since then, every time they participated in sexual activity, Delilah would make disparaging remarks immediately, ranging from "I'm not attracted to you" to "sex is disgusting." In addition, she has become extremely irritable at bedtime, specifically when he suggests any sexual activity. He said he is confused by her

reaction and is often left feeling ashamed and rejected. Recently, Mark had noticed that he has difficulty developing and maintaining an erection.

He also remarked that he felt as if Delilah controlled everything in the relationship, whether it was the household activities or daily decision-making. Mark was raised in a traditional family, in which his father was very controlling and dominating. In the beginning stages of their relationship, Mark noticed that he had exhibited some of the same behaviors with Delilah, but had recently decided that he desired an egalitarian relationship with his wife. Over the past six months, he has noticed Delilah taking on more and more responsibility and fears that she is attempting to dominate the relationship. In response, he has attempted to “put her in her place.” Delilah responded to this by becoming more determined to be in control. The therapist asked Mark if she could discuss this topic with Delilah in the individual session with her. He consented, noting that “she won’t listen to me; maybe she will to you.”

During Delilah’s intake, the therapist obtained a full history of Delilah’s sexual experiences. Delilah reported that as a child, her older brother had sexually molested her. She reported that it started when she was 10 and her brother was 13 and continued until her brother left the house at age 18. When she began to understand that this was wrong, she told him she didn’t like it. He continually threatened her and told her that no one would believe her if she told. Out of fear and shame, she has not told anyone of her CSA. She met Mark at age 19 and was reluctant to start a relationship with him. However, he was a Christian, was considerate, respectful, and persistent. She could discern his good intentions, yet never felt comfortable enough to share with him what had happened. When they began dating, they discussed how important sexual purity is to God and both vowed to remain pure until their wedding day. Knowing her husband’s strong feelings about purity made her even more hesitant to tell him. As the wedding day drew closer, Delilah felt more and more anxious. She explained that engaging in intercourse reminds her of the guilty feelings she experienced after her brother raped her. Delilah remarked she “wouldn’t have sex if weren’t for the Christian mandate to fulfill ‘his needs.’” The therapist validated Delilah’s feelings and asked her if she wanted to share her history with Mark. Delilah said that she did, but was too afraid to do it alone. The therapist offered to be present during the discussion.

During their next meeting, Delilah shared her secret with Mark. He was completely shocked, but was able to empathize with her. He said that just knowing about the situation helped him understand her better. The therapist recommended individual therapy for both Delilah and Mark in addition to couple therapy. The therapist committed to consult with each individual therapist in order to track progress and provide accountability. Throughout the therapy process, the therapist encouraged each to identify how their behavior may be contributing to the problem.

Guidelines for therapists (most are drawn from Compton & Follette, 2002)

- Confidentiality and policy on sharing information between partners must be addressed.
- Conceptualize traumatized couples from a contextual/behavioral or emotionally focused couple therapy approach (Compton & Follette, 2002; Johnson & Williams-Keeler, 1998).
- Thorough assessment is key: assess for commitment level of each spouse, obtain a full history from each partner in an individual intake, and assess couple functioning together.
- Assess current impact of traumatic experience- don’t assume that people who have had a traumatic experience are traumatized (Nelson, et. al, 2002).

- Assess for any domestic violence and/or sexual dysfunction in the couple.
- Assess for individual depression/suicidality, substance misuse, and medical problems as these may need to be addressed in individual therapy.
- Inquire about gender roles and distribution of power in the relationship. Many CSA victims possess higher needs for power. How do they obtain that power (limiting emotional intimacy, play the 'victim' role)?
- Look for interaction patterns in the relationship (one partner may demonstrate multiple behaviors in order to achieve or avoid something).
- Distinguish between single- and dual-trauma couples and note implications for each
- Some single-trauma couples have one partner that is able to provide stability
- Dual-trauma couples may be more susceptible to secondary trauma
- Understand and communicate the impact of individual symptoms on the relationship:
- Disruption in intimacy/low emotional engagement due to experiential avoidance and emotional numbing. This prevents emotional intimacy and perpetuates a continuous cycle of emotional withdrawal and invalidation.
- Refer each partner to individual therapy if necessary: Understand the possibility of secondary traumatization/trauma contagion - effects on the spouse or partner. They may exhibit PTSD-like symptoms (Nelson, Yorgason, Wangsgaard, & Kessler, 2002; Maltas & Shay, 1995).
- The role of the therapist is a consultant, teacher, and coach. Validate each partner's perspective and provide a safe environment for disclosure.
- The therapist must be prepared for discussion of painful details by the traumatized individual and for any secondary trauma that is experienced by the partner as a result.
- Some research indicates that the effects of CSA may be different for men and women, as well as the differences between male and female spouses of CSA survivors. Be aware of the interactions between gender and trauma and be able to address those issues in the therapy context (Anderson-Jacob & McCarthy-Veach, 2005).
- Implement various change strategies that promote a cooperative team approach and builds trust (making a list of behaviors that your spouse would appreciate and doing them and also acknowledging when your spouse does something beneficial for you).
- Teach communication and problem-solving skills and teach acceptance strategies (empathic joining, externalizing the problem, tolerance building, and self-care)
- Teach about common sexual issues: low sexual desire or sexual compulsion.
- Understand impact on sexually-functional partner who may experience feelings of rejection
- Promote open discussion of feelings regarding sexual experiences
- Discuss avoidance of sex and identify triggers to flashbacks and nightmares
- Distinguish between sexual activity and being emotionally present during it.
- Reduce efforts of the non-traumatized partner to view their partner as completely responsible for the abuse and the couple's progress. Encourage both partners to recognize their contributions to and responsibilities in the relationship.
- Be aware of the high potential for you, as the therapist, to experience symptoms of secondary traumatization. Practice effective self-care and seek supervision or consultation often.

Annotated Bibliography

Anderson-Jacob, C.M. & McCarthy-Veach, P. (2005). Intrapersonal and familial effects of child sexual abuse on female partners of male survivors. *Journal of Counseling Psychology, 52*, 284-297.

This article displayed research on male survivors of CSA and their female partners. Their findings were mainly consistent with past research of female survivors of CSA and their spouses. Male survivors were less likely to seek professional mental help were likely to experience masculine identity issues, sexual orientation, and gender identity issues. They typically minimized the effects of CSA. They exhibited anger-rage, and sexual acting out behaviors. Female partners reported increased irritability, anger, depression, and anxiety, as well as a loss of trust in their partners. Researchers found that female partners are more likely to take on one of four roles: caretaker (taking on too much responsibility for MP's problems), peacemaker (walking on eggshells), sleuth (monitoring MP's behaviors), or head of household (responsibility for household). Some female partners claimed that their partners took on the role of sexual teacher, which some partners valued and others did not. Some believed their partners were incapable of emotional connection during sexual activities and thus, female partners felt sexually objectified.

Compton, J.S., & Follette, W.M. (2008). Couple therapy when a partner has a history of child sexual abuse. In A.S. Gurman & N.S. Jacobson (Eds). *Clinical handbook of couple therapy*. New York: Guilford.

This chapter comprises a summary of the literature in the area of couples with CSA histories, provide clinical guidelines for therapists when working with this population, treatment goals, and possible outcomes to therapy. They provide information on assessment measures and a case vignette. In addition, they provide common obstacle to treatment progress, ways to address them, and an evaluation of their treatment protocol.

Maltas, C., & Shay, J. (1995). Trauma contagion in partners of survivors of childhood sexual abuse. *American Journal of Orthopsychiatry, 64*, 529-539.

In this article, the authors propose that sexual partners of CSA survivors experience trauma symptoms. Trauma contagion is defined as "a process in which the trauma is communicated, like a virus, to an intimate sexual partner and is thus experienced more pervasively than it is by someone in a close, but different kind of relationship to the survivor" (p 532). The partner experiences threatened beliefs/shattered assumptions, chronic stress, and a reenactment of the abuse.

Nelson Goff, B.S., Reisbig, A.M.J., Bole, A, Scheer, T., Hayes, E., Archuleta, K.L., Henry, S.B., Hoheisel, C.B., Nye, B., Osby, J., Sanders-Hahs, E., Schwerdtfeger, K.L., & Smith, D.B. (2006). The Effects of trauma on intimate relationships: A Qualitative study with clinical couples. *American Journal of Orthopsychiatry, 76*, 451-460.

This article discusses the interpersonal impact of various types of trauma on romantic relationships. They found multiple interactive themes, including increased sexual intimacy problems, increased relationship distress, and also relationship resources. The authors concluded that due to a number of positive characteristics found among participants (support from partner, relationship resources), relationships of trauma survivors are not inherently impaired. They suggest future research in this area.

Nelson, B.S., Yorgason, J., Wangsgaard, S., & Kessler, M.H. (2002). Single- and dual-trauma couples: Clinical observations of relational characteristics and dynamics, *American Journal of Orthopsychiatry, 72*, 58-69.

This article distinguishes between single- and dual-trauma couples and the unique challenges each type of couple faces. Among clinical cases, they found themes of polarized emotional roles, imbalance in the family system, and rules of secrecy among single-trauma couples. Among dual-trauma couples, the following themes were prominent: issues of power and control, competition between partners, external boundary ambiguity, and preoccupied-dismissing couples. Both have extreme pursuer-distancer patterns (violent or extremely avoidant behaviors) and individual symptoms in one or both partners.

Additional References

Balcom, D. (1996). The interpersonal dynamics and treatment of dual trauma couples. *Journal of Marital and Family Therapy, 22*, 431-442.

Barnes, M.F. (1995). Sex therapy in the couples context: Therapy issues of victims of sexual trauma. *The American Journal of Family Therapy, 23*, 351-360.

Compton, J.S., & Follette, W.M. (2008). Couple therapy when a partner has a history of child sexual abuse. In A.S. Gurman & N.S. Jacobson (Eds). *Clinical handbook of couple therapy*. New York: Guilford.

Johnson, S. M. & Williams-Keeler, Lyn (1996). Creating healing relationships for couples dealing with trauma: the use of emotionally focused marital therapy. *Journal of Marital and Family Therapy, 24*, 25-40