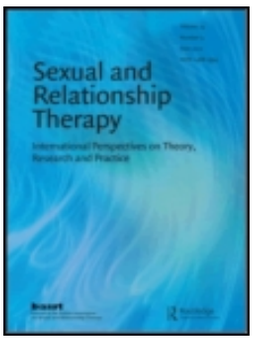

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# Child sexual abuse and couple therapy

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ABSTRACT *There has been a dramatic increase in recent years in our awareness and understanding of the incidence, causes and treatment of child sexual abuse. However, the impact of such experiences on victims' adult intimate relationships and in particular, the implications of such experiences for the focus and process of couple therapy has remained substantially ignored. This article seeks to remedy this situation by considering the research evidence relating to child sexual abuse and exploring the complex links between child sexual abuse and couple problems. Our contention is that in the light of this evidence, couple therapists can now no longer afford to ignore the possible existence and impact of early childhood experiences of sexual abuse in their work with couples and that, apart from the therapeutic importance of addressing such issues, such work may have a significant contribution to make in breaking the 'cycle of abuse'.*

## Introduction

A significant phenomenon of the past decade for those in the helping professions has been the increase in awareness and understanding of the incidence, causes and treatment of child abuse in general and child sexual abuse in particular. Among the reasons for this is the willingness, after decades of denial both at individual and societal levels, to believe the hitherto previously unbelievable about what adults are capable of doing to children, and to challenge widely held assumptions concerning what behaviours are taboo in modern western societies.

The principal focus for this debate has developed, understandably, around concerns about the protection and treatment of child victims, the impact of such abuse on families, and how best to respond to the problems presented by perpetrators. Inevitably therefore, in view of the pressing need to respond quickly in terms of child *protection*, the primary locus for this debate has been within and between statutory agencies with responsibilities for child welfare, health and development, and for law enforcement.

What has remained largely unaddressed, however, has been the question of *prevention* in the longer term, in the sense of seeking to identify and intervene in the processes by which patterns of abusing behaviour are apparently sustained across generations—the cycle of abuse; of the *amelioration* of the impact of childhood sexual abuse on the adult lives of victims, particularly within the context of their

intimate relationships; of the possible contribution of other agencies and workers such as marital therapists to this process; and of the implications of such early experiences for the focus and process of therapy with couples.

Particularly noteworthy in this context is the finding that those individuals abused as children tend not to maltreat their own children when they are in an intact, long-term stable relationship with husband or boyfriend (Egeland, 1988). Equally, marital problems were cited most frequently out of a range of problems experienced by couples who abuse their children (NSPCC, 1989). Taken together, these findings suggest that work directed towards resolving difficulties in the couple relationship may be highly significant in ameliorating the problem of child abuse.

Such issues are beginning to assume even greater significance in the light of the changing policy context in which work with marital problems takes place (James & Wilson, 1991). Of particular significance are the recent proposals of the Law Commission for the reform of the law relating to divorce (Law Commission, 1990). These proposals recommend a number of important changes which reflect the gradual trend during the last two decades away from the notion of fault in divorce proceedings. Of particular interest, however, are proposals for the introduction of a 'cooling off' period during which couples will be advised and encouraged to avail themselves of services offering marriage guidance, counselling and conciliation.

However, such proposals also reflect a degree of ambivalence about the direction of policy changes and a growing unease about the stability of modern marriages in the light of divorce rates, which are once again rising after a period of relative stability in the early 1980s (Family Policy Studies Centre, 1991). Linked with the need to mitigate the difficulties for so long associated with the process of divorce, there is also growing evidence of a re-emerging concern for marriage saving such as was evident in the late 1970s (Home Office, 1979). Such ambivalence is clearly reflected in the recent response of the Lord Chancellor to the proposals of the Law Commission, in relation to which he commented:

> The majority of those who responded to the report understand and sympathise with the philosophy and the methods proposed. But there is quite a strong feeling in some people's minds that the Law Commission did not recognise sufficiently clearly the need to strengthen the institution of marriage (Family Policy Studies Centre, 1991: p. 8).

The time therefore seems right for a careful examination of these issues by those helping professionals involved in therapeutic work with couple relationship problems, in order to engage positively with the challenges of new knowledge and a changing policy context. This article will therefore consider the research evidence relating to child sexual abuse and explore the complex links between child sexual abuse and couple problems; examine the literature, mainly derived from clinical experience, on work with adults who have been sexually abused as children; and discuss some of the implications of this analysis for couple therapy.

## The prevalence and aetiology of child sexual abuse

Our basic contention is that, given what is now known about the prevalence and impact of child sexual abuse on victims, couple therapists can now no longer afford to ignore the possible existence and impact of early childhood experiences of sexual abuse in their work with couples and that, apart from the therapeutic importance of addressing these issues, such work may have a significant contribution to make in breaking the cycle of abuse. This contention of course makes the assumption that therapists currently *do* ignore such issues and we are certainly not in a position to claim that this is universally so. Howeve, a brief review of a selection of recent literature on work with couples (Clulow & Mattinson, 1989; Hawton, 1985; Hooper & Dryden, 1991; James & Wilson, 1986) has revealed no significant references either to the substantive issues or to their therapeutic implications, a fact which tends to support our view.

There is also some evidence (cited in Jehu, 1989) that professionals in general tend to avoid the issue, not only failing to detect histories of abuse but also failing explicitly to diagnose it or, once diagnosed, to keep it as a subject for discussion in therapy. There is however a small but growing body of specialist literature which considers the specific treatment needs of this client group. One of our purposes in this paper is to demonstrate ways in which knowledge from this literature and from other research concerning the impact of child sexual abuse may be incorporated into therapeutic work with couples.

The evidence of the existence of comparatively widespread sexual abuse of children is persuasive. As in any attempt to pull together and compare research findings, there are important methodological issues which must be borne in mind, such as the different definitions of what constitutes child sexual abuse which have been adopted by different researchers. Nonetheless, the evidence is compelling. Studies from the USA by Finkelhor (1979) and Russell (1984) point to the possibility that about 16% of women experience some form of incestuous abuse by the age of 18, while 31% of Russell's sample had had at least one experience of sexual abuse by a non-relative by the time they were 18.

## The impact of child sexual abuse

Other research has focused on the impact of child abuse on its victims. Although it is only too evident that the experience of being sexually abused as a child can cause both short- and long-term problems for the victim, at present there is little satisfactory evidence concerning the proportion of sexually abused victims who experience psychosexual problems in adult life. However, Douglas *et al.* argue that "Sexual problems are very common among women incestuously abused as children" (1989: p. 143) and cite research (Herman, 1981; Meiselman, 1978) which suggests that "this group has a very high probability of developing sexual difficulties with prevalence ranging from 55% to 82%" (1989: p. 144).

In one of the more informative studies, that conducted by Baker & Duncan (1985) involving face-to-face interviewing with a nationally representative sample of 1049 women, 51% (of 119 female victims) considered the abuse to have been

unpleasant but to have had no long-lasting effects; 13% considered it to have been permanently damaging and 34% considered it to have had no effect at all. However, in a study by Russell (1986) involving 152 victims in a random sample, 25% considered the abusive experiences to have had great long-term effects. Clearly the problems identified in relation to establishing prevalence rates are to be found here too. Different definitions of sexual abuse may for example make it more or less likely that victims will report serious long-term effects; common coping mechanisms such as denial or minimization may reduce the levels of reported adverse effects; and so on.

Even where long-term negative consequences are reported, the extent to which these are attributable to the sexual abuse *per se*, or to other factors such as a negative adult response to the child's attempt at disclosure (Browne & Finkelhor, 1986), or other problems in the family background (Rieker & Carmen, 1986) is unclear. The extent to which psychosocial problems of victims are comparable to those in the general population is also unclear, although some studies have attempted to establish whether or not sexual abuse is a pathogenic influence over and above other events (e.g. Fromuth, 1986; Russell, 1986). Nonetheless, the relationship between an identified problem in the adult victim and the experience of sexual abuse remains problematic. For example, Fromuth found in her college sample that previously sexually abused women were more likely to describe themselves as promiscuous than non-abused women, although the two groups did not differ markedly in sexual activity. Thus certain behaviours (events) may be perceived as problematic by a victim because, for example, of a characteristic propensity for self-blame rather than because the behaviour is in itself problematic.

Although the prevalence and epidemiology of problems associated with abuse is thus unclear, there is nonetheless a developing body of research which seeks to identify those experiences of child sexual abuse which are more likely to be predictive of lasting harm. Duration and frequency of abuse is strongly associated with severity of long-term consequences (Bagley & Ramsay, 1986; Browne & Finkelhor, 1986); certain types of abuse, namely bodily penetration including intercourse, have been linked with severity of long-term effects, although the evidence is not conclusive (e.g. Russell, 1986); the closeness of the relationship with the abuser and the degree of trust within the relationship is significant, greater closeness and trust producing the greater trauma; more severe effects are evident where the child has been abused by more than one individual, especially when the abuse has involved both parents (Hall & Lloyd, 1989; Browne & Finkelhor, 1986); and although the available evidence is not clear on whether intra-familial abuse is more damaging, there is strong evidence that abuse by natural fathers or stepfathers is especially traumatic (Browne & Finkelhor, 1986; Russell, 1984). There is also some, though not conclusive, evidence that younger, pre-pubertal children make a poorer long-term adjustment (Browne & Finkelhor, 1986); and finally although the evidence does not allow any firm conclusion to be reached on the commonly held assumption that secrecy is damaging and disclosure helpful, a negative reaction on the part of an adult to the child's disclosure is associated with an adverse later outcome (Browne & Finkelhor, 1986).

## Long-term effects of childhood sexual abuse

A growing body of literature charts the long-term effects of abuse on its victims and provides, as Hall and Lloyd point out, "a sobering account of the real and severe difficulties faced by many women as a result of their childhood experiences" (1989: p. 247).

A review by Browne & Finkelhor (1986) indicates that the long-term effects most frequently reported are self-destructive behaviour, anxiety, feelings of isolation and stigma, poor self-esteem, a tendency towards revictimization and substance abuse. Problems in interpersonal relationships with both men and women, problems in sexual relationships, and problems in relationships with their children are frequently reported by women victims.

Although a wide range of parenting problems are evident, of particular concern are those relating to intergenerational abuse. Some retrospective studies, for example those using clinical data concerning abused children or examining child protection registers, have suggested that a large majority of abusing parents were abused as children (Steele & Pollock, 1968). There are methodological problems inherent in such studies; nonetheless, findings from a longitudinal prospective study suggest that about one third of parents who were abused as children are subsequently at risk of maltreating their own children (Egeland *et al.*, 1988). Moreover, a study by Goodwin *et al.* (1981) which specifically addressed problems of sexual abuse suggests that women who have been victims of incest as children are more likely to abuse their own children.

In his account of work with 51 adult women victims, Jehu examines *inter alia* their problems in relation to three distinct (but clearly interconnected) areas—those of disturbances of mood, interpersonal relationships, and sexual dysfunction.

### *a) Disturbances of mood*

Jehu considers mood disturbances to be fundamental to the difficulties experienced by many previously abused women, noting that 47 women in his programme reported low self-esteem, 45 feelings of guilt, 36 depressive episodes and 47 at least one of these mood disturbances, findings which were supported by evidence from assessment questionnaires. Related problems of attempted suicide and self-destructive substance abuse are commonly reported among previously abused women (Browne & Finkelhor, 1986).

In a useful discussion of the aetiology of these problems, Jehu argues that certain distorted beliefs are associated with the victims' sexual abuse in childhood, postulating that distorted or unrealistic beliefs concerning the abuse lead to distressed feelings and inappropriate actions in later life. Such distorted beliefs include self-blaming beliefs concerning responsibility for the abuse, such as having experienced physical or emotional pleasure or shown sexual curiosity, having kept the abuse secret, compliance and seductive behaviour. Closely related are beliefs of a self-denigratory nature which give rise to low self-esteem, guilt and depressive episodes. These beliefs include a sense of worthlessness or badness, a sense of being different from others, stigmatization, inadequacy and inferiority and a subordination of self to

others. A common physical response is a disassociation between mind and body, so that the body is experienced as separate (Dale, 1991).

*b) Problems in interpersonal relationships*

In relation to problems in interpersonal relationships, Jehu notes that all the victims in his programme had some problem in their interpersonal relationships and that of those who were married or cohabiting, all reported discord, oppression or physical abuse in that relationship. A sense of isolation, insecurity, discord and inadequacy permeated many of these interpersonal problems.

Such findings of feelings of isolation and difference are consistent with those of Briere (1984) and Herman (1981), who attribute them to the self-blame and self-denigration arising from the victims' participation in the abuse:

> Many of the women described themselves as 'different' or stated that they know they could never be 'normal'... The sense of being an outsider... often reached extreme proportions... Many women made an explicit connection between their feelings of isolation and the incest secret (1981: pp. 96–7).

Although the problems that pervade these adult relationships often originate in the abuse experience in childhood, it is also clear that limited social skills on the part of the victims, which may in themselves be a consequence at least in part of the childhood abuse, may serve to maintain and exacerbate such problems. As Jehu suggests:

> isolation may be maintained by communication difficulties, insecurity may persist because the victim is unable to handle stress or to be assertive and discord may continue because the necessary problem solving skills are lacking (1989: p. 109).

*c) Sexual dysfunctions*

Problems in sexual relationships are widely reported by adult victims of abuse. These may include sexual dissatisfaction, impaired sexual motivation, impaired arousal or orgasm, phobic or aversive reactions to sexual activities, including 'flash-backs' to the victimization experience, dyspareunia and vaginismus. This view is supported by a study by Fritz *et al.* (1981) who reported that 23% of the women who had been sexually molested in childhood by adults reported problems in their current sexual relationships, compared with only 10% of boys who had had such experiences. McCabe (1989), in a study of women presenting with a sexual dysfunction, found that adolescent attitudes towards sex, and child and adolescent sexual abuse played an important part in determining adult sexual functioning, the experience of abuse resulting in low levels of sexual desire and high levels of sexual dysfunction in adulthood. Douglas *et al.* (1989) cite evidence suggesting that disruptions of the desire and arousal phase are the most frequent problems. Jehu

notes that of the women in his programme, 94% reported some form of sexual dysfunction, with negative reactions to sex such as those indicated above; such frequency findings are supported by a number of other studies, e.g. those of Becker & Skinner (1984), Tsai *et al.* (1979) and Briere (1984).

It is not uncommon for these problems to emerge some time after the sexual relationship has begun. Sgroi and Bunk, for example, discussing adult survivors who manifest a late presentation of problems, suggest that precipitating factors include a cooling of the marital relationship, sometimes accompanied by sexual dysfunction experienced by one or both partners (but always accompanied by distancing behaviour and problems with intimacy) (1988: p. 153). Jehu noted that in early sexual encounters, the problems may be masked by their novelty and limited commitment, but that:

> once a relationship becomes more established and closer, then feelings associated with victimisation by an adult who was 'related' to the child may be reactivated. Sometimes women will say that their partner has changed and has become more like the offender (1989: p. 224).

## Therapeutic work with victims of child sexual abuse

Much of the emerging literature on therapeutic work with adult victims has implications for work with the couple relationship. We consider first the principle themes identified with individuals, before considering these specifically in the context of work with the partnership.

Certain issues such as, for example, the acknowledgement of the problem, assessment and the establishment of a therapeutic relationship, characterize all therapeutic encounters, but their application in working with abused adults requires particular knowledge and skill on the part of the therapist.

### *a) Problem identification*

The initial disclosure of a history of child sexual abuse may come from the incest survivor who has requested help in coming to terms with the abuse, from the client with whom a therapeutic relationship has been established, or it may be divulged in response to routine questions concerning family and childhood or to specific questions concerning child sexual abuse (Hall & Lloyd, 1989: pp. 91–2). Jehu suggests that in view of the commonness of the problem, "it seems quite appropriate to ask all clients if they had such an experience" (1989: p. 6). Such routine questioning has both advantages (e.g. in signalling that the therapist is comfortable with the issue, in raising the subject in a non-threatening or stigmatizing way, in providing the relief of acknowledgement) and disadvantages (e.g. the client may not be ready to disclose, or routine questioning may convey the impression that the therapist views the problem as no more stressful than any other). Jehu suggests that such an inquiry is seldom if ever regarded as intrusive or offensive by clients, but that in the absence of routine questions, certain problems and histories may alert the

therapist to the possible history of abuse. In addition to some of the long-term effects cited above (especially sexual problems, perceptual disturbances, fear or avoidance of men, self-destructive behaviour and a history of unresolved psychiatric problems), a combination of the following factors is highly indicative:

- no fond memories of or, alternatively, overly positive descriptions of childhood;
- certain childhood histories (e.g. running away from home, isolation from peer group, persistent urinary tract infections, frequent unexplained absence from school);
- certain behaviours during adolescent (e.g. self-mutilation, running away, early sexual promiscuity, the contraction of sexually transmitted diseases, becoming pregnant in early adolescence);
- evidence in family history of abuse of a sibling or another child, or of violence/alcoholism in parents;
- a history of prostitution.

Exploration of the issue should be tentative, allowing the woman the freedom to deny the abuse or remain silent. If abuse is acknowledged, it is vital that the therapist responds positively since a negative reaction (e.g. minimizing the effects, excessive interest in sexual detail, expressions of disgust, anger or shock) make it likely that the client will withdraw from therapy (Josephson & Fong-Beyette, 1987). Hall & Lloyd (1989) suggest a number of helpful responses to the disclosure (e.g. acknowledging the difficulty of doing so, offering further exploration of the problem if and when the client wishes to do so, being alert to the need for support, reassurance). They also suggest that although, for a variety of reasons, the client may not at this time make a disclosure, in their experience the client is relieved by the acknowledgement on the part of the therapist of the possibility of child sexual abuse.

*b) Intervention*

In working directly with the experience of abuse, certain characteristic themes emerge which Sgroi & Bunk (1988) identify as: Why did I go along with the abuse? What really happened to me? Why did I keep it secret? Am I damaged for life? Why is it so hard for me to stay connected to others?

In discussing the therapeutic interventions which in their view constitute an effective response to these themes, Sgroi & Bunk conclude that insight oriented psychotherapy is not in itself enough and that as well as helping the victims understand the basis for their confusion, anger and sense of being overwhelmed and out of control, treatment "must include opportunities to practice more functional and effective responses and coping mechanisms" (1988: p. 160). Developing the ability to reflect on roles and to be assertive in renegotiating these if necessary may be a major aspect of this (Dale, 1991: p. 16).

The fact that people who have suffered abuse often lack the ability to form intimate relationships or sustain friendships has major implications for the

therapeutic relationship, in which the issue of trust is likely to be a dominant theme, with direct or implicit questions concerning caring, availability, lack of interest, judgementalism, being abandoned, and a testing out of the therapist's own sexual boundaries. Dale (1991: p. 16) suggests that although clients may experience considerable anxiety and defensive response patterns, the therapist's "open acknowledgement and exploration of feelings of attachment and affection, differences and conflict, will deepen the relationship rather than threaten it". In our own clinical practice, this has often been the central ingredient of therapy, providing an experience of intimacy which can gradually be developed outside the therapy sessions. Helping the client to establish and maintain firm boundaries between herself and others is also an important focus in the early stages of work.

Noteworthy here are those studies which have sought to understand how the inter-generational cycle of abuse occurs by focusing on those individuals ('the exception group') who were abused as children but who go on to provide adequate care for their own children. Drawing on the work on attachment by Main (1983) and Browne & Saqi (1988) among others, Egeland argues that:

> Once established, representational models of the attachment figure are difficult to change... New relationships formed by the individual are assimilated into existing models as long as the new experiences do not deviate too greatly from existing structures. Experiences of love from a mate or friend may not make sense to parents with a history of abusive relationships (1988: p. 93).

In spite of this difficulty, individuals in the exception group were very aware of their past history of abuse, were able to talk about it in great detail and had in general been "able to modify their representational model through having participated in a positive therapeutic experience" (1988: p. 94).

In this context of providing alternative models of attachment through the therapeutic relationship, Sgroi & Bunk (1988) underline the associations between promise keeping, limit setting, contract negotiation and the slow and steady trust building that occurs as a result of these behaviours. The therapist may, realistically, openly acknowledge to the client that "It will probably be a long time, if ever, before you feel as if you can trust me... That's okay... It is only necessary that we all behave in a trustworthy fashion" (1988: p. 159).

## Implications for couple therapy

The above analysis raises a number of issues in relation to the practice of couple therapy. As Jehu points out, the relationships of many clients who were sexually abused in childhood are characterized by discord, "often arising from the exploitation of the victim by the partner, the over dependence of the partner on the victim, and the dissatisfaction and distress of the partner concerning certain aspects of the relationship" (1989: p. 136).

Key questions which arise specifically in treating a couple with a history of childhood sexual abuse concern the identification of the problem, decisions about

the structuring of therapy (e.g. gender of therapist, conjoint or individual work) and the process of intervention.

Awareness of the problem of child sexual abuse in the general population is increasing, thus making it rather more likely that the couple may already have identified this as a problem. Many couples seeking help, however, even with sexual problems, will not have done so. The implication of the earlier discussion on initial disclosure is that in all cases, and particularly where one partner presents with one or more of the areas of difficulty delineated above, the therapist must consider *inter alia* the possibility of childhood experiences of sexual abuse. It is self-evident that such issues must be broached with great sensitivity, bearing in mind that the memory of such experiences may have been suppressed for many years and that the other partner may also be unaware of the problems. Therefore, if the therapist has any lingering doubts or concerns about their existence, it may be appropriate at an early stage to offer separate interviews in order to facilitate discussion of previously undisclosed experiences. To proceed with a conventional behaviourally orientated therapeutic programme where such issues remain unaddressed may well serve to compound rather than ameliorate problems in the relationship.

Indeed, as Douglas *et al.* (1989) argue, since the current problem situation echoes the experience of incest, involving as it does sex with a related and loved person, knowledge of the details of the past abuse may be very important in terms both of designing and managing the treatment programme. Although there is no necessary or predictable correspondence between the nature of the abuse and the current problems,

> an awareness of the details of the original abuse allows the therapist to be alert to assignments that are likely to be particularly anxiety provoking and to plan these accordingly... The gradual approach of sex therapy, with an emphasis on strong limits which are not to be over-stepped, provides the woman with a safe environment in which she can explore her sexuality... Sex is thus gradually rehabilitated (1989: pp. 149–51).

Where such problems are disclosed, the literature is at present unclear on whether work should proceed with the victim alone or in a couple format. Guirguis has argued that:

> The modern sex therapist should also be able to take one of the partners out of couple therapy to deal, in individual therapy, with any personal difficulty. Examples of this difficulty are a history of being abused as a child... Once the personal problem is dealt with couple therapy can be resumed (1991: p. 141).

Sgroi & Bunk (1988) (who advocate peer group therapy for the later stages of treatment) suggest a time-limited period of individual work but do not examine this as an alternative to conjoint intervention. However, Douglas *et al.* argue that whenever past experiences remain a major preoccupation, it would be wise to consider the need for individual therapy before embarking on conjoint therapy, arguing that:

> many women will require some preparatory individual therapy. This is especially likely to be the case where the incestuous abuse has been of long duration, where the abusing adult has been a father, or step-father and where coercion or pain has been involved... a detailed knowledge of the nature of the abuse is relevant as the therapist is forewarned about likely areas of difficulty in the subsequent conjoint therapy... Individual therapy is important in forming a strong therapeutic bond between therapist and patient which provides a basis of trust for the difficult shift into sex therapy (1989: pp. 144–45).

In their view therefore, individual therapy is a prerequisite which paves the way for couple therapy, rather than an optional extra and they consider that such therapy may be a key element in the success of sex therapy and the improvement in such women's well-being generally.

Jehu reports in relation to the programme (cited above) that it was usual for partners to attend most sessions, with some individual sessions for both partners, so that the concerns of the non-abused partner, who he describes as suffering from 'secondary victimization', could be given specific attention. However, he examines in some detail the problems which can arise where the victim has presented as the identified client with a range of urgent and distressing problems which were the prime focus in the early stages of therapy, arguing that:

> This made it difficult for the therapist to give adequate attention to the partner, who tended to think also that it would be inappropriate, unfair and therapeutically damaging to expect the victim and therapist to yield therapeutic time to his concerns (1989: p. 303).

Moreover, partners were often resistant to abandoning their role of helping the victim and entering the client role themselves.

In general therefore, we would argue that careful consideration should be given to the need for continuing work with the couple while such individual therapy is being undertaken; the extent to which work with the individual should be kept separate from work with the couple; whether the partner has a positive role to play in the therapeutic process; and if so, what this should be. Failure to continue to engage the other partner may set up feelings of rivalry, jealousy and/or hostility, or engender counter-productive fantasies as a result of being excluded from therapy. Such work may however require the simultaneous use of several different theoretical perspectives and therapeutic approaches, requiring careful management and agenda setting with the couple.

The gender of the therapist may also need to be considered when working with couples where there is a history of abuse, but we have found no empirical data on the issue of whether or not the process and outcome of treatment are significantly influenced by this. There is some indication that a female therapist may have advantages, at least in the early stages of therapy, but male–female co-therapy teams in conjoint work, as in other couple therapy, may be more appropriate and the preference of the adult survivor should be considered carefully.

Whether therapy proceeds by way of conjoint or individual sessions, initially work is likely to focus on an exploration of the abuse experience, commonly reflecting the concerns delineated by Sgroi & Bunk (1988) referred to above. Jehu (1991) suggests that reactions to the abuse experience may be usefully considered as post-traumatic stress reactions, and that the management and alleviation of these involves three concurrent processes of intervention, namely the exposure to stressful features of the abuse in a safe setting, training in coping skills and changing the meaning of the abuse. We consider these in turn.

First, in order to provide therapeutic exposure to features related to the abuse, clients may be helped to recall traumatic memories and, importantly, to express the emotions associated with them, sometimes with the use of appropriate materials, such as autobiographical accounts of abuse, to assist the process of recall. Total recall is not considered essential, and the therapist must ensure that the process is paced so that clients do not become overwhelmed by the intensity of their memories. Other methods of exposure include writing about the experiences (including writing a letter to the abuser which may or may not be sent); imaginal flooding; imaginal desensitization (where clients are trained in relaxation and then asked to imagine stressful features in a graded manner, starting with the least disturbing item); role play; and undertaking real life tasks.

Secondly, training in coping skills may include breath control and deep muscle relaxation; 'grounding' or 'reality orientation' (involving a range of techniques to enable the individual to reduce intrusive thoughts from the past by focusing on the 'here and now'); and guided self-dialogue (involving the use of prepared coping statements when faced with stressful reactions associated with the earlier abuse). These coping skills may be combined into a coping plan devised by the client and the therapist, which may be practised in role-play, or rehearsed and practised in imagination by the client.

Thirdly, Jehu notes that "the meaning of the abuse for individual clients can influence considerably their reactions to the trauma" (1991: p. 240) and suggests cognitive restructuring as a corrective approach, whereby the individual is first helped to identify beliefs about the abuse which may be contributing to current problems, to reorganize any distortions, and to explore more accurate and realistic alternative beliefs.

Thus, reactions to earlier traumatic events, and the associated self-blaming and self-denigrating which are rooted in the past, need to be addressed before the client can be free to address interpersonal problems and finally problems of sexual dysfunction within the couple relationship. There are indications also that the "successful treatment of sexual dysfunction usually requires the prior alleviation of mood disturbances and marital discord" (Jehu, 1989: p. 305). Furthermore, a specific focus on sexual problems within the couple relationship may prove unnecessary once the mood and interpersonal problems have been alleviated.

## Specific problems

As we have indicated above, therapy with couples where there is a history of abuse

may involve specific issues concerning the shift or maintenance of the focus on the couple relationship, given the urgent need initially to address the individual's experience of abuse. It is also important for the therapist to remain aware of the specific problems which may affect the non-abused partner, both in relation to the abusive experience itself (where they may feel themselves to be vicarious victims or feel immense hostility and anger towards the offender) and in adapting to the victim's increased assertiveness, enhanced self-esteem and the reallocation of roles in the relationship.

Finally, the therapist needs to be aware of ethical dilemmas which may present themselves in the course of therapy. Parents who were abused as children often find themselves overcompensating in relation to their own children in the sense that they strive to provide everything which they themselves missed in childhood and may become over protective in seeking to shield their children from damaging, particularly sexually abusing experiences. Equally, some may consciously or unconsciously expose their children to similar abuse experiences, sometimes indeed through contact with their own abuser. Couple therapists need to recognize that in developing a readiness to acknowledge and work with their clients' experiences of childhood abuse, they also increase the likelihood that a disclosure of abuse is made, or other concerns about risk to the couple's children will arise during the course of therapy. Thus inevitably issues of confidentiality arise which, as one of the present authors argues elsewhere (Wilson *et al.*, 1992), are particularly problematic for those working in the field of child abuse.

Therapists working in both statutory and private settings are bound by a code of ethics in relation to child abuse which requires them to share information concerning abuse with the relevant statutory authorities. When a disclosure or other concerns about abuse occur, questions therefore inevitably arise both in relation to confidentiality, which is important if a trusting therapeutic relationship is to be sustained, and in relation to process, where the therapist may be faced with the possible need to move from an approach which is reflective or interpretative to one which is investigative. This may be the more problematic if, because of the initial focus of intervention, no prior warning has been given by the therapist concerning possible limits to confidentiality.

Where an unequivocal disclosure of abuse is made, the therapist in our view has little alternative but to invoke child protection measures and where possible to address the couple's consequent feelings, which may range from betrayal and anger to relief and a wish for continuing support. Perhaps more problematic are those situations where the therapist is concerned about risk to the children but has no definite evidence of abuse. Here the decision as to whether or not to explore this further must rest on the therapist's assessment of the degree of risk to the child, and the likelihood of obtaining clearer evidence by changing the therapeutic approach to one of investigation.

If one of the couple discloses a history of having been abused, this also raises difficult issues concerning the perpetrator and the criminal law. While this may not be an immediate problem within the confines of a confidential therapeutic relationship, the process of therapy may, as Douglas *et al.* (1989) have argued, stir up the

past to such an extent that the woman or her husband may wish to confront the perpetrator, possibly thus taking the issue outside the bounds of confidentiality. This, in turn, may raise the question of the extent to which husband should be made aware of all of the facts relating to the abuse and who should determine this, since this too has clear implications for both the process and possible outcome of therapy.

It will be clear from the above that therapists need to think through their position concerning confidentiality, and what assurance it is appropriate to give clients about it, in advance of undertaking work with the couple.

## Conclusions

There is a developing literature on work with adults who have experienced childhood sexual abuse, much of which, as we have demonstrated, is highly relevant to working with couples where this has been identified or emerges as a problem in the course of therapy. Some attention in the literature has also been paid to addressing these problems specifically in the course of therapy with couples, notably by Jehu (1989). However, it is also clear that clinicians have only recently begun to address these problems, especially as they emerge in the couple relationship, and that there are considerable gaps in the available knowledge. Most noticeable here is the relative neglect of the problems of male victims in the professional literature; the discussion in this paper has largely derived from work with women, although Jehu, in considering the techniques of therapeutic exposure described above, and the need to reduce the 'dread of affect' commonly experienced by adult victims, refers briefly to their relevance for work with males "who are socialised into denying and suppressing their feelings" (1991: p. 236). It seems likely that many of the problems and the techniques for addressing them will be relevant to male victims, but nonetheless the ways in which these problems are experienced and can emerge may require different strategies which urgently need to be developed.

Over and above this, couple therapists need to be alert to the prevalence of childhood experiences of sexual abuse and to the possibility of this as a problem in the couples presenting themselves for help. We have discussed in this paper some of the ways in which this awareness may influence the process of therapy. Although these may involve changes in approach, we do not consider that such recognition requires a major revision of the methods of intervention currently adopted by therapists in their work with couples, since many of these, for example in relation to sexual difficulties, will be appropriate whatever the aetiology of the problems. Nonetheless, knowledge of aetiology is vital to a full understanding of sexual and other couple problems and sensitivity on the part of the therapist to the possibility that problems are embedded in earlier abusive experiences may be essential in helping the couple to acknowledge and address them. Perhaps most important of all, such interventions may significantly enhance the couple's ability to parent their own children, thus breaking the inter-generational cycle of abuse.

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