The Impact of Childhood Sexual Abuse: A Qualitative Analysis of Healthy `Couples’ Perceptions

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THE IMPACT OF CHILDHOOD SEXUAL ABUSE: A QUALITATIVE ANALYSIS
OF HEALTHY COUPLES’ PERCEPTIONS

by

Brian C. Doane

A dissertation submitted to the Graduate College
in partial fulfillment of the requirements
for the degree of Doctor of Philosophy
Counselor Education and Counseling Psychology
Western Michigan University
August 2015

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Childhood sexual abuse (CSA) is a problem affecting millions of individuals, with a prevalence rate of 28% to 30% for women (Cobia, Sobansky, & Ingram, 2004) and 14% for men (Breire & Elliott, 2003). Because of the psychological trauma associated with CSA and the potential impact on the survivor’s sexuality, a couple’s relationship satisfaction may be reduced and survivors may experience difficulty in maintaining healthy intimate relationships. How CSA impacts an individual has been studied extensively, but its effect on committed couple relationships has received much less attention in the literature. Additionally, very few studies have incorporated the non-abused partner’s perspective in the relationship and no current research has been reported on healthy couples with a history of CSA. The following is a qualitative research study exploring how eight couples reporting average to above average dyadic functioning and a history of CSA with one partner, show resiliency in overriding the potential negative impacts of CSA on their relationship. The experiences of healthy couples were studied through a phenomenological approach, gathering data from both partners using dyadic interviews in a semi-structured format.

The major findings in this study include the following themes: (a) the impact of childhood sexual abuse on intimate relationships; (b) developing and sustaining trust; (c) developing and sustaining communication/working through conflict; (d) developing and
sustaining sexual intimacy; and (e) overcoming the impact of CSA. Discussion of the findings includes comparison to existing research on CSA and couple functioning, suggested future research, clinical implications including how psychotherapists could improve therapy with couples in which one member experienced CSA, and limitations of the study.
ACKNOWLEDGEMENTS

There is an old proverb that states, “It takes a village to raise a child.” In this case, it took a village to complete a dissertation. There are several people who I would like to thank for their support and encouragement throughout this research. I am so proud of this work but would never have finished without them.

This research could not have even begun without my committee chair, Dr. Alan Hovestadt. His insight into couple dynamics, methodologies, passion for research, and genuine interest in my professional growth provided the foundation for everything in the following pages. Beyond this research, he has been a constant mentor as I’ve grown into a counseling psychologist. He is my committee chair but will always be a dear friend and colleague.

I would like to thank my committee members Drs. Gary Bischof and Dennis Simpson. Without Dr. Bischof’s words of encouragement years ago, I never would have attempted to earn a doctorate, let alone begin this line of research. He taught me couple’s therapy, supervised my first therapy with a couple, and guided me in this research with couples. Dr. Simpson has been an unwavering source of support for me. He has provided insight into the logistics of this research, often in areas that were unforeseen.

I also need to thank research assistant Theresa Nutten. Theresa shares a passion for couples work and a growing interest in the effects of childhood sexual abuse. She combed over transcripts, hundreds and hundreds of codes, and spent hours with me on the
Acknowledgements—Continued

phone while we hashed out the results. Theresa worked tirelessly with only the incentive of gaining knowledge in the field. She truly cares about others and the profession.

My own family has been a wonderful support system through this process. Both of my parents were eager with words of encouragement and always had an interest in the process. During the small victories along the way, it has always been heartwarming to hear my parents say things like, “I’m going to need to sew the buttons back on my shirt because my chest is just filled with so much pride.” My brother Jon and his wife Andi have also shared in providing support. Andi with her kind words and Jon with his own dissertation work providing a little competition to push me further. Jon—Although you finished first, I’m happy to report that a Doane has finally created a piece of research worth reading.

And most of all, I want to thank my wife Morgan. Standing by someone’s side during this process is often in the shadows, and the effort involved, while equally as intense, can go unnoticed. She has been all things in this process, caretaker, accountability partner, editor, and my rock. Beyond those qualities, she was willing to share our story of overcoming her abuse which was and continues to be so brave. This research is about how survivors and partners make it in relationships in an effort to help others. This work is for them but it was about us. I couldn’t have done this without you. I am honored to be your husband and partner.

Brian C. Doane
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CHAPTER I

THE PROBLEM AND ITS UNDERLYING FRAMEWORK

Overview of the Study Topic

The following is a qualitative research study exploring how healthy couples, in which one partner has a history of childhood sexual abuse (CSA), override the potential negative impacts of CSA on their relationship. How childhood sexual abuse impacts an individual has been studied extensively, but its effect on romantic relationships receives much less attention in the literature. Additionally, very few studies have incorporated the non-abused partner’s perspective in the relationship and no current research has been conducted on healthy couples with a history of CSA. The experiences of healthy couples were studied through a phenomenological approach gathering data from both partners. The purpose of this study is to examine the essence of the lived experience for these couples, specifically in how they create trust, communication, and sexual intimacy in the relationship.

Background and Key Research Findings

CSA is a problem affecting millions of individuals, with a prevalence rate of 28% to 30% for women (Cobia, Sobansky, & Ingram, 2004) and 14% for men (Breire & Elliott, 2003). Because of the psychological trauma associated with CSA and the potential impact, women reporting a history of CSA are more likely to be socially isolated (Harter, Alexander, & Niemeyer, 1998). Part of this social isolation may stem from an increased dissatisfaction in relationships. In a study by Parker and Herrera (1996), CSA survivors were found to experience an increase in conflict and a diminished sense of intimacy with close friends. It is not clear if CSA survivors socially isolate
themselves because of a lack of satisfying relationships or if other factors are encouraging seclusion. In any case, an intimate relationship that does not have the healthy influence of a social network could be emotionally draining for both members of the couple.

Along with isolation, many studies have shown CSA survivors to report lower satisfaction in intimate relationships (Alexander, 2003; DiLillo & Long, 1999; Finkelhor, Hotaling, Lewis, & Smith, 1989; Mullen, Martin, Anderson, Romans, & Herbison, 1994). Some of the dissatisfaction may be linked to social isolation, but other studies have shown a connection to CSA and higher rates of relational conflict (Alexander, 2003; Courtois, 1978; Noll, Trickett, & Puttnam, 2003). A combination of higher conflict and lower satisfaction can easily create an unstable and unhappy relationship.

Another possible link to CSA and its effect on the couple is a lack of trust. Much of the literature points to trust as a central problem in relationships with one partner having experienced CSA (Davis & Petretic-Jackson, 2000; DiLillo & Long, 1999; Rumstein-McKean & Hunsley, 2001). The violation of one’s personal body during childhood when individuals are developing their sense of self leaves many survivors with a suspicious view of individuals with the same gender as the perpetrator. This suspicion can also lead to dampened emotional expressivity (Waltz, 1994). One can see how the effects of CSA might impair even the healthiest couple when a relationship lacks trust, promotes suspicion, and has limited emotional expression.

Not surprisingly, many CSA survivors report problems with sexual relationships as adults. As many as 50% of these women will experience some sexual difficulty (Sprei & Courtois, 1988) compared to only 35% in non-abused populations (Sarwer & Durlak,
Based on a review of the current literature, Polusny and Follete (1995) concluded that survivors of CSA also have a greater likelihood of developing a sexual disorder in adulthood. More specifically, disorders of sexual desire and inhibited orgasm are more prevalent especially if the abuse involved penetration and force (Sarwer & Durlak, 1996). Other sexual symptoms that can affect the couple are flashbacks during sexual activity, painful intercourse, and psychological numbing or disassociation (Elmone & Lingg, 1996).

In a 25-year longitudinal study by Colman and Widom (2004), 908 abused children and another 667 non-abused children used as a control were interviewed in a double blind setting. Although the abused children in this study may have experienced abuse that was not sexual in nature, the results are worth noting. The researchers found that childhood abuse did not significantly decrease the likelihood of a survivor marrying. They did find that a history of abuse increased the likelihood of cohabitating with romantic partners. A history of abuse was also linked with an increase in relationship dysfunction. Survivors were twice as likely to walk out on a romantic partner. Compared to controls, abused females were also significantly more prone to infidelity and less likely to view their partners as caring, supportive, and open to communication. The authors also found that abused and neglected individuals who married were twice as likely to have been through a divorce as the control group.

Focus of the Study

**Practical Problem**

In response to the strain these effects place on the relationship, many survivors seek out individual therapy. Although this approach can be helpful, individual therapy is
typically focused on the survivor’s perspective while largely ignoring the survivor’s relationship (Reid, Wampler, & Taylor, 1996). The long-lasting effects of CSA will likely affect the partner as relationships are reciprocal. To ignore the relationship is to ignore the partner. Moreover, the partner of an abuse survivor can be secondarily traumatized simply by living with the effects of the abuse (Graber, 1991). This is not to diminish the importance of the victim working through the abuse, but recognizes the need for the partner to be involved. Without an opportunity to be a part of treatment, partners can feel left out and the therapist may be prevented from having a more complete assessment (Follette, 1993).

Even though there is growing literature that partners should be involved with the treatment of the survivor’s CSA, few studies within that literature give attention to how therapy should be practiced, and even less explore the perspective of the partner. In a review of the current literature, only three such studies focusing on the partner’s perspective were found in a search within the ERIC, PsychINFO, and ProQuest databases. All three studies were published in the mid-1990’s, suggesting that the current literature is not only scant but also dated.

Couples counseling appears most often in the literature as a method of incorporating the partners of survivors. Although many therapists may use couples therapy in the treatment of CSA, there is still a void of research that uncovers the best practices. Historically, research on CSA has asked participants to report current symptoms of distress (Hyman & Williams, 2001). Researchers then use the data to suggest treatments to alleviate symptoms. Even though treating the symptoms may be appropriate, there may be other sources of knowledge or insight that have not been
researched. By only using data from distressed samples, the literature is only capturing the experiences and knowledge from one segment of the targeted population. A sample of couples in a healthy relationship may uncover new and beneficial information about CSA as well as influence methods of treatment.

**Researchable Problem**

While the term “healthy couple” is somewhat ambiguous (later defined for the purposes of this study), to date, there is no known study of how a CSA survivor and his or her partner function in a healthy couple relationship. Because of the lack of literature, any therapeutic treatment of CSA can only be based on individuals’ or couples’ reported symptoms. This approach to helping these individuals may be flawed in that solutions to symptoms may not address all the factors associated with the impact of CSA. Given the complexity of CSA noted previously, it is very possible distressed individuals and couples may be limited in expressing what is needed to promote health in the relationship.

In addition to a narrow scope of sample selection, the non-abused partner’s perspective needs further research. Partners have reported grief, frustration over a lack of sexual intimacy, and even anger over not being included in the survivor’s therapy (Bacon & Lien, 1996; Reid, Wampler, & Taylor, 1996). Clearly partners may be affected by the survivor’s signs and symptoms of CSA. There needs to be further research that helps give a voice to the partners of CSA survivors in an attempt to acknowledge their role in the relationship and widen the scope of potential treatment options.
The Purpose

This study attempts to broaden the perspective of current research by employing a sample of healthy couples with a history of CSA in one partner. The perception, experiences, and development of a healthy couple may be very different from those still struggling with the impact of abuse. The reported experience of a healthy couple offers a glimpse into the ultimate goal of therapy. By studying the perspectives of healthy couples, the researcher may unearth a greater depth and awareness of how CSA not only impacts the couple, but also how they successfully navigate through it.

This study also addresses the lack of research surrounding the experience of the partner of a CSA survivor. By incorporating the partner’s perspective, the study accounts for the unique relational and systemic issues that are known to exist in a couple with a history of CSA. Giving a voice to the partner helps enrich the data and continue to expand the knowledge base of their experiences.

Research Questions

The overarching research question guiding this study is: What is it like for healthy couples manage the potential negative impact of CSA on their relationship and create or sustain a healthy partnership? The sub questions that make up the research question are based on the current literature suggesting that distressed couples with a history of CSA report problems with trust, communication, and sexual intimacy. Additionally, healthy couples with no history of CSA report trust, communication, and sexual intimacy as vital to their success. The sub questions for the study include:

1) How does the history of childhood sexual abuse affect healthy intimate relationships?
2) What is it like for healthy couples with a history of CSA to develop and sustain trust?

3) What is it like for healthy couples with a history of CSA to develop and sustain communication and work through conflict?

4) What is it like for healthy couples with a history of CSA to develop and sustain sexual intimacy?

5) What do couples with a history of CSA believe to be important in overcoming the impact of CSA?

These questions address the researchable problem and purpose of the study by focusing on the how a healthy couple manages the impact of abuse. As mentioned previously, the common issues faced by couples with a history of CSA are problems with trust, communication, and sexual intimacy. The sub questions provide an opportunity to discover how couples with a history of CSA successfully handle those difficulties.

**Significance of the Study**

This study is applicable to many mental health professionals. The results are intended to assist in developing new ways of approaching the conceptualization and treatment of CSA. The study may provide practitioners with new goals or treatment plans that address the issues of CSA. It would be beneficial to have a “model” of a healthy couple when working with couples in distress. Currently, professionals can only speculate what that model looks like.

Another intended benefit of this study includes adding to the existing literature of potentially effective interventions in treating CSA as well as helping treatment providers choose therapeutic techniques that best fit their clients. What healthy couples describe to
be important in overcoming some of the issues of CSA may add to the current repertoire of therapeutic techniques. Couples may also report issues in the relationship as a result of the CSA that are currently unknown in the research. Potentially, there could be impediments to healthy functioning caused by CSA that cannot be recognized while still in distress. Lastly, it was hoped that the data also unveil advantages to partnerships with a history of CSA. There may be an inherent assumption that CSA only has a negative impact on the relationship as no literature has been published suggesting otherwise. It is possible that couples may find benefits such as an increased sense of resilience that would otherwise be absent.

Definition of Terms

The following terms are defined within the context of this study.

**Childhood Sexual Abuse**

Childhood Sexual Abuse (CSA) is defined by Fairweather and Kinder (2013) as, “any sexual contact between a child under the age of 16 and someone at least 5 years older; or unwanted and/or forcible sexual contact between a child under 16 and someone of any age.” (p. 545). Although there are many definitions of CSA, this one is most commonly found in the CSA literature (Fairweather & Kinder, 2013).

**Couples with a History of CSA**

Couples with a History of CSA is defined as two adults in a romantic relationship and one of the adults reports a history of childhood sexual abuse.

**Family of Origin**

Family of Origin is defined by Carter and McGoldrick (1999) as families that are comprised of, “…people who have a shared history and a shared future. They encompass
the entire emotional system of at least three and frequently now four or even five
generations held together by blood, legal, and/or historical ties.” (p. 1).

**Healthy Couple**

Healthy Couple is defined as any two people in a romantic relationship that report
an average to above average level of dyadic functioning. While this definition is fairly
broad with its use of “dyadic functioning” it simply acknowledges that the literature uses
a variety of ways to measure health in a relationship including agreement, emotional
expression, satisfaction, and cohesion (DAS, 1992).

**Partner**

Partner is defined as an adult romantically involved with an adult survivor of
childhood sexual abuse.

**Survivor**

Survivor is defined as anyone who has experienced sexual abuse as child. The
term “survivor” is commonly used in the literature and in treatment of childhood sexual
abuse to help empower individuals in shifting from a mindset of being victims to working
towards recovery (Graber, 1991).
CHAPTER II
REVIEW OF THE LITERATURE

Introduction

The purpose of this study is to examine the lived experiences of healthy couples in which the female survivor reports a history of childhood sexual abuse. Currently, there are few studies that examine the experiences of the partners of survivors. There is also little known on healthy survivors as researchers historically ask participants to report current symptoms of distress (Hyman & Williams, 2001) and relatively few studies were found purposefully sampling healthy survivors. It is likely this will be the first study to investigate couples with a history of CSA that report a healthy relationship as well as add to the small existing research on the partner’s perspective. The objective of this study is to provide information to couples with a history of CSA and mental health professionals to increase the understanding of how CSA affects intimate relationships.

The following sections of the literature review provide an overview of the impact of CSA on the individual including a discussion of risks of psychopathology, substance abuse, health, and vocation. The impact of CSA on the couple is also provided covering problems within the relationship including satisfaction, stability, trust, sexual intimacy, communication, and the impact on the non-abused partner. Resiliency against the impact of CSA is discussed. These include characteristics of abuse and the survivor as well as the role of family of origin. After describing the role of relationship satisfaction, the review examines what non-abused couples believe contributes to the success or health of their relationship. These factors include trust, communication, and sexual intimacy. Upon finishing this review, the reader will have a basic understanding of how CSA
affects the individual and couple; factors that promote resiliency of CSA; and perceived elements of healthy relationships.

Impact of Childhood Sexual Abuse on the Individual

Childhood sexual abuse occurs at a rate of 28% to 30% for women (Cobia, Sobansky, & Ingram, 2004). The average age for the onset of abuse is between the ages of seven and nine (Briere & Runtz, 1988; Hunter, 1991) and typically abuse lasts between two and six years (Briere & Runtz, 1988). Although sexual abuse may not involve touching (ex. exposure to pornography), about 50% of survivors report experiencing oral, vaginal, or anal intercourse or an attempt at oral, vaginal or anal intercourse (Finkelhor, 1990). The result of these experiences may continue to affect the survivor well into adulthood (Cole, Sarlund-Heinrich, & Brown, 2007). The following sections will describe the negative outcomes of CSA in adults with regard to psychopathology, substance abuse, health, and work.

Risk of Psychopathology

Individuals with a history of CSA have a higher risk for developing psychopathology as adults (Browne & Finkelhor, 1986; Tong & Oates, 1990). Survivors are more likely to experience depressive symptoms than non-abused individuals (Sarkar, 2010; Carter, Bewell, Blackmore, & Woodside, 2006). The severity of depressive symptoms also increases if the survivor experiences penetrative abuse and CSA at a younger age (Lee, Lyvers, & Edwards, 2008; Gamble et al., 2006). The relationship between the severity of CSA and depression has also been duplicated in racially diverse groups including African American and Latina women as participants (Sciolla et al., 2011). Not surprisingly, the number of different perpetrators a survivor encounters may
also affect the number of depressive episodes they experience as an adult (Liu, Jager-Hyman, Wagner, Alloy, & Gibb, 2012).

In addition to depression, survivors are also at risk for developing anxiety as adults. A study by Mancini, Van Ameringen, & MacMillan (1995) compared 205 individuals seeking outpatient treatment for anxiety. When the sample was separated by types of childhood abuse, participants with a history of CSA had significantly elevated levels of anxiety beyond the non-abused participants. While a specific diagnosis of anxiety was not linked to CSA, CSA survivors had increased state and trait anxiety. Using data from the 4141 participants in the National Comorbidity Survey-Replication, researchers were able to add to the existing literature by identifying specific anxiety disorders. Individuals with a history of CSA had higher rates of social anxiety disorder, panic disorder, generalized anxiety disorder, and posttraumatic stress disorder (Cougle, Timpano, Sachs-Ericsson, Keough, & Riccardi, 2010).

Post-traumatic stress disorder (PTSD) is an anxiety disorder associated with various types of trauma. The frequency of PTSD among CSA survivors varies from 33% to 86% in previous studies (Polusny & Follette, 1995). This makes intuitive sense as many survivors of CSA may perceive the abuse as a traumatic event. Similar to previously mentioned types of psychopathology, the severity of CSA has also been correlated to the manifestation of PTSD (Saunders et al., 1992). One explanation for the high rates of PTSD in CSA survivors is the shame that often accompanies sexual abuse. Repetitive feelings of shame may prevent the individual from processing the abuse and consequently maintain its symptoms (Sarkar, 2010).
There may also be racial or ethnic differences with regards to the development of PTSD in survivors. Researchers evaluated the prevalence rates of PTSD in 50 African American, Hispanic, and Caucasian girls ages 5-17 (Clear, Vincent, & Harris, 2006). The results showed African American and Caucasian girls had significantly higher rates of post-trauma avoidance than Hispanic girls. These findings fit with previous research that suggests African American females primarily use avoidance as a coping mechanism to CSA (Clear et al., 2006).

A study by Ullman and Filipas (2005) examined potential gender differences as a moderating variable for PTSD symptoms in survivors. Using a sample of 733 college students, the researchers found that women reported more PTSD symptom severity than men. Interestingly, the greater delay in time between the abuse and disclosure increased PTSD symptom severity in women but not in men. These results also suggest the avoidance of dealing with CSA may contribute to more severe PTSD symptoms later on in life.

Survivors of trauma report a rate of suicide attempts two to five times that of the non-abused population (Lopez-Castroman et al., 2013). Additionally, the frequency of suicide attempts and level of intent for completing suicide in CSA survivors increases as the age of onset for abuse decreases (Lopez-Castroman et al., 2013). The relationship between CSA and suicide attempts is particularly alarming. Given the prevalence of CSA noted previously, and the seriousness of suicide, more research needs to be completed in understanding how individuals and couples overcome the psychological damage linked to CSA. While symptoms of anxiety and depression is concerning, the risk of suicide among survivors demands more immediate attention.
The impact of CSA on suicidal ideation may vary based on gender. A study using 166 male and female participants who have recently attempted suicide examined the impact of CSA on suicide (Spokas, Wenzal, Wiltsey Stirman, Brown, Beck, 2009). The researchers found 32% of the participants had a history of CSA. Male CSA survivors had higher levels of hopelessness and suicidal ideation compared to non-abused males. Male survivors also had a history of more suicide attempts. Hopelessness was a significant predictor between CSA and suicidal ideation for both males and females. These results suggest that CSA experiences may impact males and females differently. Male survivors have reported more experiences with physical abuse concurrent with sexual abuse (Watkins & Bentovim, 1992), which could explain higher levels of psychological distress leading to suicidal ideation.

Lastly, the psychopathology of eating disorders is also linked to CSA. There is some research showing a small correlation between anorexia nervosa and CSA (Carter, Bewell, Blackmore, & Woodside 2006). However, most studies including a thorough literature review suggest of all eating disorder types, CSA creates the highest risk for bulimia nervosa. (Wonderlich, Brewerton, Jocic, Dansky, & Abbot 1997; Sanci et al., 2008). Kearney-Cooke & Striegel-Moore RH (1994) go so far as to suggest that bulimia nervosa appeals to CSA survivors because it repeats the abusive cycle of shame and guilt but is followed by purging as a form of self-purification.

There is an abundance of literature connecting the impact of CSA and various forms of psychopathology. The unique contribution that depression, anxiety, PTSD, suicidal ideation, or eating disorders may have on the health of an individual is substantial. Unfortunately, survivors are also likely to experience a comorbidity of
symptoms (Carter, Bewell, Blackmore, & Woodside 2006) and the psychological distress stemming from CSA may be crippling. Additionally, those experiences and symptoms do not operate in isolation as the totality of influence with CSA does not stop at the individual. Survivors will form relationships with others that may grow into partnerships. As survivors experience symptoms, their partners will feel the ripple effects.

**Risk of Substance Abuse**

Because of the psychological distress associated with CSA, survivors are more likely to use substance abuse as a form of coping (Hiebert-Murphy & Woytkiw, 2000). This is further evidenced by the increase of substance abuse within the survivor population. In a review of the existing literature, Simpson & Miller (2002) found samples of CSA survivors report twice as many substance abuse problems as the general population. They also found individuals in substance abuse programs reported a rate of CSA twice the general population.

A New Zealand study compared 298 CSA survivors to non-abused participants using questionnaires and qualitative interviews (Mullen, Martin, Anderson, Romans, & Herbison 1993). The researchers found survivors who experienced intercourse as part of the CSA had higher rates of substance abuse. CSA survivors reported alcohol abuse at a rate of 34% and prescription drug abuse at 25%. This was significantly higher when compared to the non-abused sample which reported rates of 9% and 4% respectively.

**Health Risks**

The health risks associated with CSA are also troubling. The very nature of CSA is obviously sexual and the impact of the abuse carries into adult sexual behavior. A study by Greenberg (2001) examined the relationship between sexually transmitted
diseases (STD’s) and CSA and provided some insight into how CSA affects future sexual behavior. In a sample of 825 women across three major cities who had reported at least one risky behavior linked to acquiring STD’s, 38% to 66% of the women in each city also reported a history of CSA. The study also revealed survivors reported less condom usage, higher rates of drug use before sex, a greater number of male partners in their lifetime, and higher numbers of different STD’s than participants without a history of CSA. The implications of acquiring STD’s within the survivor population are quite serious. Besides the health risks including death, the psychological impact of an STD could have ramifications that negatively impact the survivor’s psyche. The survivor’s propensity to experience shame with their own sexuality may be exacerbated by acquiring an STD. If associations around sex are already sensitive, adding a significant medical condition will likely make the situation even more delicate.

In addition to the higher risk of STD’s, survivors may also have physical changes to their body as a result of abuse. A study by Heim et al. (2000) used a sample of 49 participants to examine the relationship between adrenal output, autonomic responses, and childhood abuse. Their sample was broken down into four groups, (a) women without a history of life stress or psychiatric disorder; (b) women with a history of childhood sexual or physical abuse and without a history of depression; (c) women with a history of childhood sexual or physical abuse and with a history of depression; (d) women without a history of abuse but a diagnosis of depression. By inducing stress on the participants while measuring vitals and stress hormones, the researchers found survivors of CSA had increased adrenal and autonomic responses over that of the control
group. These elevations were six times the controls in CSA survivors who also had a history of depression.

Because increased adrenaline levels are associated with characteristics of fight or flight response, the survivor’s ability to handle a stress in a relationship may be very challenging. Most people experience an emotional reaction during a heated disagreement with their partner which can make communication strenuous. If the survivor is also experiencing the symptoms of fight or flight such as increased heart rate, muscle tension, sweat, and hyper focus, the capacity to successfully or healthfully interact with their partner may be further diminished (Laurent, & Powers 2006).

**Work Outcomes**

The connection between CSA and vocational outcomes has also been briefly reviewed in the literature. Lee & Tolman (2006) used a sample of 632 single mothers who had requested financial assistance from the Temporary Assistance for Needy Families program. Using both surveys and interviews to measure a history of CSA and employment variables, the participants were followed over the course of 33 months. CSA survivors worked an average of one month less than those without a history of CSA. Research did not reveal a clear explanation between the differences in the two groups. However, the authors suggested survivors may have more difficulty transitioning to a new job or problems with attendance that are associated with mental illness and health problems. The implications of this study reveal how the impact of CSA does not stop with the individual but extends into their workplace environment. This study was limited in that it only measured work place absence. It may be interesting to see how workplace stress is affected by CSA as well as how that stress might affect intimate relationships.
The previous sections have revealed the potential impact of CSA on the individual adult survivor. Survivors are at a greater risk for issues with mental health, substance abuse, health problems, and difficulties with employment. This illustrates how the effects of CSA are far reaching into the various domains of the individual. The following sections will expand on the impact of CSA and review how it has the potential to affect a variety of domains within the survivor’s intimate relationship.

Impact of Childhood Sexual Abuse on the Couple

In addition to affecting the survivor intrapersonally, CSA can also influence the survivor interpersonally. Survivors have reported several problems with relational functioning (Rumstein-McKean, & Hunsley, 2001) including higher rates of separation and divorce (Colman & Widom, 2004). The following paragraphs will provide an overview of the common struggles survivors and their partners have reported including relationship satisfaction, relationship stability, trust, sexual intimacy, and communication. This topic concludes with a summary of reported experiences of the partner.

Decrease in Relationship Satisfaction

The literature on relationship satisfaction of couples with a history of CSA is scant but survivors tend to report less overall relationship satisfaction than couples without a history of abuse (DiLillo & Long, 1999). Although the idea of relationship satisfaction is complex, the literature around couple satisfaction frequently uses the Dyadic Adjustment Scale (DAS) as a measure to quantify the concept. Fairweather and Kinder (2013) used a quantitative approach with 287 heterosexual undergraduate female participants. The authors used the DAS to measure relationship satisfaction and surveyed if CSA had occurred, along with its severity. Thirty-three percent of the sample reported
experiencing CSA. Of those survivors, 18% reported abuse at a moderate to severe level (Fairweather & Kinder, 2013). The researchers suggested the experience of CSA predicted lower relationship satisfaction and the severity of abuse was negatively correlated with relationship satisfaction. Even though the DAS is a broad measure of relationship satisfaction, it indicates that couples with a history of abuse are negatively impacted by the abuse. The following paragraphs will describe more specifically how relationship satisfaction can be affected.

Literature around couples therapy provides a framework in how to understand the dynamic relationship of a couple. One theme in that area of research is the concept of the pursuer-distancer pattern. The pursuer-distancer pattern involves one partner attempting to gain control in the relationship by extreme involvement or pursuit of the other. The other partner’s natural response is to avoid or distance themselves from the pursuer. This type of interaction has been connected to single trauma couples and existing in extreme forms (Nelson, Yorgason, Wansgaard, Higgins Kessler, & Carter-Vassol, 2002). An example of this concept often appears around sex. The partner may pursue sex but the survivor may not be willing. The stronger the partner pressures the survivor for sex, the more resistant he or she becomes. The dance between these partners creates an unhealthy cycle of stress. In the case of a trauma survivor, the emotional impairment from the trauma may make these couples more susceptible to the pursuer-distancer theme (Nelson et al., 2002). If these types of patterns continually repeat in the relationship, neither partner will likely feel satisfied or understood.

In addition to problems with the pursuer-distancer pattern, partners of survivors may have a lack of understanding on the effects of CSA. In a qualitative study with 17
heterosexual husbands of survivors, Reid, Wampler, & Taylor (1996) reported that participants commonly felt confused about how CSA impacts their relationship as well as how the process of psychotherapy would affect the survivor. The participants stated that having a greater understanding about CSA early in the marriage would have helped tremendously. Ignorance around the experience of CSA reportedly led participants to feel alienated from their partner. This line of research emphasizes how CSA extends beyond the survivor. Not only are the partners of survivors affected, but they must take an active role in education to help mitigate potentially negative experiences. Given the few studies available that focus on the partner, it also reinforces that there may be value in continuing to include partners in research.

Even with education around CSA, partners of survivors may inadvertently become associated with the perpetrators of the abuse. Many times perpetrators of CSA will use psychological coercion involving love and affection to help maintain the abusive relationship (Cobia, Sobansky, & Ingram, 2004). When the survivor moves into adulthood, those associations of love and abuse may continue and even transfer into new intimate relationships. This overgeneralization of the abuse can clearly impact sexual intimacy and lead to feelings of guilt for the survivor (Noll, Trickett, & Putnam, 2003). If a partner’s expression of love is associated with past abuse, both partners perception of the relationship may become confusing as intimacy and guilt are not emotions that can easily coexist.

**Relationship Stability**

The romantic relationships of trauma survivors differ from non-abused individuals within the stability of those relationships. Survivors of common types of
trauma have reported greater rates of divorce, separation, and cohabitation than non-abused control groups (Colman & Widom, 2004). More specifically, CSA survivors consistently report increased instances of divorce and separation (Mullen, Martin, Romans, & Herbison, 1994). Despite the negative outcomes of long term partnerships, CSA survivors do not report less frequency in seeking marriage (Colman & Widom, 2004). Female survivors may have a predisposition to pursuing romantic relationships that are based on casual intimacy with little expectation for long term stability (Arriola, Louden, Doldren, & Fortenberry, 2005). The lack of relational commitment within the survivor population may be connected to the issues of intimacy and trust (DiLillo, 2001) and will be discussed in the next sections.

**Problems with Trust**

The components of a healthy relationship will be discussed later in this review but one of the core elements is trust. One of the long term effects of CSA is difficulty developing trust in adult relationships because the act of CSA is in itself a violation of trust (Graber, 1991; Maltz, 1988). This may stem from feelings of betrayal that are commonly associated with CSA (Finklehor & Browen, 1985). In response to lack of trust, both trauma survivors and their partners have reported trying to test the relationship to see if the other would end it prematurely (Henry et al., 2011). Survivors have explained this kind of behavior being motivated by insecurities lingering from previous relationships as well as the abuse (Henry et al., 2011). Testing the limits of a relationship suggests a lack of trust in the other partner and may partially explain the higher divorce rates among survivor couples.
The difficulty cultivating trust in couples with a history of CSA may come from the survivor’s perception of the partner as well as a sense of betrayal. The study by Mullen et al. (1994) mentioned previously, found that survivors were more likely to perceive their partners as uncaring and over controlling compared to the non-abused women. It was not clear in the study if these partners were indeed more uncaring and controlling or if survivors had developed an inaccurate identity for their partners. Regardless of the reason, if the survivor feels like the partner is not caring there may be difficulty developing trust.

**Problems with Sexual Intimacy**

Although not well researched in the literature, couples affected by CSA may struggle with a variety of sexual problems that affect intimacy (Davis, & Petretic-Jackson, 2000). In a review of the literature, Davis and Petretic (2000) describe three patterns of sexual intimacy that commonly emerge in the CSA literature. The first occurs when the survivor has difficulty trusting people and may use sex as a way of relating to others. This pattern can result in sexual relationships that are casual and short-lived. If the relationship begins to foster a deeper level of intimacy, the survivor may abandon the relationship because the heightened sense of closeness is uncomfortable. The second type is different from the first in that the survivor will attempt to avoid sex and intimacy all together. In the third type, survivors experience a fear of sex and intimacy but their desire to be in a relationship is compelling enough to find a partner regardless of those feelings. As a result, survivors may seek partners without monitoring their sense of trust or self-worth and may be at a higher risk for abusive relationships.
Sexual desire as an adult may also be impacted by CSA. Wincze and Carey (1991) describe three approaches to sex survivors may use to cope with CSA. Some survivors may have a neutral approach to sex. That is to say they do not necessarily seek it out as an activity nor do they shy away from it. Others may have more negative feelings. These individuals described feeling guilty about their low drive for sex. Some survivors may also feel anxiety associated with sex because the fear of injury during the abuse has not been separated from healthy sexual functioning. Maltz (2001) makes note that many survivors with a neutral approach to sex are unlikely candidates to seek therapy on their own. She described experiences in her own practice of couples seeking therapy because the partner expresses frustration over a lack of sex. An imbalance between sexual drive may lead to feelings of sexual obligation or resentment from the survivor (Jehu, 1988). In each of these styles of coping with CSA, the survivor seems to be motivated by self-protection. Unfortunately, these survival approaches may be detrimental to a healthy relationship.

Potential changes in sexual desire are not the only differences in sexuality for survivors. Childhood sexual abuse may also contribute to a number of problematic experiences for the survivor during sexual activity. During the abuse, disassociation is a defense mechanism that can be used to psychologically remove oneself from the traumatic event (Hughes, 1994). Even though the child is there physically, the conscious mind of the survivor is focused on something else entirely. Dissociation can continue to occur during sexual activity as an adult. The mechanism that protected the survivor as a child may impair their future consensual sexual experiences as adult survivors complain that they feel their body is separate from their identity (Maltz, 1988).
In addition to disassociation, survivors may experience triggers and flashbacks that make sexual activity problematic. Triggers are stimuli that are picked up by the survivor’s senses during the abuse (Hughes, 1994). For example, the perpetrator’s deodorant may be associated with unpleasant feelings or memories of abuse. If the survivor’s adult partner was wearing the same deodorant, the survivor may be triggered by the same smell. Maltz (1988) described various triggers including cigarettes, sounds, feeling a partner’s body weight, even moaning or specific sexual words. Once a trigger occurs, the survivor may experience an intense and visceral remembrance of the abuse called a flashback (Hughes, 1994). These memories may feel very real and in the present moment. They can be visual, auditory, bodily feelings, or involve tasting and smelling (Davis, 1991).

Disassociation and flashbacks are some of the psychological problems during sexual activity but survivors may also experience pain during sex. Commonly referred to as dyspareunia, painful intercourse has been reported at higher incidences in survivors. Jehu (1988) found that pain during sex, either from lack of lubrication or involuntary muscle contractions, occurred in 27% of a clinical sample of abused women compared to none of the non-abused group. A study using a college sample affirmed Jehu’s findings with a rate of 25% (Jackson et al., 1990).

**Problems with Communication**

Survivors and partners may experience difficulties communicating with each other. Some research has suggested that these challenges are directly related to feelings of shame, stigmatization, and inferiority that are already linked to survivors (Finkelhor, 1988). Another study affirmed the connection with shame but added problems with
mistrust and low self-esteem as contributors to unhealthy communication (Reid, Wampler, & Taylor, 1996). Interestingly, partners have also reported feelings of betrayal because survivors were unwilling or unable to share information about the abuse. This withholding of information reportedly led to dysfunctional styles of communication (Reid, Wampler, & Taylor, 1996).

Shame and other detriments from CSA may contribute to problems with communication but it does not elucidate the specific issues with communication. Pistorello and Follette (1998) videotaped 55 female survivors in therapy groups and analyzed the difficulties they reported in relationships. One of the most widespread themes reported was difficulty communicating emotions to their partners. The authors explain this phenomenon as a childhood coping mechanism for CSA. Abused children may be reluctant to share intimate details or emotions as a way of protecting themselves. Unfortunately, this survival tool may act as a barrier if it continues to be used in adult intimate relationships. The prevalence of problems with communication was examined in a 1994 study (Mullen et al.) that found 23% of survivors reported lacking any meaningful communication with their partners. When compared to a rate of 6% in the non-abused sample, the effect of CSA on the depth of couple communication is quite striking.

**Impact on the Non-Abused Partner**

Understandably, much of the literature examines the impact of CSA on the survivor with substantially less focusing on the couple. As researchers learn about the survivor and couple, the experience of the partner becomes difficult to overlook. Over the last 20 years, a handful of studies have used qualitative methodology to understand
how CSA affects the partner. The most notable contribution emerging is the concept of secondary trauma experienced by the partner (Graber, 1991; Maltz 1988). The close association and shared experiences between the partner and survivor can create symptoms of trauma in the partner (Maltas, & Shay, 1995). Recall the symptomatic impact of CSA described previously and consider the emotional toll it may create on those close to the survivor, particularly the partner.

Part of the secondary trauma experienced by some partners may be rooted in the unpredictability of emotions in the survivor. Bacon and Lein (1996) used a qualitative approach to study the perspectives of six male partners. The participants reported feelings of frustration over the seemingly random triggers for the survivor’s anger. The men in this study also described feeling like their partner’s anger was unreasonable and misdirected at them. The challenges created by this turmoil reportedly led to feelings of grief around the relationship. Participants described the long term impact of abuse with a sense of loss over the relationship they once had.

In addition to studying the experiences of partners in the relationship, the literature has begun to address the partner’s perspective on the treatment process for CSA. Reid, Wampler, and Taylor (1996) used a qualitative approach to examine how 17 male partners viewed the survivor’s therapy for treating CSA. The participants reported that individual therapy for the survivor provided a positive forum to share details about the abuse. Conversely, they also described feeling isolated from the survivor’s experience in therapy and suggested it was due to the preference of the therapist rather than the survivor. Participants also reported that therapy was not enough to address all the relational issues created by CSA. They specifically reported problems with
communication, sexual activity, and non-sexual physical touch as problems still existing after therapy. The data presented by Reid, Wampler, and Taylor (1996) strengthen the case for the importance of the present study. Partners are reporting that therapy does not fully address their relational problems. Perhaps interviewing healthy couples may help uncover how to help distressed couples that have already been through therapy take the next step.

The preceding paragraphs provides an overview of how the partner may be experiencing the impact of abuse. Just being partnered with a survivor may be enough to experience similar symptoms of trauma as a ripple effect from the abuse. Partners have also reported feeling alienated from therapy and acknowledged that therapy itself did not fully address all the problems in the relationship. Now that the reader understands the extent of how CSA can impact an individual and their partner, the review will turn toward the variables that predict resiliency or coping with abuse.

Resiliency and Mediating Factors

At this point the reader should be familiar with the intrapersonal and interpersonal impact of CSA. The degree to which those negative experiences manifest may be influenced by a number of factors that create one’s resiliency. Although there is no universal definition of resiliency within the literature, a simple definition is the absence of pathology and a high level of well-being in spite of a life stressor (McClure, Chavez, Agars, Peacock, & Matosian, 2008). This part of the review examines the factors that have been associated with resiliency in survivors of CSA including characteristics of the abuse and survivor as well as the impact of the family of origin.
Characteristics of Abuse and Survivors

As one might expect, there are many different forms, contexts, and situations in which CSA is perpetrated. These variables may influence how the survivor functions as an adult. Abuse from family members, penetrative abuse, and the use of physical force in addition to sexual abuse have been associated with higher levels of distress in adulthood (Russell, 1986). Additionally, abuse at a younger age, increased frequency, and longer periods of abuse have also been correlated with increased psychological problems for survivors (Bagley & Ramsey, 1986; Browne & Finkelhor, 1986). This line of research further reinforces the complexity of CSA. Even though two people may fall under the description of “CSA survivor” the experiences and details of abuse likely differ and contribute to their resiliency outcomes.

While many valuable studies will be described in the following paragraphs, it is important to highlight two pieces of scholarship; a study by Bogar and Hulse-Killacky (2006) and another by Valentine and Feinauer (1993). These studies stand out as no other research was found in the literature that purposely sought out a healthy sample of survivors. The Bogar and Hulse-Killacky qualitative research is noteworthy as it uses a sample of 10 female survivors that self-report as being healthy and in stable relationships. This is similar to the present study in that it focuses on non-distressed participants although it did not include their male partners. The authors examined the role of resiliency in the couples. They found that participants reported five common themes: (a) interpersonally skilled in areas of verbal ability and emotional expression; (b) competence and ability to identify areas of talent or success; (c) high self-regard; (d) identified some form of spirituality; (e) identified a beneficial life circumstance that
fostered resiliency in adulthood. Interestingly, the results seem to reinforce the notion that CSA impacts survivors in many different areas of their functioning as the participants reported areas of resilience are quite diverse.

Similar to the Bogar and Hulse-Killacky (2006) study, Valentine and Feinauer (1993) investigated resiliency variables in healthy female survivors as all 22 participants self-described as “functioning well”. A qualitative analysis revealed themes of: (a) seeking support outside the family; (b) positive self-regard; (c) religion or spirituality; (d) externalizing blame; (e) an inner locus of control driven by internal values. The overlap in findings with the previous study of positive self-regard and religion/spirituality may suggest that there is some consistency in resiliency factors for survivors of CSA. Identifying potential common resiliency factors is especially interesting given the substantial variations in a survivor’s experience with CSA (i.e. duration, frequency, age at time of abuse, etc.)

As indicated in the previous two studies, spirituality may play an important role in how the survivor is impacted by abuse. Research suggests that spiritual coping predicts distress levels in survivors (Gall, 2006). The type of spiritual coping can have an impact as well. Survivors that use spirituality as a source of blame for the abuse reported more depression while survivors that use spirituality as a source of comfort reported lower levels of anger and depression (Gall, 2006). There is also some evidence to suggest that the age when the abuse occurred affects the survivor’s utilization of spiritual coping. Adults who reported being abused at younger ages were less likely to use God as a support in recovery from abuse (Gall, 2006). Ganje-Fling and McCarthy (1996) suggest that connection between CSA and mistrust can carry over into a child’s trust of God.
Children that were abused at a young age may have more issues with trust and project those suspicions into a relationship with God.

In addition to spirituality, the type of defense mechanisms employed by the survivor has been shown to influence the connection between CSA and intimate relationships. A previously referenced quantitative study using 287 heterosexual undergraduate females measured if CSA had occurred, a number of relationship variables, and whether the participants tended to use mature or immature defense mechanisms (Fairweather & Kinder, 2013). The authors described immature defenses as those employed at a young age such as denial or pretending something did not happen. They described mature defense as those used later in development such as sublimation or taking unwanted feelings and finding a way to apply them towards a productive purpose. The results of the study suggest that survivors who use mature defense mechanisms to deal with CSA are more likely to participate in activities with their partner (known as dyadic cohesion) regardless of the severity of abuse.

There may also be predictive factors of resiliency for survivors within their demographics. Unlike the research described previously, Hyman and Williams (2001) used a longitudinal study with 136 women. Participants were assessed in the areas of history of CSA, family functioning, demographics, and psychological well-being. The results revealed six variables that contribute to the concept of resilience: stability in the home as a child, the abuse was not incestuous, the abuse did not include physical force, absence of arrests as a juvenile, graduating from high school, and never being re-victimized in adulthood. The authors reported graduating from high school as the strongest predictor of resilience.
The significance of the education variable is critical as it may create a feeling of empowerment over the abuse. It would be unlikely if the survivor is able to choose whether the abuse is incestuous or physical force is involved, but in many cases, survivors will have the opportunity to graduate high school. If survivors are aware that education can help mitigate the adverse effects of CSA, it may foster a feeling of control over something that feels out of their control. The results of this study also shape the present study by informing the types of demographic questions that will be used on the intake form. For example, requesting information on the participant’s highest level of education will be helpful to further the existing research by evaluating the role of education in healthy couples.

**Family of Origin**

The impact of family of origin has been historically connected to adult mental health (Bowen, 1978). Not surprisingly, a survivor’s resiliency to CSA may be correlated with their family of origin. Several studies have shown that issues like depression may be mediated by a survivor’s family of origin (Edwards, & Alexander, 1992; Romans, Martin, Anderson, O’Shea, & Mullen, 1995). The concept of family of origin is complex and is comprised of many different pieces that make up family functioning. Many of these pieces are broken down and measured through various assessment tools. For example, Meyerson, Long, Miranda, and Marx (2002) used the Family Environment Scale to measure cohesion and conflict within the families of 131 adolescents. Participants were also surveyed for past experiences with abuse and psychological well-being. Family conflict was described as aggression and anger within the family and family cohesion represented the level of support. The results suggest that female
survivors reported more conflict and less cohesion within their family of origin. These conclusions were consistent with adult survivors as well (Benedict & Zautra, 1993). Previous research has shown family cohesion acts as a protective factor against other life stressors (Cohen & Willis, 1985) and its role in limiting the negative impact of CSA may be similar.

Alexander and Lupfer (1987) surveyed 586 undergraduate students and compared various types of sexual abuse and the family environment. Like Meyerson et al. (2002), they found higher rates of conflict and lower cohesion in survivors’ families of origin but also reported survivors having problems with family adaptability. Survivors in this study described more rigidity in family structure and when responding to stress than non-abused participants. A 1990 study using undergraduate women (Jackson, Calhoun, Amick, Maddever, & Habif) found survivors described their family as more controlling than non-abused participants. Similar to family cohesion, perhaps families with more flexibility and freedom provide an environment that reduces problems in adulthood for the survivor.

Nelson and Wampler (2000) offered one of the few studies incorporating family of origin variables and history of CSA in a sample of heterosexual couples. The authors used the Family Adjustment and Cohesion Scales (FACES III) on 161 couples with 96 reporting at least one partner identifying as a survivor of physical or sexual abuse. Interestingly, couples with a history of abuse reported lower scores on family cohesion compared to the non-abused couples. The lower score on cohesion suggests these couples lack the closeness of emotional intimacy experienced by non-abused couples.
It should be noted that within the shared CSA and family of origin literature lies a problem in methodology. Many studies survey survivors for influences of family environment on psychological well-being in adulthood and make predictions on the impact of CSA. The problem researchers face is that family environment is known to predict psychological well-being regardless of a history of CSA (Briere, 1988). The question for many of these studies is if family functioning is mitigating the impact of CSA or if family functioning itself is causing the problems for the survivors. In a thorough review of the literature, Draucker (1996) noted several studies that separate the influence of both CSA and family environment on adult functioning. She reported that the relationship between the two variables is complex but ultimately concluded that family of origin variables contribute to predicting the impact of CSA on adult survivors.

Within the resiliency literature is the concept of family resiliency. Walsh (2006) defines family resiliency as the coping and adaptational processes in the family as a functional unit. As noted earlier, the research suggests CSA operates on a systemic level within relationships and it may be helpful to then examine resiliency through the same systemic lens. Walsh (2010) further indicates that family resiliency creates a shift from focusing on the deficits and limitations to strengths, resources, and potential.

Walsh’s (2010) research suggests resilient families have displayed key components of resilience worth noting. These are belief systems, organizational patterns, and communication processes. The belief systems include how families find meaning in the crisis, a positive outlook including hope, and a spiritual practice or faith that can help connect families to a broader existence. The organizational patterns include being flexible in the face of challenges, providing mutual support and collaboration, and having social
and economic resources. Lastly, communication processes include clear and consistent messages of truth, sharing feelings and respecting differences, and teamwork. These factors of family resilience further inform this study in that it highlights potential strengths that may be reported in healthy couples with a history of CSA.

The recent push in the literature to examine resiliency in CSA survivors is encouraging. The research is uncovering important factors such as types of abuse, spirituality, defense mechanisms, demographics, and family cohesion and adaptability to help explain why some survivors report a particular symptom and others do not. This form of research is along the path of the present study in that it looks for solutions to overcome the impact of CSA rather than focusing on the problem.

Relationship Satisfaction in Healthy Couples

Previously described in the review was a summary on declining relationship satisfaction in couples with a history of CSA. Not surprisingly, relationship satisfaction is commonly used in the literature to assess the health of the relationship as low satisfaction rates are linked to separation (Gottman, 1993). The literature on relationship satisfaction is similar to the previous literature on the impact of CSA on couples; it tends to report on symptoms or aspects that weaken the relationship rather than what sustains it (Beck & Clark, 2010). Because of this bias, literature on what constitutes a healthy couple is surprisingly dearth while data examining relational deficits is plentiful. Researchers agree that there needs to be an increased focus on the positive processes of healthy couples (Ebling & Levenson, 2003; Rosen-Grandon, Myers, & Hattie, 2004). This section will review the concept of relationship satisfaction and how trust, communication, and sexual intimacy contribute to a healthy relationship.
Relationship Satisfaction

Constructing a definition of relationship satisfaction may be challenging as the literature varies in how it interprets the meaning. In a review of the literature dating back 50 years, McCabe (2006) found that researchers attempted to measure relationship satisfaction by using length of time in the relationship, the level of intimacy, amount of shared activities, and general declarations of happiness in marriage. While each of these variables may contribute to what most consider relationship satisfaction, it clearly points to the lack of a universal way of understanding it. Relationship satisfaction is a complex construct and the reader should be aware of these variations when drawing conclusions from the literature.

How individuals understand relationship satisfaction may vary by experience. Younger individuals at the life stage of selecting a partner have reported interesting assumptions about happiness in intimate relationships. These beliefs have a Romeo and Juliet persona as the individuals imagine there is one true love and their perfect love will protect them from any challenges in the relationship (Weaver & Ganong, 2004). These beliefs are cross-cultural as young individuals in other countries have reported that healthy relationships rarely have arguing and require little work to preserve happiness (Goodwin & Gaines, 2004). This research suggests that many young people have a more romantic than realistic view of partnership. This may become problematic as their idealistic sense of relationship satisfaction begins to deteriorate.

The expectations that partners bring into the relationship may also impact the satisfaction. In a study by Sullivan & Schwebel (2013), researchers found that participants surveyed expected their relationship satisfaction while dating, engagement,
and marriage to exceed their perception of the average couple. Participants also described an expectation of ever-increasing relationship satisfaction as time progressed over the course of the relationship. Interestingly, the participants with more realistic expectations of relationship satisfaction actually reported more satisfaction than those with unrealistic beliefs (Sullivan & Schwebel, 2013).

These unrealistic beliefs coincide with a trend of declining happiness in marriage for men over the past 40 years. Sixty-three percent of males and 66% of females reported being happy in their marriage today compared to 69% and 61% respectively in the early 1970’s (National Marriage Project, 2012). The drop in relationship satisfaction may be partially explained by declining rates of marital interaction over a similar time period (Amato, Johnson, Booth, & Roger, 2003).

Although relationship satisfaction may be dropping for men at a societal level, the satisfaction level for most happy couples remains the same throughout the relationship. In two separate studies by Lavner & Bradbury (2012), 251 newlywed couples were assessed for relational satisfaction, relationship problems, aggression, stress, negative attributions, and self-esteem every six months for four years. Their results suggest that couples who report high levels of satisfaction at the onset of the marriage maintain that level over time. Couples that initially report lower levels of satisfaction had a significant decline over the course of the study (Lavner & Bradbury, 2012). The authors also reported that couples with lower initial relational satisfaction had separation or divorce rates three to four times higher than those with higher levels of satisfaction. The results of this study are consistent with previous research that found couples with the highest
initial level of satisfaction saw the least decline over time (Kamp Dush, Taylor, & Kroeger, 2008).

The results from the previous studies help shape the present study. Because participating couples will have been in a relationship a minimum of two years, couples who report higher relational satisfaction via the DAS will likely maintain a similar level of satisfaction throughout the relationship. These results suggest that the healthy couples being studied are not in a “phase” of being healthy but are indicative of the longitudinal health of the relationship.

Another noteworthy factor in evaluating the satisfaction in relationships is the presence of counseling. In a quantitative study of relational satisfaction, Mirecki, Chou, Elliot, and Schneider (2013) found that couples who were currently in counseling reported significantly lower levels of relational satisfaction. Naturally, couples seeking counseling are likely in distress. This study also helps inform the present study as couples currently in counseling will be excluded from participating in an effort to ensure the sample is comprised of healthy couples.

The presence of dyadic coping may also be a sign of health in the relationship. Dyadic coping is an interpersonal pattern where one partner experiences distress, communicates that distress to the other partner, and receives support in managing the stressor (Bodenmann & Randall, 2012). The couple’s ability to use each other in managing the stress experienced by one member has been shown to be a predictor of relationship stability and functioning (Bodenmann, Pihet, & Kayser, 2006; Papp & Witt, 2010). The usefulness of dyadic coping may force the couple to rely on each other for problem solving. This form of stress management may be especially important for
survivors and their partners as they are more likely to experience the stressors previously reported in this chapter.

**Trust**

Some researchers have suggested that the role of trust in intimate relationships goes back to early stages of development (Erickson, 1959; Bowlby, 1973), while others focus more on the present circumstances of the relationship (Kelley & Thibaut, 1978). Trust may also vary based on the stage of the relationship. Holmes (1991) claimed that individuals early in a dating relationship report trusting their partner, but what was described as trust was actually hope that the other partner trusted them. In order to firmly establish trust in the relationship, the partner must display the concept of dependability which is described as reliability and fulfilling his or her promises (Rempel, Holmes, & Zanna, 1985).

Not surprisingly, trust has been reported as an essential component of the relationship in healthy couples. Levitt et al. (2006) used a qualitative methodology to examine relationship factors in a sample of eight individuals in healthy relationships. Seven of the eight participants reported trustworthiness as an important piece of successful relationships. They described the concept of trust as being made up of reliability, safety, maturity, decisiveness, and similarity to self (Levitt et al., 2006). These results seem to coincide with previously mentioned literature on problems with trust in couples with a history of CSA (Graber, 1991; Maltz, 1988). If safety is a core element of trust for healthy couples, survivors may have problems developing trust because of the childhood violation of trust through experienced abuse.
The importance of trust may vary depending on the gender of the partner. McCue (2006), surveyed 50 couples on relational satisfaction and trustworthiness. The author found that while trust predicted relational satisfaction for both genders, it had a stronger effect for males than females. It is not clear why males may place more importance in perceived trust and further research in this area may be useful.

Additionally, McCue (2006) also examined the role of honesty and expectations about the relationship. The author found that perceived honesty in the other partner was the best predictor of participants reporting a favorable future in their relationship (McCue, 2006). In other words, if individuals believe they have an honest partner, they are more likely to be optimistic about the relationship. This makes intuitive sense and corroborates the hypothesis that trust is essential to a healthy and long lasting relationship.

**Communication**

While trust is an important component of a healthy relationship, the way couples communicate with each other may be the most important piece in maintaining relational health (Gottman & Notarius, 2002; McKenzie, 2003). Higher divorce rates have also been associated with problems communicating (Birditt, Brow, Orbauch, & McIlvane, 2010; Gottman & Notarius, 2000) and conflict between partners may make communication more challenging (Busby & Holman, 2009). Distressed couples have reported less constructive communication, avoidance of communication, and more psychological distance than non-distressed couples (Christensen & Shenk, 1991). Clearly the impact of communication on the health of the relationship is paramount.
The importance of communication in a healthy relationship is also evidenced by how distressed marriages are usually treated. Most empirically tested relationship programs used to help couples are focused on a couple’s communication skills (Halford, 1999). Two popular models that emphasize communication are the Prevention and Relationship Enhancement Program (PREP; Markman, Stanley, & Blumberg, 1994) and Facilitating Open Couples Communication Understanding and Study (FOCCUS; Markey, Micheletto, & Becker, 1997). While the long term impact of relational education programs has yet to be sorted out in the research (Halford, Sander, & Behrens, 2001), the initial increase in relational satisfaction from completing these interventions further suggests the importance of communication skills (Hahlweg, Markamn, Thurmair, Engel, & Eckert, 1998).

If communication is vital to relational success, how couples communicate must be explored. Dindia, and Baxter (1987) evaluated 50 couples for relational satisfaction and asked them to list up to ten ways they maintain their relationships and up to ten ways they repair their relationship. After analyzing the data, the authors reported five strategies that were associated with higher rates of satisfaction: (a) making time to communicate with each other in an honest way; (b) communicating about how they communicate – particularly around problem solving; (c) pro-social strategies like being nice and cheerful to each other; (d) utilizing ceremonies and rituals to express affection; (e) spending time together with shared activities. Four of the five strategies have a clear connection to the importance of communication. The depth of communication for healthy couples even went so far as to involve metacommunication, suggesting that simply communicating is not enough. Happy couples talk about how to talk about issues. Additional research on
intimate relationships lasting an average of 30 years confirmed the significance of communication but added the importance of not avoiding communicating about differences between partners (Mackley, Diemer, & O’Brien, 2004).

**Sexual Intimacy**

In the same way communication has been linked to the satisfaction of the relationship, sexual intimacy can also impact relational satisfaction (Christopher & Sprecher, 2000; Young, Denny, Luquis, & Young, 1998; Hulbert & Apt, 1994). Researchers have also reported that sexual intimacy is one of the most important contributors to relationship satisfaction (Henderson-King & Veroff, 1994). These results conflict with previous research by Gottman (1994) suggesting that communication is the most important contributor. Perhaps Trudel, (2002) was able to make sense of this discrepancy in finding that relationship satisfaction was highly correlated with communication about sex in couples under the age of 60. Regardless of ordinal importance, sexual intimacy and communication are clear contributors to the health of intimate relationships.

The manner in which sexual intimacy affects relational satisfaction may be different across genders. McCabe and Cobain (1998) reported that problems with sexual intimacy had a significant impact on relationship satisfaction for females but less so for males. Given that relationship satisfaction is correlated with sexual satisfaction for both genders, it is interesting that problems with sex affect the female partner more than the male. Previous research suggests that men experience less sexual intimacy than women in relationships (Greeff, & Malherbe, 2001) and therefore may not be as impacted by problems with sex. Further research into these variables would be beneficial. The
current study may provide additional data regarding gender differences on sexual satisfaction as it affects martial satisfaction in healthy couples with a history of CSA.

Even though the impact of sexual satisfaction on relationship satisfaction may be different for both genders, the experience of what individuals want out of sex may be similar. Case (1999) surveyed 73 heterosexual couples who had been together for at least six months. She gathered data on the couples’ sexual and relationship satisfaction, as well as expectations for sex. Both males and females reported an equal desire to feel loved, wanted, needed, and not ignored. Possible limitations for this data stem from the sample of undergraduate students. As reported previously in Weaver and Ganong (2004), younger couples may have unrealistic expectations for relationships. Without a more diverse sample, it is unknown if expectations for sex may also vary according to age.

The previous paragraphs described the concept of relationship satisfaction as its existence and perception in the relationship is indicative of the relationship’s health. Research commonly uses relationship satisfaction as a measure of health. More specifically, elements of trust, communication, and sexual intimacy seem to make significant contributions to relationship satisfaction despite being experienced differently by gender.

**Summary**

This chapter provided a review of the literature on CSA. Within these sections, exists a thorough description of how CSA impacts the survivor. Because of the interpersonal nature of CSA, as well as the focus of the study, a review of how CSA affects intimate relationships was also provided. Several factors that may influence the degree to which CSA alters the survivor and the partner by proxy were described. The
last section offered the reader an understanding of what creates a healthy intimate relationship. This review also noted several limitations in the research including a lack of information on the partner’s perspective as well as using healthy couples with a history of CSA to propose a model of relational health for those couples. This study attempts to reduce the gap in the research by using a phenomenological study with healthy couples with a history of CSA to better understand their lived experiences.
CHAPTER III

METHODOLOGY

Research Design

The design used in this study is a phenomenological approach that is rooted in qualitative research. A phenomenological study attempts to describe the lived experiences of several individuals that have a common phenomenon (Creswell, 2007). The experiences and behaviors of the people experiencing the phenomenon are inseparable from the phenomenon itself (Moustakas, 1994). Phenomenological research shifts the focus onto the collective experiences and reports on the essence of that experience (Creswell, 2007; Moustakas, 1994). This is done using research questions that typically begin with, “What’s it like to…?” This study summarizes the common experiences of healthy couples with a history of CSA into the essence of that lived phenomenon.

Because there is little known about the relational styles of healthy couples with a history of CSA, a phenomenological study is a natural fit for further research. Currently, there is a gap in the research exploring the experience of how to overcome the effects of CSA in an intimate relationship. This study describes and captures the lived experiences of being in a healthy relationship in which one partner has a history of CSA in order to expand the research and knowledge base for improving treatment. A phenomenological study provides the opportunity to diminish the size of that gap.

Research Questions

The overarching research question guiding this study is: What is it like for healthy couples to manage the potential negative impact of CSA on their relationship and create
or sustain a healthy partnership? The sub questions that make up the research question are based on the current literature suggesting that distressed couples with a history of CSA report problems with trust, communication, and sexual intimacy. Additionally, healthy couples with no history of CSA report trust, communication, and sexual intimacy as vital to their success. The sub questions for the study include:

1) How does the history of childhood sexual abuse affect healthy intimate relationships?
2) What is it like for healthy couples with a history of CSA to develop and sustain trust?
3) What is it like for healthy couples with a history of CSA to develop and sustain communication and work through conflict?
4) What is it like for healthy couples with a history of CSA to develop and sustain sexual intimacy?
5) What do couples with a history of CSA believe to be important in overcoming the impact of CSA?

Setting, Access, Participants, and Sampling

Before any recruitment began, the researcher obtained permission through WMU’s HSIRB as this study involves human subjects. The proposal was approved on February 19th, 2014 after a full board HSIRB review. Access to participants and data collected expired on December 18th, 2015. There were no reported concerns or problems during the recruitment phase.

The participant sample consisted of eight couples. Because each couple must have experienced the phenomenon of being in a relationship with a history of CSA,
criterion sampling was used. With criterion sampling, participants must meet a set of inclusionary criteria to be included (Creswell, 2007). All participants were required to be a minimum of 21 years old. Marital status for the couples did not influence participation, but each couple was required to have been cohabitating for a minimum of two years. A minimum of two years was used to establish the stability of the relationship and a consistent level of relationship satisfaction. Lavner & Bradbury (2012) reported that couples with higher relationship satisfaction at the beginning of the relationship maintain a similar level of satisfaction over time. For the purposes of this study, the relationship satisfaction reported by couples cohabitating for at least two years will likely represent their long term satisfaction rather than an anomaly during the assessment.

The researcher also sought out couples with survivors of CSA who were male or female. One couple in this study included a male survivor while the remaining seven reported a female survivor. The researcher also made a concerted effort to recruit same-sex couples through advertisements that explicitly asked for their participation, but only heterosexual couples responded. In an attempt to isolate the effects of CSA on the relationship from other types of childhood trauma, couples with any reported history of childhood physical abuse or neglect were excluded. Couples in which both partners have experienced trauma may create relationship dynamics distinctive from single trauma relationships including competitiveness, preoccupation with trauma, and dismissing of complaints (Nelson et al., 2002). This study excluded dual trauma couples in order to focus on data for single trauma couples.

Mirecki et al. (2013) found that couples currently in counseling report higher levels of distress. In order to maximize the likelihood of a relational healthy sample,
couples currently in couples or individual counseling were excluded. Excluding couples currently in counseling may also help in collecting data that is not heavily influenced by current therapeutic concepts or techniques. The potential benefit of this study is to learn how couples mitigate the impact of abuse beyond what is already assumed to be clinically therapeutic.

In order to create a sense of safety and privacy, the researcher encouraged couples to be interviewed where they felt most comfortable. If the participants were local to the researcher they were given an option of interviewing at their home, at a local counseling center with private room, or over Skype. Participants not local were interviewed via Skype and encouraged to find a space where they felt comfortable to talk openly and without distraction. Three couples were interviewed in-person at their residence while the remaining five couples chose to be interviewed over Skype.

Potential participants were recruited through flyers posted on Western Michigan University’s Campus (See Appendix A), e-versions of the flyers posted on internet forums, word of mouth, social networking sites (i.e., Facebook), and snowballing. Snowballing is a recruitment technique in which the researcher asks the participants to recommend any other individuals that would be a good fit for the study (Creswell, 2005). Individuals were invited to respond via telephone or email. When a potential participant responded, the researcher used the initial telephone and email response script (See Appendix B) to respond to the inquiry. The researcher communicated with one member of the couple and let them determine if the couple met the initial criteria and would like to learn more about the study through the mailed packets containing a detailed description of the study.
If he or she verbally agreed to participate in the study, a packet including instructions (Appendix K), demographic form (Appendix E), consent form (Appendix D), and a list of mental health resources (Appendix G), and copies of the Revised Dyadic Adjustment Scale and Family of Origin Scale were mailed. Potential participants were asked to return the completed informed consent document in one stamped envelope provided and each partner’s copy of the Demographic Form, Revised Dyadic Adjustment Scale (RDAS), and Family of Origin Scale (FOS) into the other stamped envelope. Responses to all research questions and information on all forms were anonymous and tracked using a coded number assigned to each couple with the exception of the informed consent document. This prevented anyone from connecting data about the couple to the names of the participants if an envelope was lost in the mail. All packets sent in the mail were returned to the researcher.

Once both envelopes were returned to the researcher from the couple, the researcher would verify the informed consent document was signed and use the demographic form and RDAS to determine if the couple met the requirements to participate in the study. If so, the couple was then contacted by the researcher using the response script (Appendix C) to invite them for an interview. Every couple that completed the questionnaires met the criteria to participate and agreed to complete an interview. Three couples chose to have the researcher meet them at their residence for an in-person interview and the remaining five couples participated over Skype. After the interview, the couple was either handed or mailed a $15 gift card to Walmart as an honorarium for their participation.
Instrumentation

Each participant completed the Revised Dyadic Adjustment Scale (RDAS) to determine the “health” of their partnership (Busby, Christensen, Crane, & Larson, 1995). The RDAS is a 14-item self-report measure that is designed to measure the quality of adjustment in marriage and similar dyadic relationships using the shortened and widely accepted Dyadic Adjustment Scale (Graham, Liu, & Jexiorski, 2006). A factor analysis was completed on the instrument revealing three subscale categories: Dyadic Consensus (6 items), Dyadic Satisfaction (4 items), and Dyadic Cohesion (4 items) (Busby et al., 1995). A sample item of the Dyadic Consensus subscale asks the respondent to rate “Making major decisions” on a 6 point likert scale ranging from “always agree” to “always disagree.” A sample item from the Dyadic Satisfaction subscale asks the respondent to rate “How often do you discuss or have you considered divorce, separation, or terminating your relationship?” using a 6 point likert scale ranging from “always” to “never.” A sample item from the Dyadic Cohesion subscale asks the respondent to rate “Do you and your mate engage in outside interests together?” using a 5 point likert scale ranging from “all of them” to “none of them.”

The RDAS provides three subscales that are added together creating a total score. The researcher will only use the total score for the measure to determine the health of the couple. Scores on the RDAS range from a low of 0 to a high of 69, with higher scores indicating greater levels of relational adjustment or satisfaction. Divorced and married couples score an average of 41.6 and 52.3 respectively (Busby et al., 1995). There is no “healthy” cutoff score but it is assumed that individuals scoring above 48 are in a “non-
“distressed” relationship (Crane, Middleton, & Bean, 2000). For the purposes of this study, a minimum score of 48 for each partner was required to participate.

Reliability for the RDAS is very high. With an Alpha reliability of .90, the RDAS appears to be consistent in its findings (Crane et al., 2000). To test the criterion-related validity, the RDAS was also administered to 242 couples and compared with the DAS to discriminate between distressed and non-distressed couples. The RDAS was equal to the DAS in correctly classifying the distressed and non-distressed couples 81% of the time (Busby et al., 1995). To determine the construct validity, the DAS was compared with the Locke-Wallace Martial Adjustment Scale and found to correlate at .68 and the original DAS at .97 (Busby et al., 1995).

In addition to relationship satisfaction, participants were also evaluated on their family of origin. Family functioning was not used as inclusionary criteria but as a supplemental source of information for the qualitative analysis. The impact of family functioning was measured using the Family of Origin Scale (FOS; Hovestadt, Anderson, Piercy, Cochran, & Fine, 1985). The FOS is a 40-item, retrospective self-report measure of an individual’s perceived health in their family of origin based on responses about the individual’s family of origin. The instrument uses a 5-point Likert scale from 1 (strongly disagree) to 5 (strongly agree). A total score is created from 10 domains of healthy family functioning first published in 1979 by Lewis et al. including (a) Clarity of expression: Thoughts and feelings are clear in the family; (b) Responsibility: Family members claim responsibility for their own actions; (c) Respect for others: Family members are allowed to speak for themselves; (d) Openness to others: Family members are receptive to one another; (e) Acceptance of separation and loss: Separation and loss
are dealt with openly in the family; (f) Range of feelings: Family members express a wide range of feelings; (g) Mood and tone: Warm, positive atmosphere exists in the family; (h) Conflict resolution: Normal conflict are resolved without undue stress; (i) Empathy: Family members are sensitive to one another; and (j) Trust: The family sees human nature as basically good (Hovestadt et al., 1985). Typical statements in the FOS include, “My parents encouraged family members to listen to one another” and “In my family, people took responsibility for what they did.”

Reliability for the FOS is quite good. Internal consistency was .97 using Cronbach’s alpha. A test re-test of reliability produced a .97 alpha overall, a .73 for intimacy items, and a .77 for autonomy items (Hovestadt et al., 1985). Construct validity is also acceptable as the FOS has been positively correlated with other measures of family functioning such as the Family Relations Index and the Family Environment Scale (Hemming, Blackmer, & Searight, 2012) and the Family History of Distress subscale of the Marital Satisfaction Inventory (Snyder, 1982).

The demographic (Appendix E) used gathered demographic information regarding the inclusionary and exclusionary criteria as well as resiliency and risk factors previously reported in the literature review. The demographic form also invited information about the frequency in which the topic of CSA comes up their relationship. This is important as it is unknown if healthy couples frequently discuss the impact of CSA or rarely have it come up.

The researcher used an interview protocol to guide the interview (See Appendix F) as recommended for in-depth interviewing in phenomenological research (Moustakas, 1994). The first question was a general inquiry about their relationship and how they
met. This was to help the couple warm up and perhaps feel more comfortable with the researcher. The second question was an open-ended invitation to talk about how CSA has affected the relationship. The next three questions addressed areas in the literature that couples with a history of CSA have reported to be problematic in their relationship and what healthy couples reported to be integral to the success of the relationship. These topics are trust, communication, and sexual intimacy. The next question asked the couple what they might tell a couple who is struggling with the impact of CSA. This question explored strategies and potential solutions to common problems for couples with a history of CSA. Lastly, the couple was asked if there was anything else they would like to share. This provided a forum to help the researcher uncover possible areas of the relationship not yet explored in the literature.

**Data Collection Methods and Procedures**

Before data was collected, the researcher spent considerable time attempting to bracket out his experiences related to the phenomenon. A statement of the person of the researcher and my experience of the phenomenon appears below. This is commonly referred to as an epoche (Creswell, 2007). If the researcher is able to investigate his own experiences with the phenomenon, he or she will be better equipped to push those thoughts and feelings aside when interviewing and interpreting data (Moustakas, 1994). This allows the researcher to experience the data with a minimal amount of subjectivity and may allow him or her to have a fresh perspective in learning about the experiences of others.

Data for this phenomenological study will be collected via in-depth interviewing as recommended by Creswell (2007), Marshall & Rossman (2011), and Moustakas
In phenomenological studies, interviews generally consist of three parts: 1) past experiences with the phenomenon, 2) present experiences with the phenomenon, 3) a combination of both past and present to describe the participants’ overall experience with the phenomenon (Marshall & Rossman, 2011). For this study, the researcher used a set of open-ended questions to help structure the interview (See Appendix F) and had the freedom to expand on points of interest and ask follow-up questions or probes when appropriate. This created more of a “conversation” than a “question and answer” type interview. The interviews for each couple occurred with both partners present at the same time. The initial protocol questions were asked to the couple as a unit with some follow-up questions directed towards each member. Both partners were given the opportunity to answer each protocol question. The length of the interviews ranged in time from 61 to 95 minutes with a mean of 79 minutes. The three couples interviewed in person averaged 85 minutes per interview while the remaining five couples interviewed over Skype averaged 76 minutes.

To date, there is not a large body of literature discussing the methodology of dyadic qualitative interviews. Perhaps one potential risk in dyadic interviewing is one participant agreeing with the other participant’s opinion rather than generating her or his own input. Morgan, Ataie, Carder, & Hoffman (2013) provide the most current information by critiquing three separate dyadic studies. They indicated that the risk of excessive agreement between participants was not evident. Instead, they reported that one participant’s responses may stimulate new ideas and bring up old memories for the other participant. This is in contrast to an individual interview in which new ideas or memories are limited to what the individual can remember on his or her own. Another advantage of
dyadic interviewing stated in the 2013 study suggests researchers may be able to access information that may be too uncomfortable for participants to disclose individually. They concluded that participants had a greater sense of ease when discussing topics that may feel private because of the presence of someone who shares a similar experience. Given that CSA is typically a topic that can feel private or uncomfortable, interviewing the couple together was the best choice in creating both a sense of security and depth in content.

Each interview was audio recorded for transcribing. The audio data was stored on a hard drive that was password protected and kept in a locked box in a locked WMU office. Only the research team listed on the approved HSIRB application had access to the recorded data. The audio files were transcribed into Microsoft Word documents by the researcher. Transcriptions were then reviewed again for accuracy three times before beginning analysis. Transcriptions do not include the real names of the participants and have been changed to reflect common names used for the participant’s gender. Transcription information was also edited using brackets if a participant provided information that might be revealing to their identity such as a small town or name of a therapist. Once the data was transcribed and verified for accuracy, the audio files were deleted from the drive. The transcribed data will be locked in the principal investigator’s office within the department of counselor education and counseling psychology for at least three years.

**Data Analysis Processes and Procedures**

Creswell (2007) provides a framework for phenomenological data analysis and was used in this study. As noted earlier, the researcher first described his experiences
with the phenomenon in an attempt to remove himself from the data. The interview data used in this study was captured through audio recordings and then transcribed by the researcher conducting the interviews. The researcher made every attempt to transcribe the interviews as soon as they were completed. Each audio recording was played back several times by the researcher before transcribing so he could immerse himself in the data. Once transcriptions were completed for each interview, the researcher again listened to the recording while checking the transcription for accuracy in content.

After all the transcriptions were finalized, they were uploaded into MAXQDA software. This software was used to analyze the content of each interview looking for meaningful words or phrases called “codes” that capture the participants’ experiences. The use of a computer program also allows for the organization of codes, maintaining accuracy, and queries that look for repeated words or phrases. Careful judgment was used to treat each statement as having equal worth while avoiding overlap. Codes were also separated between “survivor” and “partner” status. This allowed the research to analyze codes for each question as an entire group as well as the shared experience of either being a survivor or partner. Based on the results of the analysis in MAXQDA, codes for each question were grouped into clusters with similar content. These clusters were then reviewed for commonalities to develop themes within the data set and themes were grouped together to form overarching themes. These overarching themes represent the essence of the sample’s experiences.

The aforementioned procedure fits well with a phenomenological study as it attempts to describe the shared experience that is common to healthy couples with a history of CSA. The results from using In Vivo coding analysis allow the participant’s
language to describe the themes and experiences. This not only gives a voice to the sample but it adds to the richness and depth of the data collected. Rather than trying to speak for the participants, the participants are able to speak for themselves.

**The Researcher**

This topic is especially important to me as I have a personal connection to it. I am the partner of a CSA survivor. During the ten years my wife and I have been married, we have been through plenty of ups and downs that seem to have been influenced by her history of CSA. As a therapist, I naturally went into the literature to be better informed of ways that I could be supportive to my wife and better understand my own experiences. What I found fell short of expectations. There was little information offering how to help a couple with a history of CSA and almost nothing giving attention to my experience as the partner of a survivor. We were left to navigate the complex workings of an intimate relationship without any role models or guidance to help along the way.

Despite feeling isolated with our struggle, I think we have managed to reach a place where we have a healthy relationship. In fact, I would describe our relationship as very healthy. We have found a way to maintain intimacy, build trust, and communicate. I even wonder if her CSA forced us to work on those things beyond a typical couple. Interestingly, it is not entirely clear to me how we were able to get to this point. I suspect this study is important to me in part because I want to know how other survivor couples are able to find happiness. I want to hear about their journey and use those experiences to help others. The next time a partner of a CSA survivor seeks out help for his or her relationship, I want there to be answers.
In the early stages of this study, I often wondered how my experiences as a partner could influence my role as a researcher. Because I have shared a similar experience to the sample, I have a bias of anticipating what couples might report. One piece I expect to hear is talking about the frustrations of both the partner and survivor. I know I have an assumption that the abuse made a part of their relationship more difficult in some way. From my own experiences, part of the frustration came from wanting to help my wife when the abuse was more present, but not knowing how. So part of the bracketing process for me was avoiding the assumption that the abuse had a negative impact and that the partner may sometimes feel helpless in the solution. Additionally, there may also be a pull for me to want to give the partner a stronger voice in the data, as sometimes I have felt reticent to express my own frustrations out of wanting to protect my wife from further guilt in feeling responsible for the impact of the abuse.

It is also important to note the culture in which I view my own experiences. I am a White, heterosexual, middle class, able-bodied, educated, man. My wife carries the same identities except for identifying as a woman. These life experiences have deeply shaped the way I might see resilience or even health. The sample used in this study might vary from my identities and the data will need to be evaluated for the cultural context of the speaker.

I plan to manage my connection with the topic by writing an epoche and maintaining it throughout the study. Clearly I have the potential to have strong biases as CSA can be a powerful influence in someone’s life. I hope that my experience and training as a therapist will help me maintain my own reactions. I have sat with many clients over the years that have described their experiences with CSA. I have been
purposeful in attempting to remove my experiences from their story because the parts of my story interjected into their experience prevent me from truly empathizing and understanding them. I have worked very hard to keep the lens that I see someone’s story through as clear as possible. I anticipate this study bringing new challenges but I expect my epoche to help keep me as objective as possible.

**Trustworthiness**

In an attempt to maintain credibility in this study, the issues that are brought up from participants will be drawn out by using probes that encourage the participants to expand on specific points to achieve a greater depth to the data. Eight couples participated in this study. As the researcher conducted interviews, he began to recognize overlapping themes from the participants. Interviewing continued until the point of saturation where it was determined further interviewing would likely not generate any new substantial themes. This stopping point fit the expected sample size of eight couples. As mentioned previously, the researcher also created an epoche to help address any personal connection to the content of the topic.

The study provides a clear and elaborate description of all the participants in the study. The reader has enough information on the time, place, context, and culture as it applies to data collection to make an informed decision about trustworthiness.

In order to ensure credibility, the researcher kept the data grounded in the interviews. This was accomplished by pulling codes or segments of meaning verbatim from the transcriptions using a process called *In Vivo* coding (Saldana, 2013). This process occurred over and over until all relevant data were processed. Once organized into groups, the researcher began to look for existing themes in the groupings of codes.
The researcher tracked these groupings and ideas throughout the process to allow for transparency around the findings of the study. It should be clear to another researcher how and why the themes presented surfaced from the original data.

A researcher must also work towards maintaining a fair perspective on the data and the participants. Similar to credibility, authenticity began with writing an epoche about the researcher’s connection to the topic. From there, the researcher revisited the data during the analysis phase looking for any data that was missed. This process also included considering alternative explanations or themes that may have been overlooked. By paying attention to his own biases and predisposition to the topic, the researcher was more open to seeing the data from multiple perspectives.

Qualitative research can also be strengthened by using an independent party to examine the conclusions made by the researcher. This “devil’s advocate” adds to the conformity of the study by keeping the researcher accountable in the development of codes, themes, and overarching themes. Essentially, it is the checks and balance for data accuracy, relevance, and meaning. For this study, a WMU counseling psychology doctoral student who is familiar with both the topic of childhood sexual abuse and is licensed as a marriage and family therapist was used to maintain conformity. Both researchers discussed their findings and were able to develop new themes and refine existing ones. As an example of this process, the independent researcher challenged the theme of patience as part of healthy sexual experiences and stated that some codes clustered as “patience” could also be seen as setting appropriate boundaries. This helped the researcher separate the larger theme of patience into two themes of patience and boundaries.
Delimitations

One of the challenges to a phenomenological study as presented by Creswell (2007) is the importance of selecting participants who have experienced the phenomenon so the researcher can uncover the essence of the experience. One inherent problem with studying CSA is that it is very complex in that it has significant variability in terms of severity, duration, impact, and even acknowledgement by the survivor. No two people experience CSA in the same way and thus finding the essence of the experience may require more participants to uncover common themes beyond what is presented in the findings. As mentioned previously, data collection was stopped when themes began to overlap but there may be more data if given a wider sample of participants.

This study was also limited in that it only sampled couples from the eastern half of the United States. Although it is likely minimal, the regional specificities may limit the transferability to other areas. The race, ethnicity, sexual orientation, and preference for organized religion of the sample were also quite homogenous. Additionally, all but one survivor identified as female and all but one partner identified as male. It is possible that these variables may impact the couple’s experiences with CSA and their perspective in finding health. Dual trauma couples and relationships lasting less than two years were specifically excluded from this study and the results may not be applicable to those demographics. The RDAS was used in this study because of its wide acceptance in couple literature. It is seemingly limited however, in that its standardization sample is based on a very narrow demographic.
Summary

The design used in this study is a phenomenological approach that is rooted in qualitative research. Inclusionary and exclusionary criteria were used to sample a population of healthy couples where one partner experienced CSA. In order to reduce bias and increase creditability, the researcher used common techniques in qualitative methodology including writing an epoche, journaling, and using a “devil’s advocate” before and during the analysis of interview data. Delimitations were also discussed. Findings from the analyses will be reported in Chapter IV.
CHAPTER IV

FINDINGS

The chapter begins with a review of the purpose of the study followed by a description of the participants’ background. This section includes details gathered in the survey forms including demographic information and experiences with CSA. It also includes a discussion of the data gathered from the RDAS and FOS for each couple. The next portion is comprised of a description of the analyzed data with a discussion of the findings in detail. Lastly, the chapter provides a collective narrative to capture the essence of the experience for couples with a history of CSA for one member, as well as the experience for the survivor and his or her partner.

Purpose of the Research

This study attempts to broaden the perspective of current research by employing a sample of healthy couples with a history of CSA in one partner. By studying the perspectives of healthy couples, the researcher may unearth a greater depth and awareness of how CSA not only impacts the couple, but also how they successfully navigate through it. This study also addresses the lack of research surrounding the experience of the partner of a CSA survivor. The overarching research question guiding this study is: What is it like for healthy couples to manage the potential negative impact of CSA on their relationship and create or sustain a healthy partnership? The sub questions that make up the research question are based on the current literature suggesting that distressed couples with a history of CSA report problems with trust, communication, and sexual intimacy. Additionally, healthy couples with no history of CSA report trust, communication, and sexual intimacy as vital to their success. The sub
questions for the study include: (1) How does the history of childhood sexual abuse affect healthy intimate relationships? (2) What is it like for healthy couples with a history of CSA to develop and sustain trust? (3) What is it like for healthy couples with a history of CSA to develop and sustain communication and work through conflict? (4) What is it like for healthy couples with a history of CSA to develop and sustain sexual intimacy? and (5) What do couples with a history of CSA believe to be important in overcoming the impact of CSA?

These questions will be answered using a phenomenological approach in asking couples with one partner who has experienced CSA about experiences in their current romantic relationship. During the interviews, couples were asked how they create and maintain health in a variety of different dyadic functions. It was assumed in this study that CSA does impact each couple’s relationship in some way and their approaches to maintaining relational health may offer new insight into the current literature. Their experiences were explored utilizing face-to-face, semi-structured interviews.

Summary and Description of Participants

The sample consists of eight couples who were asked to participate because of their experience in managing the impact of CSA on their relationship. Of the 16 participants that responded to the study, all of them met the inclusionary criteria and were invited to participate in an interview. The following paragraphs provide demographic information and data from the assessment measures. See Appendix J for a brief description of each couple and observations about the couple’s dynamics made by the researcher during the interviews.
Eight participants identified as female and eight as male. Their ages ranged from 24 to 70 with a mean of 47 and a median of 49. Despite attempts to find participants with diverse backgrounds, all participants identified as White and were in heterosexual relationships. The lowest reported combined income was $29,000 and the highest was $120,000 with a mean of $74,000 and a median of $77,500. Of the eight couples, five identified as following a protestant Christian religion, one as Mormon, and two couples had one partner identify as “Christian” while the other partner chose “N/A” or “None.” Seven of the eight couples were married and one couple had never married. Couples reported being in their current relationship from 5.5 years up to 51 with a mean of 25 and a median of 21. All but one couple had children.

Highest level of education within the sample varied with one participant earning a GED, two high school diplomas, one associate’s degree, six bachelor’s degrees, four master’s degrees, and two doctorates. Education levels can be seen in Table 1.

Table 1
Highest Completed Education of Each Participant

<table>
<thead>
<tr>
<th>Level of Education</th>
<th>1s</th>
<th>1p</th>
<th>2s</th>
<th>2p</th>
<th>3s</th>
<th>3p</th>
<th>4s</th>
<th>4p</th>
<th>5s</th>
<th>5p</th>
<th>6s</th>
<th>6p</th>
<th>7s</th>
<th>7p</th>
<th>8s</th>
<th>8p</th>
</tr>
</thead>
<tbody>
<tr>
<td>H.S./GED</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Associates</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Bachelors</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Masters</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Doctorate</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

Note: Participant sub-identifier “s” and “p” refer to “survivor” and “partner” status respectively.

Participants were also asked about their history with problems that are strongly associated with CSA. Interestingly, all but one survivor and partner reported some struggle with mental health or sexual difficulty at some point in their life and none of the participants reported ever having problems with drugs or alcohol. It was expected that
couples would not currently be using substances to cope, but the lack of reported substance abuse in their lifetime is surprising. There is substantial literature suggesting survivors often use substances to manage problematic symptoms stemming from CSA (See Chapter II for more info). See Table 2 for a breakdown of reported problems.

Table 2
History of Mental and Sexual Health Problems

<table>
<thead>
<tr>
<th>Reported Problems</th>
<th>Participant</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1s</td>
</tr>
<tr>
<td>Depression</td>
<td>X</td>
</tr>
<tr>
<td>Anxiety</td>
<td>X</td>
</tr>
<tr>
<td>Sexual difficulties</td>
<td></td>
</tr>
<tr>
<td>Suicidal thoughts</td>
<td>X</td>
</tr>
<tr>
<td>Drug/Alcohol abuse</td>
<td></td>
</tr>
<tr>
<td>PTSD</td>
<td>X</td>
</tr>
<tr>
<td>Eating disorder</td>
<td></td>
</tr>
</tbody>
</table>

Note: Participant sub-identifier “s” and “p” refer to “survivor” and “partner” status respectively.

It was also important to gather information about the types of childhood sexual abuse experienced by participants. This was used to screen and potentially exclude any partner who also experienced abuse and better understand the survivor’s CSA. The most common abusive behavior was fondling which was reported by every survivor. The results are shown in Table 3. Information on the nature of the relationship between the CSA survivor and the perpetrator of the abuse was not formally gathered for this study. Four of the couples though revealed this information in the interview. Three of the
perpetrators of the CSA for these couples included step-fathers while another stated the perpetrator was a family member.

Table 3
Types of Sexual Abuse

<table>
<thead>
<tr>
<th>Abusive Behaviors</th>
<th>1s</th>
<th>1p</th>
<th>2s</th>
<th>2p</th>
<th>3s</th>
<th>3p</th>
<th>4s</th>
<th>4p</th>
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<th>6p</th>
<th>7s</th>
<th>7p</th>
<th>8s</th>
<th>8p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fondling</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Sexual kissing</td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Oral sex</td>
<td>X</td>
<td>X</td>
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<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Penetration</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Exposure to pornography</td>
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<td></td>
<td></td>
<td>X</td>
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<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

*Note: Participant sub-identifier “s” and “p” refer to “survivor” and “partner” status respectively.*

The sample was also asked several questions about when and how often the topic of CSA has come up in the current couple relationship. Six couples indicated the abuse was first brought up in the relationship either while dating or in the first year of marriage. One of the two remaining couples noted that it was brought up 8 years into the marriage, but immediately after the survivor had begun to remember the abuse for the first time. Couples were also asked when the abuse was talked about the most in the relationship. All but two couples reported discussing the abuse most frequently within the first year after the initial disclosure. Of the remaining two couples, one indicated within the first two years while the other reported within the first four years. When asked about how often couples currently discuss the abuse, eight participants reported “couple times a year, five noted “every few years” or “almost never”, two indicated “once a week or month”, and one stated “once per year.” There was a wide range of when couples reported last talking with each other about the abuse. Three couples indicated it was
discussed within the last year, three stated within the last few years, and the remaining
two couples either couldn’t remember or thought it was over 10 years ago.

Instrumentation Results

Revised Dyadic Adjustment Scale

As part of the screening, potential participants were given the Revised Dyadic
Adjustment Scale to evaluate their current dyadic functioning (Busby et al., 1995). Each
participant was required to score a minimum of 48 out of 69 to participate. For this
sample, the highest score was 60 and the lowest was 51 with a mean of 55 and a median
of 53.5. Interestingly, the highest difference in total score within the couple was five and
the lowest was one. The mean of a difference of 2.5 within the couples for this sample
may suggest that couples not only self-describe healthy dyadic functioning but share a
similar level of health as their partner.

Of the potential 69 total points within the RDAS, 30 are used to account for the
consensus in decision making, values, and affection. The scores on the dyadic consensus
subscale in this study ranged from 28 to 22. With 30 points possible, individuals who
score at least 22 are most likely in a non-distressed relationship and see themselves as
having a similar amount of agreement within the relationship (RDAS form). Having a
similar dyadic consensus is particularly helpful in this study. Couples were interviewed
at the same time with the risk that one person might influence the other’s opinion. The
results of the RDAS and specifically the consensus scale suggest that risk was no greater
in this sample than a typical non-distressed relationship.
Family of Origin Scale

Each participant was also given the Family of Origin Scale which quantifies the self-reported health of family histories into a total score and 10 subscales: Clarity of Expression, Responsibility, Respect for Others, Openness to Others, Acceptance of Separation and Loss, Range of Feelings, Mood and Tone, Conflict Resolution, Empathy, and Trust (Hovestadt et al., 1985). Higher scores indicate higher perceived health. The potential range for each subscale is 4-20 and 40-200 for the total score. The total scores in this sample ranged from 67 to 178 with a mean of 121.3 and a median of 120. Interestingly, the difference between total scores, which was computed by subtracting the higher total score of one member of a single couple from the other member’s, ranged dramatically from 99 to 7. Half the couples had a difference between 7 and 26 while the other half had a difference between 71 and 99. These results are not consistent with research indicating similar levels of FOS total scores within couples are correlated with higher levels of reported dyadic adjustment (Wilcoxon & Hovestadt, 1983). Within this sample, this may suggest that the perceived family functioning in one’s family of origin does need not to be similar to their romantic partner’s in order to maintain health in the relationship. The discrepancy between survivors and partners might also suggest survivors’ individual work and/or the strength of the couple relationship have helped to overcome a less than optimal FOO experience. None of the 10 subscales appear to have any consistent pattern when comparing couples to each other.

It was expected the survivors would have a lower total score than their partners as CSA may negatively impact family of origin functioning (Alexander & Lupfer, 1987; Meyerson et al., 2002; Nelson & Wampler, 2000). When participants were sorted into
survivor and partner groups, the total score means were 110.8 and 131.9 respectively. It should be noted, however, that three survivors had a higher total score than their partner. Although not evaluated for statistical significance, the partner group also scored a higher mean than the survivor group on each of the 10 subscales. The smallest difference in subscale means between groups was .1 on the trust subscale. The largest difference in means between groups was 4.0 on the conflict resolution subscale, where the survivor group reported witnessing lower levels of conflict resolution in their FOO. Subscales trust and conflict resolution also had the highest and lowest scoring means within all 10 of the survivor group subscales respectively.

Both trust and conflict resolution/communication are components of the research sub-questions within this study based on the current literature. It is remarkable these two subscales represent the extreme differences between survivor and partner groups’ perceived family of origin. As a sample, it appears as though both groups perceived an equivalent amount of trust within their FOO, but more difficulty with conflict resolution for the survivor group. Perhaps a similar level of trust within a couple’s FOO is more important to relational health than the conflict resolution. See Table 4 for results specific to each participant and Table 5 for survivor and partner group means.
<table>
<thead>
<tr>
<th>Subscale</th>
<th>Participant</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1s 1p 2s 2p 3s 3p 4s 4p 5s 5p 6s 6p 7s 7p 8s 8p</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Clarity of expression</td>
<td>12 8 5 14 10 14 18 6 10 8 5 18 16 19 8 19</td>
</tr>
<tr>
<td>Responsibility</td>
<td>4 6 7 15 14 16 18 9 4 6 15 14 13 17 5 8</td>
</tr>
<tr>
<td>Respect for others</td>
<td>10 9 8 11 8 15 19 7 6 8 8 19 19 13 6 20</td>
</tr>
<tr>
<td>Openness to others</td>
<td>13 8 6 11 10 14 18 12 10 8 10 16 18 18 7 16</td>
</tr>
<tr>
<td>Acceptance of separation &amp; loss</td>
<td>10 11 8 15 18 16 20 4 8 9 4 13 19 15 8 18</td>
</tr>
<tr>
<td>Range of feelings</td>
<td>13 9 6 14 15 15 16 6 6 7 6 18 20 17 10 19</td>
</tr>
<tr>
<td>Mood &amp; tone</td>
<td>12 9 6 18 16 18 19 8 5 9 9 19 19 18 9 20</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>9 8 8 16 11 15 13 8 5 10 8 17 15 16 7 18</td>
</tr>
<tr>
<td>Empathy</td>
<td>11 9 7 16 9 15 17 9 8 9 4 18 17 18 7 17</td>
</tr>
<tr>
<td>Trust</td>
<td>17 10 12 14 18 17 20 10 5 9 9 17 18 16 9 16</td>
</tr>
</tbody>
</table>
Table 4 – Continued

| Total | 1s  | 1p  | 2s  | 2p  | 3s  | 3p  | 4s  | 4p  | 5s  | 5p  | 6s  | 6p  | 7s  | 7p  | 8s  | 8p  |
|-------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| Total score (possible 200) | 111 | 87  | 73  | 144 | 129 | 155 | 178 | 79  | 67  | 83  | 78  | 169 | 174 | 167 | 76  | 171 |
| Diff. in total scores within couple | 24  | 71  | 26  | 99  | 16  | 91  | 7   | 95  |

*Note: Participant sub-identifier “s” and “p” refer to “survivor” and “partner” status respectively.*
<table>
<thead>
<tr>
<th>Table 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family of Origin Scale Means</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Participant Group Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Partner Mean</td>
</tr>
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<td>Clarity of expression</td>
<td>13.3</td>
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<tr>
<td>Responsibility</td>
<td>11.4</td>
</tr>
<tr>
<td>Respect for others</td>
<td>12.8</td>
</tr>
<tr>
<td>Openness to others</td>
<td>12.9</td>
</tr>
<tr>
<td>Acceptance of separation &amp; loss</td>
<td>12.6</td>
</tr>
<tr>
<td>Range of feelings</td>
<td>13.1</td>
</tr>
<tr>
<td>Mood &amp; tone</td>
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</tr>
<tr>
<td>Conflict resolution</td>
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</tr>
<tr>
<td>Empathy</td>
<td>13.9</td>
</tr>
<tr>
<td>Trust</td>
<td>13.6</td>
</tr>
<tr>
<td>Total score (possible 200)</td>
<td>131.9</td>
</tr>
</tbody>
</table>

*Note: Scores on subscales have a possible range from 4 to 20.*

Themes from Qualitative Analyses

The following findings will provide the reader with the overarching themes that surfaced during the qualitative analyses. Themes that create each overarching theme will generally be presented in order of consistency and depth with the most salient listed first in descending order. In order to simplify how many participants contributed to the development of a theme, the researcher has categorized the numerical frequency into a descriptive word. It is important to note that themes were developed describing groups of survivors, partners, or couples. These were used because during the interviews participants spoke from one of these three perspectives. When one participant was describing the couple, the other participant almost always agreed through nonverbal behavior or adding to the content of what was just reported. There were only a handful of moments when one member of the couple verbally or nonverbally disagreed with their
partner’s comment and the researcher categorized those statements as not representing the couple, only the single participant. The reporting group will be listed within each theme. See Table 6 for categorization.

### Table 6
Frequency of Responses and Correlating Description

<table>
<thead>
<tr>
<th>Descriptive Word</th>
<th>Number of Survivors, Partners, or Couples Making the Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most</td>
<td>7-8</td>
</tr>
<tr>
<td>Several</td>
<td>5-6</td>
</tr>
<tr>
<td>Some</td>
<td>3-4</td>
</tr>
</tbody>
</table>

**The Impact of CSA**

As reported in the literature review in Chapter II, the effects of CSA can vary significantly for individuals and couples. Despite a multitude of potential problems, the participants captured several consistent experiences as result of CSA when asked a general question about the impact of the history of CSA. Couples described CSA creating complications with trust, negatively impacting their sexual intimacy, internalizing blame, and moments of being triggered. Findings that have to do with trust and sexual intimacy are integrated below in major sections on these topics.

**Difficulty with trust.** All but one survivor reported problems trusting their partner. Interestingly, the manifestation of how the abuse affected trust seemed to fit within three areas: abandonment, safety, and secrecy. Three survivors noted a strong fear that their partner would want to leave the relationship, often without evidence supporting the concern. One survivor described how the abuse created distress through fear of abandonment by her partner.

And I was just really upset at that point in time and he couldn’t understand why, but something in my mind told me that he was going to leave me. And I thought I was going to leave before he did and I wasn’t going to be abandoned again. And
we sat and talked and I cried and I yelled. And he finally says to me, “You don’t have any faith in me.” And I said, “I don’t have any faith in me.” And I didn’t at that point in time.

Three survivors described how it was challenging to trust their partner because of the violation of safety caused by the abuse. One partner reported that his wife has trouble trusting people’s motives and needing to control their relationship to feel safe. A survivor noted, “…there has definitely been a shifting inside of me around knowing that not everyone is going to be dangerous” and how before that time it was difficult to trust her partner in protecting their child from also being abused. Another survivor described how she wrestled with the fear that came with the engagement process.

Just the mentality of the commitment of the decision-making of who this guy is going to be. Can I trust him? Is he really who he says he is? Is he going to hurt me? Is he going to hurt my kids down the road?

Two survivors reported needing to keep secrets from their partner because they believed the partners couldn’t be trusted with the truth. One survivor explained how she couldn’t trust her partner with the knowledge that she had been abused. Another survivor noted how she is often reluctant to bring up how the abuse might currently be impacting her.

And I guess one of my issues is that I keep things bottled up and I don't usually like to bring up the abuse or bring up that I’ve had flashbacks. So usually keep it bottled up and I don't say anything and he doesn't usually realize until he says something that might set me off …

**Reactions to sexual intimacy.** Several couples indicated how the abuse affected their sexual intimacy. Not surprisingly, there was a varying amount of detail in how the impact was described in the interviews. One survivor noted how she would try to evade her partner’s sexual advances by waiting until he would fall asleep before going to bed. Another described how the abuse changed her sense of safety during sex with her partner
and made her ask herself, “Are you going to respect my boundaries?” Others talked about how sex would become very difficult because it reminded them of the abuse. One survivor describes the connection between sex and the abuse.

In the beginning it would affect me a lot with physical stuff. I remember her putting her hand at the back of my neck and pushing me downwards and I freaked out about that because that's what the abusers would do. So stuff like that. Touch or even sometimes smells you know, different stuff like that. And that's the thing about sexual abuse is it's sexual but it's also abuse. So when you're in a sexual position or in a sexual mood...some of those things can remind you of the abuse because it was sexual.

Partners also noted how the abuse affected their experiences with sexual intimacy. One partner noted how it was challenging to see his wife struggle, “Yeah...so the feeling that your mate is not being completely satisfied in a sexual relationship is a tough one as you know. So that was my concern at times. Enjoyment seemed to be always more mine than hers.” One couple talked about how the partner would feel responsible for problems the survivor was experiencing because of the abuse during sex.

Survivor: For you the sex was really difficult. I would cry. I mean we were so young and we hardly ever had sex and I would cry when we did.
Partner: Yet I was really...I don't know how to describe it... It was really hard...I'd say frustrating and disappointing. It would feel like it's my fault and I would try to figure out what I did wrong.

Misdirected blame. Several survivors and some partners described feeling a sense of blame for how the abuse was creating problems. Most often survivors described negative internal thoughts about themselves. One survivor talked about how she internalized the messages from her abuser into her relationship.

Sexual abuse encompasses the psychological. It plays mind games on the victims. In my case it just continued for 25 years. The shame that came from not telling anyone else...I felt as dirty as he told me I was. So I didn't think anyone would want me. I felt like a dirty rag... I think the core damage from sexual abuse is that it eats at your self-esteem. It can truly destroy your self-esteem so you question
everything and I just looked to [her partner] for everything because I didn't feel like I knew how to make the right decision and I just felt very inept.

Another survivor explained how she felt when experiencing heightened anxiety around the abuse during the engagement period, “I have nothing. I'm done. He doesn't want to marry me. I'm crazy (crying now). Like I don't know what to do. I was so done.”

Partners also reported blaming themselves for how the abuse was manifesting in the relationship. This often came from a place of not understanding how abuse can create problems and assuming it was their fault. One partner described his thought process.

Yeah it was really hard because...I think the hardest thing about it was I internalized a lot of it and then… like would ask myself, "What's wrong with me?" You know? And not knowing a lot about sexual abuse and how that impacts the partner…that's what I did. And I think I had some anger there too.

**Triggering memories of CSA.** Some couples talked about the impact of memories of the CSA being triggered. There was clear discomfort in these experiences and often associated with fear and confusion about what was happening. One survivor described the first time she was triggered,

I don't know what happened but there was a flip that just went on or off...whatever. And I immediately felt like I was suffocating. I just...I wasn't scared of [her partner] but I felt dark black and I went almost flat. Like a flat affect. I had no emotion. I didn't think… I seriously just went flat. There's no other way to describe it and it freaked me out.

Survivors also noted they could be triggered by unexpected stimuli including smells, hair, sight and touch. Couples also reported that these triggers had a pointed impact on the relationship when the survivor projected the abuser’s identity onto their partner. One couple described this experience during a night terror.

Survivor: I used to wake up screaming in the middle of the night and that's affected him because we sleep in the same bed. It’s been traumatizing for him for me to be screaming in bed and him not being able to wake me up you know
because it's hard to wake someone up in a nightmare. I guess [her partner] could talk about what it's like to witness it.

Partner: So I'm trying to wake her up to get her out of the night terror but she thinks actually I'm the bad guy or her attacker or whatever...causing the harm. It's never lead to any violence. Like she's never hit me or anything. But it's freaky because she really thinks I'm trying to harm her and it's a weird situation.

**Developing and Sustaining Trust**

This overarching theme is comprised of themes that often seemed to separate the couples into survivor and partner groups. Every couple mentioned either reliability or consistency as a sign of trust and some reported honesty as critical component of trust.

There was a clear difference in the development of trust for survivors who described trust taking time to develop, while partners indicated that trust simply existed naturally.

Couples as a whole however noted that trust requires some form of action through behavior. And finally, some survivors explained the importance of their partner treating them with respect.

**Reliability/Consistency over time.** All couples brought up the concepts of either reliability or consistency as an important behavior in developing trust for the couple. It is worth noting that six of the survivors and three partners reported this theme. One survivor described how she needed to see her partner challenge her own inner expectations that people will eventually hurt her. She stated, “So over a period of time it became more real. He was not changing. He was not smiling at me today and trying to figure out a way to hurt me tomorrow.” Another survivor indicated how follow-through is key, “So for me to trust him he has to follow through and finish what he says he's going to do.” Partners also shared the same need. One partner noted that he has never been let down, while another
stated that the consistency grows over the course of years. A different partner described how his trust for the survivor is fostered by her consistency as a parent.

When you truly tell me you're going to do something I know you're going to do it. Like you take care of the kids. I never ever doubt your parenting ability with the kids. Sometimes it's even the small things like you manage the house, you go grocery shopping, and you know you set up stuff up with family. Just the little things you do I don't even think about because there's so much trust there.

**Honesty.** As expected, several couples noted the importance of honesty in the relationship. Four survivors used the word “honesty” and two partners discussed being very open or transparent within the relationship. A survivor explained how creating honesty between the two of them can be difficult but important, “Honesty. Just all the time. Honesty. I don’t care if I don’t like what he has to say sometimes, I still need to hear it.” Another survivor noted that it’s not just being honest in the moment that creates trusts but what she needed most from her partner was a “history of honesty.” She continued and elaborated how there is also an importance of immediacy with honesty.

And sometimes with [my partner] he becomes afraid and will sometimes not tell me things. And that can impact the trust. So I'd rather know whatever it is so I can have my reaction and move on. Because it feels like we get all stuffed up because it's not out there. So for me that's a big thing.

A partner seemed to reinforce this concept by self-describing as an honest person and felt like it was reciprocal. He stated, “And like I said, there really isn't anything that I don't share with her. You know? Like I can tell her anything and I know you'd tell me anything.”

**Differences in trust at the beginning.** The impact of CSA can clearly impact one’s ability to trust others and so it is not surprising that several survivors indicated that
trust took time to develop. Many did not enter the relationship trusting their partner or at least a strong sense that their partner was trustworthy. A survivor described her feelings.

But in me it did take a developing because I wasn’t a trusting person because I had been abused. And it took a while for me to really believe that he was as good as he appeared to be. It was a growing thing. It was there, but was this for real? So over a period of time it became more real.

One survivor stated that she was a “mistrustful person altogether” entering into the relationship and another stated that she would trust her partner with small moments and he would prove it “little by little.” One survivor had the awareness of when she had a turning point in her ability to trust her partner.

And that's one of the nice things I guess when you've been married seven or eight years...it's the time thing. It seems to me that seven or eight years is about when I just sort of went, "Oh. It's alright. We’re going to figure it out together."

Several partners reported a very different experience in how they developed trust in the other person. Survivors described specifically needing to take time while partners seemed to struggle in articulating how their trust for the survivor developed and stated that it simply exists. One exchange captures the difficulty some partners had in responding to how they learned to trust the survivor.

Partner: It’s just there.

Interviewer: How do you think it got there?

Partner: I don’t know. It’s just there. You tell me (laughter)...I just always trusted her. It wasn’t something you had to do; it was always there. If I didn’t trust her she would have been gone a long time ago.

When asked the same question different partners stated, “Trust is always there.”...“I don’t know. I just trust her I guess.”...“I just do a lot.”...“It just happens.” While the responses themselves are not particularly rich with detail, the consistency in responses
may show that partners do not require much awareness in what the survivor could be doing to enhance their own needs in developing trust.

**Trust requires action.** Another theme that emerged in the data was a general description of action behaviors in maintaining trust within the relationship. Several survivors reported specific instances of what was needed to foster trust. Most often this was a behavior from their partner. One survivor juxtaposed her partner’s behavior with how her abusive step-father treated her mother. This proved to be helpful in mentally separating her partner from the abuser and creating trust.

He never gave me a reason not to trust him. He would come home from work and he’d give me his paycheck. I’d take his paycheck and put it in the bank. I’d go buy groceries and gas for the car and rest of it would stay in the bank unless he needed money for something. That’s how we ended up building a home. He knew that he could trust me to do what was right with the paycheck. I could trust him that he wasn’t going to go to the bank and get it all out and go spend it. With my stepfather, my mother was never given any money.

Another survivor noted that she needed her partner to call her, “He would call me when he wasn't home. I never had to worry about him having an affair because he would call and tell me where he was at.” One survivor provided an example of when her partner helped her develop her business and noted, “I need him to like finish things that he says he'll do.”

A survivor explained how one action behavior needed to come from her to enhance trust. She stated, “And I guess letting myself be vulnerable...allowing myself to be vulnerable helps me open myself up to be trusting... So I think that the times that I have communicated that I'm having a flashback...I'm vulnerable and it gets better.” While it seemed important for this survivor to push herself to communicate with her partner, the
The vast majority of responses involving action seemed to be generated about the partner’s behavior.

**Respect facilitates trust.** Some survivors also indicated that they needed to feel cared for and respected by their partner to facilitate trust. Although not explicitly stated, the descriptions of how that respect was communicated seemed to be in correlation to how the survivor may have experienced abuse. One survivor explained.

I think not being made fun of. She doesn't use things against me when she could. I don't take very well to being made fun of and so I can trust that she's not going to do that. She's not mean. You know how like she said I have her back, she's got my back. She's not going to denigrate me in front of other people because that happened when I was growing up a lot.

Another survivor described the importance of feeling cared for.

He's just a really good man and I know that he loves me, he cares about me, and he wants the best for me. I know that he believes in me and he will be there for me. All those things make it easy to trust him.

**Developing and Sustaining Communication/Working through Conflict**

Responses around communication and conflict provided several strong themes. The strongest themes captured the importance of communication being a process couples engage on purpose and do so consistently. Participants also described similarities and differences in communication styles but with an end goal of being open and honest with each other. Couples also reported working through conflict by acknowledging that temporarily taking a break from a disagreement is okay. Another strong theme was recognizing that their communication had improved over time. Couples also explained how their communication can be influenced by their FOO as well as the abuse itself. These influences resulted in needing to communicate about potential triggers.
Making time to communicate. Several couples noted how communication was effective when they purposefully made time for it. Couples described how times for communication were often built into their schedules. One survivor stated, “You know we’re busy, but we still try and have date nights every other week or so and that helps keep the lines of communication open.” Another survivor spoke to how just being in the same physical space can help, “But I think when he's home we always sit in the same room and I might be reading or he might be watching sports but if something comes to mind we're there and we can just bring it up.” One couple noted that they eat lunch together every day. Another stated that they do a lot of activities together. One partner described how they purposefully create time to talk to each other each day,

We have a dog and I’d say most of our talking is on the morning walks to start the day or on our afternoon walks when we’ve had time to digest what’s been going on during that day. Or whatever we’ve talked about in the morning, we’ll come together and hash it out.

One survivor explained the frequency of communication, “We constantly communicate. Constantly. Like maybe too much (laughter).” Couples also described a consistency of communication with phrases like “all the time” And “…we talk a lot. We are communicators.” And “…we talk with each other during the day. We talk at night.” One partner indicated their typical communication style was constant and about every day issues.

Well I think on more of a surface level…we text during the day. I'll call her at lunch. She'll call me. And we get each other's opinions on the small things like, "What do you think about this for the kids?” or, "Hey, should we get this kind of bread or that kind of bread for the kids?” It's those little things.

Another partner echoed the importance of talking about the simple things, but disagreed with the previous partner in the format of communication.
It kind of sounds stupid but it's the simple things like sharing a meal together. Sharing dinner and talking about your day. “How was work?”...and that kind of thing. Before you go to bed we sit there and talk. I consider us old-school that way. In today's technology driven communication world, just sitting down and having an actual face-to-face conversation helps.

**Similarities and differences in communication style.** There was an interesting cluster of responses that discussed the relative ease or challenge between members of the couple in how they communicate. Several couples made note that communication seemed to occur naturally between members. As mentioned previously, couples noted that making time for communication was purposeful, but in this theme it is also described as a natural process that required little effort. One couple stated, “…as long as we see each other we just do communicate.” Another reported, “It’s not like we are just going to sit down and talk. It’s more like we have a rhythm and the rhythm is consistent and safe.” One couple was able to articulate perhaps why communication came so naturally for them.

Survivor: We tell each other everything. We don't keep secrets from each other… So it never enters my mind to not tell her. I feel compelled to tell her.

Partner: Yeah it's like that. It's like you can't wait to tell your girlfriend what happened...it's kind of like that. Like I just can't wait to talk to him.

The differences in communication style or ability also reportedly created tension in couples. There was a sense of a push/pull effect in which one member was often more responsible than the other in sustaining communication. One survivor described this tension with a little humor.

We need to communicate. We need to be together. So when I realize that we are slipping into that again and I’ll say, “Nahhh. It's time.” But I recognize it and he doesn’t until I say something…[he would say], “I thought we were spending time together. You were watching TV and I was checking for holes in my eyelids. (laughter).”
One couple described how their personalities can also create tension in communication.

Because I'm fiery tempered. So I'm passionate and fiery. And [her partner] is avoidant which can drive someone like me crazy. But what I've noticed over the years is that in my fieriness I want to deal with it, I want talk about it, I want to drive it out, I want to have a resolution. And that can't always happen.

A few partners indicated difficulty at times in conveying their thoughts and feelings. This was not from of a lack of effort but possibly a difference in personality or skill development. One stated, “…so emotions and talking about feelings are not one of my strengths. So sometimes it can be a struggle for me to talk about that stuff, but I definitely try.” Another explained the desire to communicate but needing some direction in how to begin the conversation.

Sometimes I can join in and sometimes I can't...I just can't think of anything to say you know? But if she's talking I can think and then we can have some conversation. But if she's not talking... I will want to communicate...but I have to think about what I should talk about.

Conversely, a survivor explained how she and her partner seem to have developed verbal skills but differing ways of resolving conflict when it occurs.

We are over-talkers, especially me. I want to beat something into the ground until we get to it. Like if we had a cake I would want it to be flour and eggs again like that's what I want in the resolution of conflict. And for [her partner], he needs space.

There was also a trend in which couples explained how communication involves being candid. Words like “honesty,” “truth,” and “open” were used. There were some responses describing the content of what needed to be communicated. One partner stated,

We…recognized that in order to keep that going we had to lay everything out there and talk about stuff that hurt us, talk about stuff that pissed us off, talk about stuff that we’re excited about. You know, make an effort just as much to talk about the things that we like about the other person and to talk about the things that we maybe want to mix up a bit.
A survivor described a similar experience with her partner noting that healthy communication does not always mean agreement.

So I think you have to have good communication and allow each other to speak the truth, whatever it is. You may not like what they are saying, but you respect the person. We have given each other permission to agree to disagree. We don't agree on everything, but we respect each other.

**Taking a break to resolve conflict.** Participants also provided responses in how they manage conflict. Several couples explained how they will often take a break from communication if the conflict becomes too emotional in the moment. There were variations in how long of a break ranging from taking time to “gather my thoughts for a minute” all the way to waiting a few days to resume the discussion. One partner noted a vulnerability factor in being successful in resolving conflict.

If we get into a fight after we have been out for a night, especially if we have been drinking, then it’s much more likely that it will turn into that uglier way of communicating. And often we recognize it and say, “Alright let’s just drop this for now and come back to it when we’ve slept more and haven’t been out partying.”

There is an old relationship adage that suggests couples should never go to bed angry. That was addressed in some interviews, with participants giving themselves permission to go to bed angry.

Partner: Like if we have an argument… It used to be when we had argument at night we used to work it out, but now sometimes we just go to bed and work it out the next day and it's fine.

Survivor: Because usually the next day were just like, "Sorry for being that way."

Partner: It's like you wake up and just realize you are a dummy.

Another couple dispelled the concept of never going to bed angry and how that can require trust to know it will get better.
Survivor: The whole idea of not going to bed angry...I think that's a great idea but for some people, for [The partner] and I, it might be good if we go to bed and come back to it later.

Partner: …And that's where that trust is...knowing that the level of anger [The survivor] might be experiencing on Tuesday is not to be the same as it is on Saturday.

One partner also noted that taking a break can be helpful and some of the time they do not need to revisit the discussion at all. After providing an example of a recent fight, the partner stated, “We don't always go back and talk about it, but it was just gone. But those kinds of spats are few and far between.” This may suggest that the problem resided in the emotions of the moment rather than the topic of conflict.

**Communication improves over time.** Several couples had responses that grouped together around a theme that their style or method of communication improved over time. One survivor noted that early on in their relationship she became aware of her struggle with conflict. She reported, “I didn’t know how to handle conflict and I didn’t have any tools.” Another survivor explained how she learned to provide space so her partner could have more of a voice in the relationship.

For a long time I used to talk and talk and get sick of talking and say, ‘now it's your turn.’ And he would be like a deer in headlights. But I've learned to be quiet. Like if he does speak I learned to be quiet. I used to get so excited that he would join in the conversation, but then he would stop. And that was really frustrating. So now if he starts speaking I've learned to just shut up because it will only be 10 sentences and then it will be over. I always get a chance to talk again (laughter).

Couples also reported how learning to listen to the other member was an area of growth that helped them communicate. One survivor explained how listening also created more empathy in her husband.

He's much more compassionate with the things he can't fix now than when we first started dating. Whereas before if I was being emotional, and it was
something he couldn't fix, he figured we just shouldn't talk about it. But he's grown a lot as a person in that area.

Another partner also indicated that listening was developmental in their relationship for both members of the couple.

You know, trying to listen to each other. I mean we’re still growing in that I don't think we do it perfectly by any means. But I think that helps us communicate more when we’re frustrated with each other and I think that's part of that trust too. There's some boundaries where you just kind of know with each other where not to go with each other.

Communication is influenced by history. Some survivors also referenced their own family of origin in discussing how they communicate with their partner. One survivor connected her FOO with conflict in her marriage.

But sometimes when [the partner] leaves the room it reminds me of when I was growing up. Because when I was a child there would be conflict and people would walk away and it was never resolved. So when he leaves the room it reminds me of my childhood which is uncomfortable, but I know that he’s always going to come back.

Another survivor explained how there was a learning curve between her and her partner because she would often raise her voice during conflict while he would not. In contrast to her husband’s FOO, she stated, “I just get my yelling from my mom. You know, in our family yelling was normal.” A different survivor connected her “family of storytellers” to her own verbose style and how that sometimes felt overwhelming to her husband’s shy temperament.

Some couples brought up the important of communication specifically about the abuse. When asked about a specific moment when communication was helpful, one partner described how important it was that his wife shared her history of abuse.

Probably just, you know, one of the things that stuck out is when she first shared the abuse with me. You know, trusted me enough to explain...you know…what happened and how it's affected her and wanting me to understand some of the
emotions and feelings that she gets. It helped me understand why she would come home emotional as opposed to normal and gave me that background information I needed.

Communicating about the abuse was not always something both members of the couple wanted. Discussing the impact of the abuse or the details of what happened could be very uncomfortable. One survivor recalled the progression in how communication around the abuse developed over time.

In the beginning, I knew from my own work...my own therapy... that I had to talk about it. I knew that if I didn't talk about it, it was going to be the poison in the relationship. So I probably made [partner] talk about it more than he wanted to…And I remember wondering if I was torturing this poor guy or if he really wants to know. I remember those feelings of how much to share or am I hurting him by sharing. But I knew that it had to be talked about. But over time we just talk and so it's just part of the fabric of that communication. It's just part of all of it.

Some survivors also explained that communication patterns can also be impacted by the previous abuse. They described being triggered in the moment by certain events during conflict resolution. One survivor spoke broadly about how other survivors need to help their partners understand what can create triggers through conversation, “It was so important to tell him everything and what my dad did so he would not do those things. Or we would do different things so not to trigger them. And that helped me so much.” Another noted that arguments can remind her of, “…feeling sorry for myself or neglected.”

**Developing and Sustaining Sexual Intimacy**

A few strong themes emerged from the data about these couples creating healthy sexual experiences. All couples discussed the importance of creating boundaries around sex, including expectations on who would initiate sex, acceptable sexual acts, and the right to discontinue a sexual experience. Partners discussed the importance of
communication regarding sexual boundaries. Couples were also forthright in explaining that their sexual health improved over time, with some indicating that it was not at all healthy in the beginning of the relationship. Additionally, survivors mentioned the importance of patience around sexual activity with their partners.

**Creating sexual boundaries.** Couples were unanimous in bringing up the importance of boundaries related to their sex life. Several partners discussed how they respect the boundaries of survivors when trying to initiate sex. One partner indicated there was no pressure to engage in sex if the survivor was not interested. Another stated, “While being respectful of when the other person may want to or not. To me that's all part of a healthy sexual relationship because the other person might not necessarily be ready to do anything at the same time.” Another partner made a point to say that when his wife says “no” he does not take it personally. A different partner stated, “A simple yes or no is usually enough.”

Survivors often reported needing to know their boundaries or limitations in participating in certain sexual acts would be respected. One survivor explained, “We do what the other person is comfortable with.” Another survivor went so far as to suggest her partner’s respect for her sexual limitations actually allowed her to become less inhibited.

We have established over the years that there are certain things that I cannot do and so there's no expectation of that, and I wonder if I was with a partner who wanted me to get over that, then that would make it different now…without the expectation, I am much more willing to try things I wouldn’t have.

A different survivor explained that, because of the abuse, she was actually surprised in her partner’s respect for her boundaries. She stated, “And it evolved in time, because at
first when we were married I really thought it was a surprise that he wasn’t more demanding and there was a mutual consent with everything.”

Survivors also described the importance of feeling empowered to discontinue a sexual encounter if uncomfortable. This was often a confidence that was built up over time in knowing their partner would cease sexual activity if the survivor wanted to stop. A survivor explained how difficult it was to engage in sex because of the messages she heard from her abuser. She noted that a comforting thought was how her husband had, “proven himself that he’ll stop whenever you say stop.” Another survivor who often experienced tension during sex which would cause pain stated, “Just being able to say ‘I’m really tense right now; I need to relax’ and [her partner] saying, ‘Okay let's take a second and relax’ really helped.”

**Communication of sexual boundaries.** A theme of communication about sex was reported by several partners. A partner described that communicating about how to initiate sex was important. He stated, “I think our communication has evolved to a place where if one of us is in the mood and the other is not we have kind of signals or ways of testing the waters and respecting the boundaries.” Another partner noted that communication about the abuse was able to improve their sexual experiences. Partners also identified the importance of communicating about how to feel safe during sex. A partner pointed out that they needed to, “…talk about how to make her comfortable.” Another partner stated, “I mean it was really when [the survivor] felt safe that she could say that she was safe and what she needed to happen to feel safe.”

**Sexual intimacy evolves.** Several couples reported how their sexual health had improved over time. Rather than being stagnant or even sexually healthy from the
beginning, there was a theme of growth by working at it. One survivor indicated how she learned to have more control in engaging in sex.

It was a growing experience to learn that it was okay, and that just because you hug each other it doesn’t mean it’s going to turn into something more. And there’s times when you do hug and hold each other close, it’s okay when it does turn into something more. And it took me a while to grow into that and it wasn’t something that I had to do, it was something that I wanted to do.

Another stated it simply took time to learn what both members enjoy during sex and make an effort to do those things. A different couple described how they learned from an outside resource, “We read a book called, Sheet Music (Leman, 2003) together and that was really fun. I think we learned some new ways to have sex and took some more risks after reading that book together.” A partner jokingly explained that learning more about his wife’s anatomy after being married for some time was a big step for both of them, “I think when a man finds a woman's clitoris, that's a big deal in life for both parties (laughter).” Another couple had an exchange in how they saw their sex life improving over time.

Survivor: Well the sexual relationship is also changed. There's more freedom and less weirdness.

Partner: Exactly. Yeah that's a very good point.

Survivor: There's not the awkwardness.

Partner: There's not the caution.

Sexually patient partners. Some survivors provided responses that were grouped into identifying their partners as being patient regarding sexual activity. This was in the context of either being patient in allowing their sexual health to develop slowly over time or having patience around initiating sex. One survivor linked patience to sustaining the marriage. “And I know if it had been someone else that I had married,
there’s such a good chance that it wouldn’t have worked because [the partner] is very patient. And he’s very kind.” Another survivor stated that her own inhibitions slowed down the act of sex and appreciated her partner’s patience in giving more time before beginning the physical aspect of sex.

**Overcoming the Impact of CSA**

Every couple made it a point to mention that problems from CSA do get better and hope was critical in the process. Couples highlighted receiving and providing support for each other. Couples also noted that part of the process requires patience, particularly with respecting each other’s pacing in moving through the effects of abuse. Couples described the importance of disclosing the details of the abuse to the partner and maintaining an ongoing conversation about its effects. Couples also indicated that perseverance or even “stubbornness” about the relationship can be an asset. Many partners also recognized the benefit of avoiding blame for the abuse towards the survivor. Couples also noted forms of resilience in response to the experience of CSA including adaptive ways to cope. Not wanting to sugarcoat the experience, couples mentioned that CSA can have a lasting impact on someone. Participants also talked about the importance of religion as well as therapy in their experience. Lastly, couples described the value in simply listening to the survivor to gain insight into the experience of CSA.

**Knowing it can get better.** Couples were unanimous in wanting to communicate that problems stemming from abuse in a relationship decrease over time and with hard work. Participants varied in describing what particular aspect of abuse improves. Some spoke more broadly, for example, one survivor stated, “There’s life after abuse. And there’s life more abundant if you just look for the good things in life.” Another stated that
in her work with other couples who have experienced abuse she often tries to help them join together in their growth, “Because it's both of their journeys together if they're going to stay together. And I tell anyone that does, your marriage is going to be better than ever. It'll be better than ever. Hang in there.” Others gave encouragement like, “…just stick it out. It’s worth it.” One partner indicated that it may take years, but will get better.

Participants also provided more specific messages of hope like, “So you’re not always going to be where you are right now with regard to your sexuality, communication, and trust.” And a partner provided this advice, “It’s not one person against the other…It’s like if we stick together through this we’re going to come out stronger.”

**Receiving and providing support.** All but one couple described the importance of being supported by the other partner. The form of support varied among couples but could be grouped into either experiencing or giving empathy, compassion, or affection. Throughout the interviews, partners discussed a struggle in figuring out how to help the survivor in their own way. One partner noted that this process included learning how to be emotionally available to the survivor but being very empathic along the way. “I do know in the first part of the relationship when it was brought up...directly brought up...I would cry over her childhood. Terribly. I felt so much helplessness.” Another partner explained how the support in the relationship creates a sense of commitment, “In the end, being open with one another and having love and compassion for each other...if you truly care about someone you will be willing to work with them through their challenges.” A partner indicated that in order to be a support to your spouse, one needs to be willing to be uncomfortable. A survivor described how important it has been for her partner to “build up” her sense of self.
I have the right to have my opinion and so does he. And I think that is so, so important. With victims, self-worth is so fragile...him giving me validation and listening to what I have to say builds my self-esteem up. He compliments me all the time and tells me I'm his "Wow." Survivors need that. It's just so important that husbands build up their wives who are survivors and help them.

Several couples also named themselves or the other member as being caring or sensitive to the other partner’s needs. This was often a characteristic assigned to the partners by survivors in response to the survivors’ struggles. One survivor described her partner, “And when I’m having a day where I’m really anxious, he makes me laugh and doesn’t…you’re not cruel or unkind…you’re always kind and warm and patient. Rather than being “get over it” it’s just an attitude thing.” Another survivor described how she appreciated her partner’s generosity, “He always wanted to be a provider for us. He wanted us to always have the things we needed and even some of the extras. He was always giving and caring for us.” One survivor noted how significant it was for her partner to be sensitive in reminding her that he did not blame her for the abuse.

And that's a point I think of that husbands need to reassure because wives need to hear that..."I don't blame you honey it wasn't your fault. I don't blame you." They need to hear that more than once from their husbands. Because some husbands just listen to them. They don't know what to say and they don't know how to respond you know?

One survivor made it clear that her partner’s compassionate personality was significant.

He wasn’t interested in taking advantage of me and really cared about me. So I think his genuine caring personality really helped me open up about what was going on with the abuse or whatever. I don’t think I would be nearly as healthy today if I was with someone else.

**Patience to go at their pace.** Several couples also emphasized the significance of being patient with the other member of the couple. Many couples simply verbalized the need for patience, while others were more specific. A survivor explained the impact of her partner’s patience, “[He’s] really patient…really patient even when I don’t deserve
him to be. I think that’s why I’m able to talk with him or be open with him.” A different survivor explained how her partner’s patience is empowering as it allows the space for her to overcome her own problems.

[His] patience. Whenever I am troubled with something, he doesn’t always say something right away. He doesn’t have to try and manage it or fix it. He’s patient and lets me work through any issues that I have…I think his biggest strength is that he is patient and caring person and I could see that in him.

Another survivor provided an example of when someone is disclosing the abuse for the first time, patience is needed from the partner.

And at my pace because sometimes I think a victim can only tell so much and see how their spouse is going to take it. And then see if it's safe. You don't know if that spouse is going to go out and kill the abuser...you don't know what can happen here.

A partner echoed respecting each other’s pace, “You just have to be willing to work at their pace...what feels comfortable for them. And then they need to learn about my pace and my feelings too.” Another partner noted that letting go of blame and accepting the abuse can take time.

You can tell somebody that it wasn't your fault and you can tell the other person not to have blamed the person and accept her the way it is, but this is a process that you're going through and it takes months, years or whatever. So you have to have patience.

**Dialogue about the abuse.** Several couples touched on the value of communication about the abuse. A partner suggested couples have open communication about the abuse instead of trying to hide it. Another described communication as “huge.” Most often however, there was a recommendation for both members to disclose their ongoing feelings and experiences around the abuse. A survivor mentioned the value in talking about the abuse, “Well first off, I would tell the person who was abused to talk about her experiences. Even though it’s really hard to do sometimes, it’s important that
she keep the other person informed of what’s going on.” Another survivor describes why it may be important for both members to talk about their experiences.

Because abuse lives in secrecy and if you're struggling with that, the first line for coping or healing from that would be talking. You need to talk to each other about that and how it's affecting each other. Because the person who was abused...you don't always think, "This affects her too.” My abuse has affected her. You’re not going to realize that unless you talk. It can become a, "you weren't abused so you wouldn't understand" kind of thing. She understands because it affected her too.

Some couples noted that the actual disclosure of the abuse to their partner was significant. One survivor talked about the disclosure in the context of wanting to keep it secret while others stated that they did not want to hold any details back. One couple who had been friends before becoming romantically involved had differing opinions of the significance of the first disclosure. The survivor brought up the abuse on their first date because she felt comfortable with their established friendship. The partner described his reaction, “That honesty was flabbergasting. I was astounded. More often than not my method of operating was to become more closed, secretive, etc. So I was immediately impressed at the openness. That was fascinating. I remember that.” Another couple also discussed the disclosure of the abuse and both the survivor and partner seemed to internalize the event as a significant step forward in their relationship.

Survivor: How do you really share who you are, why you are the way you are, like I never really wanted to share that much of myself before. And I did tell him it was a logical piece of explaining who I am. And he didn't freak out or treat me like I was infected or any of the things you imagine or feel yourself. He was just supportive and loving and I felt like it was a...I don't know...I knew that like we were with someone different than we had been before.

Partner: Because I recognize that that's something that's hard to talk about and it's something she hasn't really shared with most people...So when she shared that with me I think for me that opened my eyes that I was someone she could trust in her eyes. I hoped that I was prior to that, but that sort of confirmation I guess made me feel a little safer. Like I could share anything with her now that we kind of knew dirt on each other...that we had the trust and respect and we wouldn't use it to hurt each other.
Value of perseverance. Most couples brought up the value of being persevering or “stubborn” in one or both members as a strength in the relationship. The stubbornness was typically described in a way that showed commitment to solving problems in the relationship caused by the abuse. Four couples used the word “stubborn” to describe their spouse while another chose “headstrong.” The remaining two couples explained how they simply keep working at their relationship no matter the cost. One partner described this strength in the survivor, “One of her strengths I would say is perseverance, which is a nice way of saying that she can be stubborn at times but that stubbornness or perseverance helps to get her needs met.” Another survivor explained how stubbornness has helped her take comfort in the relationship.

We’re both stubborn. That probably helped… I have this really vivid memory of us having a really big argument and you took [our daughter] somewhere and I was like, "Oh my gosh, he's leaving me." And I called you and said, "Are you leaving me?" And you are like, "What are you talking about?" (laughter). That was like eight or nine years ago. And now that stubbornness reinforces that we are going to get through right now. And trust that. The wrinkles come out in the wash.

A partner provided a childhood memory of his own persistence as a way of explaining how important it is to their relationship.

I am very stubborn. As an example, I started splitting firewood when I was about seven or eight. And we would have to have the wood split by the time my dad got home from work. I would split all the wood I had to split and then I would pick the nastiest, gnarliest, chunk of wood and try to split it. And we used sledge and wedge. And I had two wedges and they'd both be buried in that chunk of wood… I think I do that with all kinds of problems...with everything in life. I think we’re the same or very similar that way. We just don’t settle for a failure or not doing the best we can.

Some couples also mentioned a strong commitment to the relationship. They discussed their partnership as if there was no alternative to being together. While dating, one survivor told the partner, “’If we get married, it's forever. We are not ever getting
divorced. Like I don't care what happens, but it's off the table.' And we've never ever even said I want a divorce or even talked about getting a divorce.” Another survivor explained, “We’re in it for the long haul.” A partner provided insight into his thought process around commitment.

You know when you're having a bunch of problems and you look at your options you think, “Divorce? I'm not going to do that.” What is love and if love is that fleeting or temporary it's not that. It has to be a commitment to each other.

Reducing blame. In addition to perseverance, several partners reported on the importance of avoiding any kind of blame towards the survivor and even being purposeful in stating the sexual abuse was not the survivor’s fault.

The spouse of that victim needs to understand that this occurred when she was a child, when she was not at fault, so don't blame the person at all. If you're going to have a healthy relationship, there can't be anything like, “Well how did you let him get away with that?”

Another partner described how to help someone separate the abuse from the survivor.

I would tell the partner that she or he is not the abuse. That the abuse happened to her, but just like she isn’t the high school that she went to or the car she drives it’s something she experienced and it’s a part of her history, but she’s a person first and foremost.

Resilience. Some couples noted that the history of abuse and how they have coped with it actually improved their life or relationship in some way. Both survivors and partners noted that managing the abuse has made them a more forgiving person in the relationship. One survivor stated that she believes she is much more compassionate towards others because she would not want to cause someone harm like she experienced. A partner noted that he believes he is more forgiving and understanding in the relationship simply because he is aware of the abuse. Another partner explained how the abuse changed who she was as a person for the better.
I think because of the abuse, I'm not who I was when I married him. We're different. I think because of the abuse it's made me more of who I am now. Because if I didn't have to deal with that I would probably still be that submissive, quiet, shy person… And I think because of the abuse…like you said I found a voice and my attitude kind of changed because he's very sarcastic and a master manipulator so I had to learn to adjust and recognize that and deal with that. So I think all of that stuff kind of made me who I am now. So I can kind of stand up now to what he's doing (laughter).

Other couples specifically named the concept of resilience in the survivor as form of post-traumatic growth. A survivor who works with other survivors as part of her job responsibilities explained that she often sees the resilient mindset as a turning point in becoming healthy. She stated, “There really is some deciding that happens with [survivors]. You are either going to allow this to make you stay where you are or you are going to become resilient.” One partner described how he sees resilience in his wife even though she may not see it in herself.

...she doesn't think she's a very strong individual, but from an outsider perspective I think she's quite strong and resilient to go through some of the challenges and hills and valleys that she's had to climb…Yeah for some individuals adversity can be a turning point for some people. Some people can take adversity and channel it into self-improvement and some people can kind of take that adversity and it will burden them or weigh them down or take them down another path you know? So I think [she] has taken some of the challenges she's faced and really rose above the difficulty and done it with quite remarkable resilience although she would probably never admit to it. But I think she's pretty strong.

Another partner provided a similar description, but noted how the adversity actually created a stronger drive in the survivor than she might have had without experiencing abuse.

But I recognize how you would use that experience and say, “I’m not going to…it would be very easy to let it affect me in a negative way and I’m not going to…almost out of spite…turn it into a positive or as a reason for pushing myself further and achieving as much or more than the average person.”
**The lasting impact of CSA.** Some couples also felt it was important to note how CSA can have a lifelong impact. One survivor used a metaphor indicating the problems can get better but a person is forever changed by abuse.

…the person who was abused…they were in a really terrible accident and they were crushed in some way. And that doesn't mean that they can't function or that for the rest of their life they are crippled or they don't have to be. That there's pain that shows up every once in a while, like when a bad storm is coming in, you can feel it in your soul.

Another survivor spoke to how damaging it can be holding on to the hate she carried towards her abuser.

I've had enough hate for a lifetime. And I let it eat me up. And it made things more difficult for me in my marriage over those years because with the hate there, there was no room to let everything be right in my life.

Partners also reinforced that it will be helpful to prepare for the challenges ahead. One called it a “bumpy road” with “highs and lows.” Another spoke to the persistence of problems that abuse can create in relationships.

An appropriate perspective [is] that it's not a situation that people get over. It's not a situation in that it disappears. It's going to have an effect for the rest of your life. It's just a question of will it be an interference or will it be a part of your relationship. That's the issue.

**Role of religion.** Most of the couples in this sample identified with a form of organized religion. Some of the survivors also discussed how religion played an important role in determining who they decided to marry. Often survivors used religion as a filter in choosing who they might consider for marriage. One survivor stated, “I knew I was looking for a Christian. I wanted a man who loved Jesus and that was really important to me. I was only 17 so I didn't really know what I was doing (laughter).”

Another survivor explained how God played a critical role at the very beginning of the relationship.
I had just met him for the very first time. And I knew it like I had a peace with it. And I felt that was what God kind of told me, “This is the guy you're going to marry”… and I never looked at any other guy. I knew… I never… I just knew it was going to happen eventually.

Unsurprisingly, some couples expressed the importance of religion as part of the health in their relationship. Survivors tended to describe how their faith helped them forgive the perpetrator or let go of the abuse. One survivor explained the struggle in thinking she had to love her incestuous abuser until her pastor suggested that God could love him, which cut the emotional bond with her abuser. Another survivor stated, “Well in our faith they teach a big thing about forgiveness, and so I think that's why I was able to forgive this person…So I turn to God in those times of hardship and that's helped me get through.”

Religion was also mentioned as a way to keep the members of the couple connected to each other. A survivor explained, “…but we are very strong in our faith. That's been the biggest thing that's helped us in our relationship. Attending church together, praying together, reading our scriptures together is one of the strong points in keeping our relationship healthy.” A partner believed that their faith in God has rewarded them with having similar perspectives in life, “Like our religion and faith in Christ is the same. There are a lot of areas I feel like God has blessed us with being able to be on the same page.”

The value of therapy. Some couples suggested that people struggling with the effects of abuse seek therapy. One survivor joked that she would recommend the therapist that helped her. A partner added that seeking therapy is not enough, but to be persistent in it. A different survivor disclosed that survivors can use therapy as a tool to take ownership of improving, “I would tell the survivor to go to therapy and work on
themselves first. I’ve been to a lot of therapy for a long time and that helped me…The partner needs to respect when they are able to get better and they need to get better, but it’s on the survivor to choose to get better.”

**The value of listening.** A few couples described how listening can be an effective way of better understanding the experience of being a CSA survivor. One survivor described how her partner listened effectively, “And he would say, ‘Honey it didn't matter. I will love you. You can tell me whatever it is. Is there more?’” A partner summed up his reasoning for spending time listening to the survivor’s story.

I was never abused so I have no idea what it’s like. So I would tell the partner of the person who was abused to do a lot of listening. Because you just don’t know what their experiences are like, and you need to hear from them because it’s unique to that person. So I think I’ve learned a lot through listening, and it’s really helped us get closer you know?

A partner from a different couple echoed the importance of being patient through listening, “Sometimes when it comes to the emotional issues, fixing things instead of listening is not the best strategy.”

**Summary of the Findings**

The qualitative findings from this study provide insight into the experience of a healthy couple where one member has experienced CSA. Five overarching themes were reported: (1) The Impact of CSA (2) Developing and Sustaining Trust (3) Developing and Sustaining Communication/Working through Conflict (4) Developing and Sustaining Sexual Intimacy (5) Overcoming the Impact of CSA. The overarching themes and most salient themes have been integrated to form collective narratives to describe the essence of the experience for these couples. The participants in this study often spoke from the perspective as either part of the couple, a survivor, or a partner. A collective narrative is
provided next that concisely describes the essence of the experience of being part of a healthy couple in which one member has a history of CSA. The first part of that description is from the couple perspective, followed by the unique experiences of survivors and partners.

**Summary Description of Healthy Couples’ Experiences When One Partner has History of CSA**

**The couple.** These couples had a wide range of age, years together, income, and education level. These couples met in high school or college and described the amount of years together with pride. First disclosures of the abuse were often brought up soon after the romantic relationship began. These couples spoke about the abuse most often within the first year. These couples indicated several problems early in their relationship as a result of the history of CSA. Problems with trust, sexual intimacy, and triggering memories created challenges. Both members of the couple often internalized the problems and directed blame at themselves. Out of these problems was the opportunity for growth in areas like compassion, resiliency, and forgiveness.

These couples described trust with words like “reliable” and “consistent” with a blend of honesty. Trust needed to be shown through actions instead of just verbal reinforcement. These couples struggled with differences in the level of trust between members in the beginning of the relationship. In order to communicate effectively, these couples needed to be purposeful in making time for each other. These couples also described similarities and differences in their style of communication. Sometimes it would feel natural, while other times there was tension over a disagreement in when to engage with each other. These couples were able to give each other permission to take a break from conflict as needed and come back to talk more at a later time. These couples
also had the awareness that their communication patterns improved over time. These couples made note that talking specifically about the abuse can be difficult but important.

In order to create healthy sexual experiences, these couples needed to manage sexual boundaries. Boundaries included respecting when to initiate sex, respecting what was allowed during sex, and empowering the survivor to disengage from sexual activity at any time if needed. These couples also noted that sexual intimacy improved over time, as it took a while to develop trust and learn what the other member enjoyed. They seemed to develop more sexual intimacy, but only if the partner was patient in being supportive over a long period of time.

These couples believed it was important to remember that problems from CSA get better over time. They described several qualities that seemed vital to the success of their relationship. Members needed to feel supported by each other and be willing to manage the problems while respecting the pace of the other person. These couples noted that stubbornness or perseverance in the relationship can be a valuable tool in staying committed to each other. They believed religion, therapy, and really trying to listen to each other were also important factors in maintaining their health.

**The survivor.** These survivors experienced a variety of CSA acts including fondling, oral sex, and penetration. These survivors struggled with mental health concerns at some point in their life, most likely anxiety or depression. They witnessed trust in their FOO but not a strong example of conflict resolution. These survivors experienced a lower level of family of origin functioning compared to their partner.

In the beginning of their romantic committed relationship, survivors did not fully trust their partner and had concerns of abandonment and fears of safety. These survivors
may also have difficulty with sexual intimacy and try to avoid sex or lack enjoyment. Triggers could pop up unexpectedly reminding him or her of the abuse. Blame was internalized for these problems. Despite these problems, these survivors were resilient and found strengths in compassion and a sense of accomplishment.

In order to manage conflict, survivors often had to walk away from the argument for a time, especially when emotionally flooded. These survivors noted that conflict could trigger feelings of abuse with one’s partner. The solution to this concern was to talk about how the abuse had impacted survivors so partners could learn to avoid recapitulating the abuse. These survivors needed to feel in control of sexual intimacy. When survivors communicated his or her sexual boundaries to partners and those boundaries were respected, these survivors’ confidence and enjoyment in sex would improve. These survivors needed to know that their partner was patient through the process of establishing sexual boundaries.

The partner. Partners experienced a mental health concern at some point in their lives, most likely depression. These partners likely witnessed higher levels of warmth in their FOO and lower moments of family members taking responsibility for their actions. These partner experienced a healthier FOO than survivors.

In the beginning of the relationship, partners had high levels of trust for the survivor, but felt confused and blamed oneself when sexual intimacy and trust was not reciprocal. Triggering memories of the survivor’s CSA was also confusing. These partners had difficulty explaining why or how they were able to develop or maintain a high level of trust for the survivor, and that it simply always existed. When discussing communication, these partners sometimes had difficulty expressing their thoughts and
feelings. These partners also noted that it was very important to learn about the survivor’s sexual boundaries to help the survivor maintain a sense of safety during sex. These partners described communication about the abuse as, “huge” and felt like learning about the survivor’s abuse was a sign of trust and enhanced emotional intimacy for the couple. It was important for these partners not to blame the survivor for the abuse and remind the survivor that the abuse was not his or her fault.

In Chapter V the findings presented above are discussed, including taking into consideration how this study’s findings relate to existing literature. Limitations of this study, implications for clinical practice and future research and the overall significance of this study are also addressed in Chapter V.
CHAPTER V

DISCUSSION

The chapter begins with a review of the purpose of the study. The next section includes a discussion of the findings in Chapter IV and the current literature as it relates to these findings and the research questions. Limitations of the study are also discussed. Both the discussion and limitations of the study are combined to provide implications for future research as well as implications for future practice. Lastly, concluding remarks summarize the chapter and highlight the study’s significance.

The Impact of Childhood Sexual Abuse on Intimate Relationships

The reported mental health concerns from the sample cannot be connected to previous CSA with causation, but every survivor in the sample reported mental health concerns. This is consistent with previous research linking CSA with psychopathology (Browne & Finkelhor, 1986; Tong & Oates, 1990). More specifically, the most common mental health concern for survivors in the sample was depression and anxiety, which also fits with current research (Carter, Bewell, Blackmore, & Woodside, 2006; Cougle, Timpano, Sachs-Ericsson, Keough, & Riccardi, 2010; Sarkar, 2010). All but one partner also reported a mental health concern. While there is much less literature on the experiences of partners of survivors, there has been research on the concept of secondary trauma of the partner (Graber, 1991; Maltz 1988) which may create problems with mental health (Malta, & Shay, 1995). It was remarkable that no participant reported any history of problems with alcohol or drugs given the large body of literature correlating substance abuse with CSA (Hiebert-Murphy & Woytkiw, 2000; Mullen, Martin, Anderson, Romans, & Herbison 1993; Simpson & Miller, 2002). This may suggest that a history of
substance abuse could have a significantly higher negative impact on the health of a couple with one partner who has experienced CSA when compared to other mental health concerns. The absence of reported substance use may also be related to the participants’ identities. This sample was very homogenous with regards to race, ethnicity, and sexual orientation which have been previously correlated with substance abuse (Finkelstein, 2009).

Because the act of CSA itself is a violation of trust (Graber, 1991; Maltz, 1988), it was not surprising that all but one survivor reported problems trusting their partner. Previous research has suggested that problems with trust stemming from CSA come from feelings of betrayal (Finklehor & Browen, 1985), insecurity about the relationship (Henry et al., 2011), and the perception that partners were uncaring and over controlling (Mullen et al., 1994). None of the participants reported feelings of betrayal or distinguishing a member of the couple as uncaring. In fact, most survivors described their partner as caring. Some survivors did report initially having fears of abandonment with their partner which could be related to relationship insecurity and their history of CSA. The absence of problems with trust that are correlated with CSA relationships in this sample may point to the significance of developing trust in maintaining relational health.

Couples also reported problems with sexual intimacy. More specifically, survivors described fears with boundaries, avoidance, and pain during sex which are all previously reported in the literature (Davis & Petretic-Jackson, 2000; Jehu, 1988; Wincze & Carey, 1991). Partners also described concerns with sex resulting from feeling like the problems were their own fault or frustrated with being unable to sexually satisfy the
survivor. These reactions certainly make sense as there may be confusion in how CSA is impacting sexual intimacy causing frustrations and blame to be internalized.

Partners and survivors indicated triggering the past sexual abuse affected the relationship and was an unpleasant experience. Reports described smells, touch, and even unknown stimuli that would recreate anxiety or fear of abuse. Partners also reported feeling as though the survivor was projecting the identity of the abuser on to them when triggered. Triggers are well documented in the literature (Davis, 1991; Hughes, 1994; Maltz, 1988), and to some degree the reactions of partners from triggers (Bacon & Lein, 1996), and coincide with the reported experiences of the sample.

Developing and Sustaining Trust

Couples consistently brought up the importance of trust in the relationship throughout the interviews. This reinforces previous literature on the impact of CSA on trust (Graber, 1991; Maltz, 1988). When discussing what trust meant for them, every couple used the descriptor “reliability” or “consistency”. In a study of couples without a history of CSA, Rempel and colleagues (1985), reported that to firmly establish trust in the relationship individuals must view their partners as “reliable.” Levitt et al. (2006), found couples used the word “reliable” to describe the concept of relational trust in a qualitative study. Couples in this sample may perceive the concept of trust in their relationship similarly to couples with no history of CSA.

Couples also highlighted the importance of honesty in establishing trust. McCue (2006) found that perceived honesty in the other member of the couple was a strong predictor of optimism about the relationship. Higher perceived honesty resulted in couples having higher levels of optimism. These couples did not report on their level of
optimism in the relationship, but the emphasis placed on honesty may suggest they are also optimistic.

This study also revealed differences in how survivors and partners described how trust developed for themselves in the relationship. Survivors indicated that trust was not established from the beginning, and they needed their partners to show through actions that they could be trusted over time. This was very different from partners who struggled to articulate the development of trust over time because it was simply always present in the relationship. This makes sense in light of CSA often impacts trust and partners did not have that experience. The success of these couples may suggest the lack of trust from survivors can be temporarily balanced with the innate sense of trust from the partner.

Trust is essential in healthy romantic relationships and the strong trusting characteristic in partners could be enough to sustain trust in the relationship while survivors slowly build their trust over time.

There is also a small amount of research on gender differences and trust in relationships. McCue (2006), found that while trust predicted relational satisfaction for both genders, it had a stronger effect for males than females. Seven of the eight partners and survivors in this study identified as male and female respectively. If trust was a stronger predictor of marital satisfaction for men than women, it may explain why the female survivors remained in the relationship despite not having a strong sense of trust at the onset. It may also explain why the male partners, who reported a strong sense of trust, also remained. In this sample, those who needed a greater perception of trust in the relationship to be satisfied had established that trust early on.
The results from the FOS may provide some historical information on how the couples in this sample have developed and sustained trust. When scores for the trust subscale were averaged into partner and survivor groups, the difference between the two groups was .1. This was the smallest difference across any of the 10 subscales. It was also the highest and third highest mean for survivor and partner groups respectively. According to Hovestadt et al. (1985), the trust subscale measures how much the participant perceived their family as seeing human nature as basically good. These results could suggest that the concept of trust was fostered among FOOS in both groups above other concepts measured by the FOS. It also highlights how the level of perceived trust growing up between partners and survivors was relatively similar within the sample. This information alone may not be significant, but when paired with the qualitative data suggesting that trust was imperative to the health of the couple, it may expose the importance of a higher and similar level of perceived trust in the FOOS for each member of the couple. Essentially, survivors of CSA may benefit from not only growing up in a home where trust is nurtured, but also finding a partner who experienced a similar childhood in that respect.

Developing and Sustaining Communication/Working through Conflict

Similar to the concept of trust, couples repeatedly talked about the importance of communication. The sample’s emphasis on communication is consistent with current literature on communication in relational health (Gottman & Notarius, 2002; McKenzie, 2003) and the increased likelihood for problems with communication in couples with a history of CSA (Mullen et al, 1994). Couples reported their success in communicating often came from making a concerted effort to establish time for speaking with each other.
This was also found in the literature on healthy communication in couples (Christensen & Shenk, 1991; Dindia, & Baxter, 1987). It would seem this sample of couples reflects the current body of knowledge around relational health in placing significance on communication as well as recommending being purposeful in their communication.

Couples in the study also described an understanding for the differences in their style of communication and conflict resolution. Couples explained how often one member of the couple had a tendency to want to communicate more than the other. Couples also noted this pattern during conflict when one partner would want to engage the problem while the other would feel the pull to avoid. This potentially unhealthy pursuer-distancer pattern can be found in extreme forms within couples with a history of CSA (Nelson et al., 2002). Perhaps the difference in this sample is the recognition of the pattern occurring and couples reporting communication about how to manage it.

Research has suggested couples who communicate about how they communicate during problem solving have higher rates of marital satisfaction (Dindia, & Baxter, 1987). Mackley and colleagues (2004) added the importance of not avoiding communicating about differences between partners.

The couples used in this sample seemed to have a refined understanding of how to effectively communicate with each other. Conceivably their success is intertwined with the previously reported higher levels of trust within the sample as problems with trust have shown to contribute to problems in communication with couples with a history of CSA (Reid et al., 1996). Couples in the sample reported on the connection between trust and communication by describing how it required trusting the other member to know that the current conflict would eventually be resolved.
Several couples also described the importance of taking a break during conflict. This ranged from a few minutes to a few days. Giving each other permission to walk away is one coping skill recommended to avoid the emotional flooding that interferes with effective communication (Gottman, 1995). This particular method in reducing emotional tension may fit well with couples in this sample as CSA can cause greater levels of adrenaline during stress (Heim et al., 2000) and cause fight or flight symptoms that can impair communication (Laurent & Powers 2006). It is possible couples reported attempting to manage emotional flooding over other conflict resolution techniques because the threshold for experiencing fight or flight characteristics during stress may be much lower for survivors. The adage of “never going to bed angry” may not be the best advice to couples with a history of CSA.

The results from the FOS may also add information to how conflict resolution was perceived in the FOOs of the participants. When scores for the conflict resolution subscale were averaged into partner and survivor groups, the difference between means was four. This was the largest difference across any of the 10 subscales. It was also the lowest and fourth highest mean for survivor and partner groups respectively. According to Hovestadt et al., (1985), the conflict resolution subscale measures how much the participant perceived their family as resolving normal conflict without undue stress. Researchers Alexander and Lupfer (1987) and Meyerson et al. (2002) also found that CSA survivors reported higher levels of conflict in their FOO. These results could suggest that the concept of conflict resolution was experienced very differently between survivor and partner groups. In the context of maintaining health in a couple with a history of CSA, it may also indicate that it is important for partners to grow up witnessing
healthy conflict resolution skills, it is less important for survivors to grow up witnessing healthy conflict resolution skills, or perhaps both.

Couples in this study also talked about managing triggers to the abuse. Partners and survivors both provided examples of triggers ranging from discomfort with a specific touch to night terrors that project the abuser onto the partner. Partners described witnessing triggers as confusing and even scary, but this sample differed from previous research that has suggested partners may see triggers as unreasonable and cause significant frustration to the point of grieving the loss of the relationship (Bacon & Lein, 1996). One possible explanation for this difference is how survivors in the current study approached managing the triggers. They noted that communication about the triggers was important in helping the partners understand how to avoid recreating feelings of abuse. Perhaps survivors were able to share those triggers with their partners because they had created enough trust in the relationship and also believed that sharing would make a difference towards their relational health.

Developing and Sustaining Sexual Intimacy

Like trust and communication, several couples reported on the impact of CSA on their sexual intimacy without any direction from the interviewer. The connection between CSA and sexual intimacy is well established in the literature (Davis, & Petretic-Jackson, 2000; Maltz, 2001; Noll, Trickett, & Putnam, 2003; Wincze and Carey 1991) as well as the importance of sexual intimacy and relationship satisfaction (Christopher & Sprecher, 2000; Hulbert & Apt, 1994; Young, Denny, Luquis, & Young, 1998). Childhood sexual abuse by its very nature is a violation of trust around sex and it is not
surprising the couples in this study reported problems with sexual intimacy and perceived it as important to their relationship in a similar manner to the literature.

Every couple highlighted the importance of sexual boundaries in creating healthy sexual experiences. Couples described an established expectation of how or who might initiate a sexual experience. This proactive approach is similar to Marendaz & Wood’s (1999) recommendation for couples with a history of CSA struggling with sex to increase a sense of safety by having the couple agree that no sexual contact should occur without the initiation from the survivor. Couples in this study did not report that survivors always initiated sexual experiences, but made a point of needing to respect the survivor’s comfort level and avoid pressure that may be unhealthy. This may indicate that as couples with a history of CSA increase health in sexual intimacy, who initiates sexual contact becomes less important than maintaining the survivor’s sense of freedom to participate or not.

Couples also indicated that boundaries during the act of sex were essential. This included what sexual acts were acceptable, and survivors needed to be confident that they could choose to stop at any moment during sex. Anxiety around re-experiencing abuse can be very real for survivors during sex (Wincze & Carey, 1991) and Maltz (2002) suggests that partners be active and purposeful in learning how to help survivors regain a sense of control during sex. It would seem couples in the current study have learned the sexual limits for the survivor and when partners respect those limits, survivors become more confident in regaining control. This process appears consistent with the research.

Not surprisingly, couples reported needing to communicate about the sexual boundaries mentioned previously. Even though survivors reported on the importance of
respecting boundaries, several partners actually discussed the importance of communication about those boundaries. Maltz (2002) mandates couples with a history of CSA learn how to work as a team to address sexual intimacy through communication, yet DiLillo (2001) noted that communication about survivors’ feelings around sexuality is often neglected. The participants in this study may shed some light on previous findings. Survivors were able to describe the importance of setting boundaries for initiating and participating in sexual activity. This may suggest they developed awareness of what was safe sexually and what was not. This information seems vital to a healthy sexual experience, but needs to be communicated to partners as encouraged by Maltz (2002). It was the partners in this study who reported the need for communication about those boundaries, which could indicate they felt some responsibility in helping to create enough safety for those conversations to occur.

In addition to boundaries, couples also indicated couples with a history of CSA that their sexual health improved over time. Couples explained how it took time to learn what each other enjoyed while others noted needing to learn about anatomy and sexual positions to experience improvement. Another couple stated that time removed the awkwardness and caution while increasing a feeling of freedom. Davis and Petretic (2000) noted that a survivor’s difficulty with trust can negatively impact their ability to create healthy sexual partnerships. The survivors in the current study reported needing time and positive reinforcement from their partners to develop a healthy level of trust (see previous section on trust). If trust and healthy sexual experiences are positively correlated, it may be that survivors in this sample also needed time to develop trust in addition to the responses provided.
Overcoming the Impact of CSA

In addition to the importance of trust, communication, and sexual intimacy, the sample revealed several themes that contributed to managing the impact of CSA on their relationship. While some of these themes may also fit within the overarching themes described in the previous headings, the researcher decided they were significant enough to the sample and would be better explained separately. These themes include recognizing that problems in the relationship get better over time, needing consistent support and care through dyadic coping, patience from the partner in the relationship and with sexual intimacy, talking explicitly about the abuse, perseverance and stubbornness in relational commitment, the role of religion, and the overall theme of resilience.

Couples had many responses throughout the interviews indicating their struggles in the relationship improved over time and recognizing that it will continue to improve was helpful. The most common reported areas of improvement were communication and trust. When couples were asked what they would tell another couple struggling with the impact of CSA, unanimously they expressed wanting to communicate hope. Couples placed meaning in knowing that with hard work the relationship will continue to grow. The negative effects of CSA are well documented for the survivor’s experience, but less so for the couple. These findings may indicate that the impact of CSA on the couple is so significant that hopelessness for the couple can develop. These responses may also signify that tracking a couple’s improvement as well as encouraging hope may be a substantial influence in managing the effects of CSA.

The majority of participants expressed how supporting and feeling supported were critical to maintaining the health of the relationship. More specifically, the concept of
support was broken down into compassion and empathy for the other member of the
couple. The positive correlation between empathy and martial satisfaction is not a recent
development in the literature (Boettcher, 1977). In this study however, couples discussed
how the unique complexities that come with CSA influence how to support each other.
One survivor explained how her partner’s emphasis on building up her self-esteem was
critical because she felt so fragile. Another stated that he “believed in her” while another
said it was important to “have my back.” While empathy and compassion may be
important in any committed couple relationship, the way it manifests may be very
different in a couple working through the effects of CSA.

This kind of mutual support in the relationship is similar to the concept of dyadic
coping. Dyadic coping is an interpersonal pattern where one partner experiences distress,
communicates that distress to the other partner, and receives support in managing the
stressor (Bondenmann & Randall, 2012). Participants in this sample clearly rely on the
support from the other member during times of stress. One partner stated, “In the end,
being open with one another and having love and compassion for each other...if you truly
care about someone you will be willing to work with them through their challenges.”
Couples see the problems in one member as a problem for both of them to solve as a
team. This use of dyadic coping likely contributes to the health of the couple as using
each other in managing the stress experienced by one member has been shown to be a
predictor of relationship stability and functioning (Bodenmann, Pihet, & Kayser,
2006; Papp & Witt, 2010).

While the importance of patience for members of the couple came up
consistently, it was most often applied to the partners. Patience was displayed in the
form of listening instead of trying to fix the concern of the other person. One survivor went so far as to say if she had married someone else, the marriage would have failed because her partner was so patient. The value in patience was also applied to partners around sexual intimacy, both during the act of sex and the progression of their sexual health over time. Couples noted how patience is required in the pacing of how the abuse is managed because often it can take time to develop health. The characteristic of patience for partners certainly makes intuitive sense in overcoming relational problems from CSA, but the significance that was assigned to it seems noteworthy. This may be an indication that healthy couples with a history of CSA in one member either have a partner who is naturally patient or has the ability to become very patient.

Couples highlighted the importance of talking about the abuse. Talking included being open about what happened and how it was affecting each individual, but also the ramifications of disclosing the abuse. Both partners and survivors indicated that there needed to be consistent communication with ongoing feelings about the abuse. Survivors reported those conversations could be challenging which is consistent with previous literature (Pistorello & Follette, 1998) while partners emphasized the importance of listening. Several partners also reported that hearing about the abuse for the first time was meaningful because it was a sign the survivor trusted them. One of the few studies on partners of survivors found that when survivors withhold information about the abuse, partners often feel betrayed, leading to unhealthy communication patterns (Reid et al., 1996). It is not explicit why survivors were able to candidly share their experiences and feelings around the abuse, but the impact of those disclosures seems very meaningful to the partners. The importance for partners hearing about the survivor’s memories and
feelings about the abuse, and being able to share their own feelings, may increase the effectiveness of communication and perhaps the overall health of the couple.

An interesting finding in this study was the role of “stubbornness.” When asked specifically about strengths for participants, five couples mentioned stubbornness as an asset in managing the effects of the abuse. It was described in a similar way to perseverance in a commitment to the relationship. There seemed to be a comfort in knowing that no matter how disruptive CSA might be in their relationship, the couple would never give up. This is consistent with previous literature reporting marital satisfaction is positively correlated with commitment (Broderick & O’Leary, 1986). It was not clear if all the participants who were identified as stubborn went into the relationship with that mindset or if that grew in response to the problems created by the history of sexual abuse. Perhaps individuals that tend to be more headstrong will see the abuse as a challenge to overcome rather than a burden to the relationship.

Most of the participants in the study identified practicing a form of religion. This may be a result of the sampling method of snowballing used in this study or perhaps related to the importance of using religion to cope with the abuse. Survivors indicated that religion helped them forgive their perpetrator, which is consistent with previous research that found spirituality was a successful coping mechanism for survivors (Gall, 2006). Additionally, couples in this study described how their religion helped members feel closer and connected to each other. In two separate studies, Bogar and Hulse-Killacky (2006) and Valentine and Feinauer (1993) interviewed high-functioning CSA survivors, some of whom were in committed relationships, and also found spirituality to
be a consistent theme in coping. The participants’ descriptions of how religion was an asset in their recovery from CSA may further reinforce its potential positive influence.

Within this heading of Overcoming the Impact of CSA, several themes have been described that fit well within the existing literature of family resiliency. Walsh (2006) defines family resiliency as the coping and adaptational processes in the family as a functional unit through belief systems, organizational patterns, and communication processes (See Chapter II for more information on these concepts). Couples in this sample described components of Walsh’s belief system in reporting the hope that the current problems will improve and looking to spirituality for support. Couples also fit Walsh’s organizational patterns by indicating they needed to provide consistent support and care through dyadic coping as well as patience from the partner in the relationship. Lastly, Walsh’s communication processes fit with this sample as couples stated that talking explicitly about the abuse and simply listening to each other was important for their health. This clear overlap within the literature may suggest the broader concepts of family resilience may also uniquely describe what has been helpful for healthy couples in overcoming the impact of CSA.

In addition to fitting well within the literature around family resiliency, some of the participants reported on the concept of individual resilience from the abuse or partnering with someone who experienced abuse. These included becoming more forgiving as an individual, an increase in compassion for others, more empathy towards the relationship, and a greater sense of self-confidence. Inherent in the literature is the assumption that abuse carries a negative impact on the survivor and romantic relationship. While the researcher was hopeful couples might indicate benefits from the
abuse, it was surprising to learn of the potential significance. Forgiveness, compassion, empathy, and confidence may not be qualities of someone who is abusive or present during the act of abuse. Perhaps as survivors and partners reflect on that experience, they attempt to compensate in those areas in an effort to distance themselves from the abuse and the abuser.

Limitations of This Research

One inherent problem with studying CSA is that it is very complex in that it has significant variability in terms of severity, duration, impact, and even acknowledgement by the survivor. No two people experience CSA in the same way, and thus finding the essence of the experience may require more participants to uncover common themes beyond what is presented in these findings. As mentioned previously, data collection was stopped when themes began to overlap, but there may be more data if given a wider sample of participants.

This study was also limited in that it only sampled couples from the eastern half of the United States. Although it is likely minimal, the regional specificities may limit the transferability to other areas. The race, ethnicity, sexual orientation, and preference for organized religion of the sample were also quite homogenous. Information on employment status or profession was not gathered in the demographic questionnaire which may have offered more insight into the effects of CSA and the nature of the participants. All but one couple was married with the other engaged. Couples who are unable or choose not to marry may report different experiences. Additionally, all but one survivor identified as female and all but one partner identified as male. It is possible that these variables may impact the couple’s experiences with CSA and their perspective in
finding health. Dual trauma couples and relationships lasting less than two years were specifically excluded from this study and the results may not be applicable to couples with those demographics. The RDAS was used in this study because of its wide acceptance in couple literature. It is seemingly limited however, in that its standardization sample is based on a very narrow demographic, though pretty similar to the demographics of the couples in this study.

Other limitations include a missing universal definition of a “healthy” couple and for the purposes of this study, a “healthy couple” was defined by the couple’s own agreement in describing themselves as healthy and the lack of distress reported through the RDAS. Both members of the couple were also interviewed at the same time which may have influenced responses. Despite using a “devil’s advocate” to help remove bias from the analysis, the data collections and preliminary analysis was conducted by one researcher. A team of researchers each coding independently may have further removed any bias. Lastly, the study did not inquire into the relationship between the survivor and perpetrator of the CSA which may have been useful in understanding the survivor’s FOO and findings on the FOS.

Despite these limitations, this study remains relevant and valuable to the current body of research. Participants varied in length of time together, age, SES, education, types of experienced CSA, and mental health concerns. Even with these differences, there were several findings that are not yet established in the current literature. Additionally, there is a substantial gap in the literature that addresses the dynamics of CSA within a romantic relationship and an even larger gap providing information from
the partner’s perspective. This study may expand on what little is known about the topic and offer new ideas for future research.

Recommendations and Implications for Further Research

Although the researcher attempted to address the limitations within reason, there may be opportunities to attend to these limitations in future research. Replicating this study using participants that are more diverse in terms of geographic location, race, ethnicity, sexual orientation, marital status, and preference for organized religion may uncover how the relational dynamics of CSA intersect with each unique identity. Gathering information on employment status or profession may enrich the context of the participants’ backgrounds. Additionally, explicitly asking about the relationship between the survivor and perpetrator of the CSA may be been useful in understanding the survivor’s FOO and findings on the FOS.

It would also be enlightening to see if similar results occurred with a sample that included more male survivors of CSA. Sexual intimacy and marital satisfaction are known to be influenced by gender. It is possible that couples with male survivors may have relational concerns, strengths, and solutions related to the abuse not reported in this study. This study specifically excluded dual trauma couples because the relational dynamics may be different than in a single trauma couple. A study with dual trauma couples could be useful in distinguishing those factors even further. Couples partnered for less than two years were also excluded to control for stability in the health of the couple. It would be informing to see if couples who have been partnered for less than two years report similar results.
It may also be worth replicating this same study but furthering the data collection by not only using a dyadic interview but also interviewing each member of the couple separately and analyzing the individual data prior to the dyadic interview. This may uncover another layer to the essence of the experience for this population and provide an opportunity to clarify or delve deeper into information reported individually. Additionally, using a research team with diverse identities to analyze the data could provide new insights into analysis not possible with a single researcher.

Another potential area of research would be exploring the intersection of substance abuse with healthy couples in which one member has experienced CSA. No participant in this sample indicated ever having a concern for alcohol or drug use despite a strong connection between substance abuse and CSA within the literature. While the sample could be underreporting or based on pure coincidence, it may be worth exploring if alcohol or substance abuse has such a negative and consequential impact on partners and survivors that sustaining a healthy partnership becomes unlikely. Additionally, all but one partner reported a mental health concern at some point in their life yet there is little known about how CSA may impact a partner’s mental health beyond the concept of secondary trauma. This is even more remarkable as the specific mental health concerns surveyed were limited to those known to be correlated with CSA and did not capture the much broader scope of mental health. Quantitative research into the mental health histories of partners of survivors may uncover currently unknown information about vulnerability factors and base rates for this population.

This line of research could also push against the perceived bias in the current literature in assuming that the effects of CSA will only create problems for individuals.
To date there is no known literature reporting specifically on how CSA may actually benefit a romantic relationship. Participants in this study reported becoming more forgiving as individuals, an increase in compassion for others, more empathy towards the relationship, and a greater sense of self-confidence. These results may indicate that such benefits could exist and may be worth exploring.

Survivors and partners in this study experienced the development of trust over time very differently. Survivors needed time and reinforcement to trust, while partners were clearly puzzled in how their level of trust would have either changed or needed to grow over the course of the relationship. The reports of the survivors fit with previous literature, but the responses from the partners left lingering questions for the researcher. Further discovery into the level of trust partners of survivors have going into and throughout the relationship may shed light onto the significance of trust in this study. Perhaps partners in healthy relationships have an inordinate amount of trust for the survivor or survivors may have sought out more trustworthy partners. Comparing trust to couples without a history of CSA could determine if partners do indeed have a different level of trust and if that exists before the relationship begins or in response to the impact of CSA. More research into FOO influences as a moderating variable for trust may also illuminate the origin of trust for partners and survivors.

Couples consistently reported the importance of communication in several areas of their relationship, including certain techniques that aided them during conflict. Further research into how couples with a history of CSA communicate through conflict resolution may uncover if those techniques are uniquely beneficial to this population. For example, couples reported having success in taking a break when conflict became too intense.
CSA is also known to create a lower threshold in activating fight or flight symptoms. Comparing the physiology of couples with a history of CSA and couples with no history of CSA in real time during an argument could clarify if relational conflict creates more adrenaline in one group and best practices for managing it within the couple.

Previous literature has highlighted the importance of survivors communicating their sexual boundaries to their partners. Results from this study have suggested that partners also recognized this need and attributed it to an improvement in sexual health. Previous research has suggested this is often a difficult task for CSA survivors. What may be missing from the literature and this study is how survivors and partners specifically move from a place of withholding that information to sharing. Results from the current study suggest it may be related to trust and the partner’s awareness of how abuse can affect the survivor. Further research into the interplay between trust and awareness could help expedite this process for couples.

Potential Clinical Implications

The findings from this study may also provide direction for clinical interventions for psychotherapists providing treatment to survivors, partners, and couples with a member who has experienced CSA. Most notably, the core components of trust, communication, and sexual intimacy reported by healthy couples are consistent with those who are in a healthy CSA relationship. How those components are sustained in a couple with a history of CSA may be different from other couples. One study noted that couples with a history of CSA displayed extreme forms of the pursuer-distancer dynamic. Couples in this study reported an awareness of this dynamic (without explicitly naming it) and attempts to manage it. It may be helpful for therapists to overtly explain this
concept to this population and brainstorm alternatives. These findings also uncovered a tendency for couples to give each other permission to take breaks during conflict. It may be beneficial for therapists to provide appropriate guidelines for “walking away” or taking a “timeout” during a conflict, with assurance that both parties will return to discuss this issue when calmer.

The findings of this study confirm previous studies in discussing the importance of communication about sexual boundaries for couples with a history of CSA. Therapists may find it helpful to first examine the level of trust within the relationship and the level of education about CSA for the partner before facilitating discussions around the survivor’s sexual boundaries. Results from this study indicate boundaries include how sex will be initiated, sexual acts that are acceptable and avoided, and a sense of safety that the survivor can stop sexual activity at any time. Obviously it would be prudent to encourage the survivor to maintain control of sexual contact for the couple until sexual boundaries were firmly established.

Therapists working with CSA partners may find it helpful to assess the degree of patience in the partner. Results of the current study clearly point to the value of partners recognizing recovery from CSA is often a long process and survivors directly attribute the health of their relationship to the patience of the partner. If partners are struggling to be patient or perhaps thinking there is a “quick fix,” psychoeducation about the process could be useful and even empowering if partners believe they can contribute to the survivor’s recovery.

Therapists may also see improvements in couples with a history of CSA if they are purposeful in fostering compassion and empathy for each member. This could be
further accentuated if empathy can be cultivated by talking directly about the abuse and feelings associated with it. This is especially helpful for partners who often feel betrayed in not knowing what is happening for the survivor. It could also be useful to help the couple discuss specific triggers that are related to the abuse in an effort to prevent the couple from perpetuating the feeling of being abused.

While stubbornness is often associated as a potentially negative quality in individuals, it may be a sign of health in a couples with a history of CSA. Mental health providers may consider using moments in therapy when one member is being obstinate as an opportunity to reframe how it could potentially be a strength in the relationship. If the stubbornness is associated with perseverance in the individual, perhaps framing the impact of CSA as a challenge to the relationship rather than a fault could provide individuals with a cognitive shift towards empowerment.

Therapists may do well to offer hope to couples with a history of CSA. One of the most powerful messages in the findings of this study was the universal agreement among participants that it gets better. Couples seeking therapy are likely in distress and a provider who can offer a couple a glimpse into what healthy functioning may look like could reduce some of the potential hopelessness that is often associated with distress.

It may be helpful for therapists to probe into what strengths or positive experiences may have come from working through issues related to the abuse for either member of the couple. The findings in this study suggest that members were able to articulate positive beliefs about themselves that would not have existed without either being abused or partnering with someone who was abused. It is possible couples in distress see abuse as being “all bad” and simply posing a question to the alternative using
appropriate clinical judgment may change how the abuse is perceived by the couple for the better.

As previously reported, survivors often seek out partners that may recreate abusive experiences. The reasons why survivors have lower marital satisfaction and higher divorce rates is not entirely clear, but the results from this study may help inform how to help survivors find relational health. Participants described characteristics in partners that were vital to the health of the relationship including patience, empathy, and high levels of trust. While further research is highly encouraged to confirm these initial findings, it may be beneficial for survivors to learn about the qualities of partners that could increase the likelihood in finding relational health. For example, Facebook is one outlet of social media that has become a growing forum of shared psychoeducational information and could be a helpful tool in providing access to articles that discuss how CSA survivors have successfully partnered with people who have high levels of patience, empathy, and trust. This kind of information may guide the survivor towards partners who are a better “fit.” It could also disrupt self-shaming thinking patterns reported in this study that cause survivors to believe they are not worthy of these types of partners.

Conclusion

This study attempts to broaden the perspective of current research by employing a sample of healthy couples with a history of CSA in one partner. The findings from this study confirm existing literature and provide new insights into the experience of healthy couples with one member experiencing CSA. Couples reported on the importance of developing and sustaining trust, communication, and sexual intimacy through a variety of coping techniques and strengths that sometimes required time to cultivate. Couples noted
several character traits that aided in their health including patience, empathy, and perseverance. Some participants also described how the experience of being abused or partnered to a survivor actually improved their life in some way.

In conclusion, the results from this study may provide new insights into the practice of psychotherapy with CSA survivors and their partners. Couples reported managing strong pursuer-distancer themes that could be explicitly addressed in therapy. Therapists may want to help the couple first establish a foundation of trust before addressing sexual boundaries which were vital to the healthy sexual intimacy. Couples may also benefit from psychoeducation on how relational health can be a long process for this type of presenting problem. Counseling may also be helpful in fostering empathy and patience for the partner as those were qualities that survivors identified as significant.

Lastly, couples reported needing to instill a sense of hope which could be nurtured in therapy by encouraging the couple’s strengths. There may also be implications outside of therapy including helping survivors identify qualities in potential partners that increase the likelihood of finding long-term satisfaction in a committed romantic relationship.
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Appendix A

Participation Flyer
Appendix A: Participation Flyer

PARTICIPANTS
WANTED!

Researchers from WMU’s Department of Counselor Education and Counseling Psychology are inviting heterosexual and same-sex couples aged 21 and up for a study looking at the impact of childhood sexual abuse on healthy relationships.

Participation:
- All couples will be given a $5 gift certificate after filling out three short questionnaires.
- Some couples will be selected to participate in a 90 minute in person or Skype interview discussing your relationship to receive another $10 gift certificate.

Requirements to participate:
- The couple must be married or living together for at least two years
- One partner must have experienced childhood sexual abuse before the age of 16 but no history of physical abuse or neglect (No history of any childhood abuse in the other partner)
- Consider your relationship to be “healthy”
- Not currently in couples or individual counseling

To learn more, contact Brian Doane, Student Investigator for dissertation

Research on couples:
Brian.C.Doane@wmich.edu
(616) 735-0397
Appendix B

Initial Contact Telephone and Email Response Script
Appendix B: Initial Contact Telephone and Email Response Script

Below is a script that will be used to guide the researcher when potential participants show interest in the study.

Potential Participant (PP): *Hi. I saw the flyer and was interested in the study. Can you tell me more about it?*

Researcher (R): *Hi. Thanks for your response. This study is attempting to examine the impact of childhood sexual abuse on adult relationships. Let me go over the conditions needed to participate and if you are still interested, I can give you more details.*

1) You and your partner need to be at least 21 years old
2) You have to have been married or living together for at least 2 years
3) One partner must have experienced childhood sexual abuse before the age of 16 but not any physical abuse or neglect
4) The other partner cannot have experienced any childhood abuse
5) You are not currently in couples or individual counseling
6) You consider your relationship to be healthy

For the first part of the study, both of you will be mailed a packet of information containing a questionnaire about the conditions I just mentioned and a questionnaire about your relationship and family. It should only take about 20-35 minutes per person. After you return those documents to me, both of you may be asked to participate with your partner in an interview talking about your relationship with me in person at WMU’s campus, at your home, or over Skype. Each couple will receive a $5 gift card to Walmart just for returning the questionnaires in the mail. If selected to meet with me in person or Skype, the couple will receive another gift card valued at $10. The total time should not take more than about two hours.
Do you have any questions?

PP: I think that works for us. What do we do next?

R: I’ll need both your names, phone number, and address to mail the questionnaires and what’s called an informed consent document that explains the nature of the study as well as the risks and benefits of participating. Each partner must fill out their own questionnaires but can sign the same informed consent document. It will also have instructions and envelopes to return the questionnaires and document to me.

PP: Great. My name is Mike Sample and my partner’s name is Janel Sample. Our address is...123 Research Lane Kalamazoo, MI

R: Okay. Once I get the forms back from you, I’ll either mail you the $5 gift card at this address or I call you back about participating in an interview with your partner to receive a $10 gift card in addition to the $5 one. If I don’t receive the forms within three weeks of being mailed, I will give you a call to see if you are still interested. If it’s necessary, may I leave a voicemail stating I’m from a WMU research team on this same number?

PP: Okay.

R: Any questions?

If they are not comfortable with a voicemail – Okay. Is there a time and day that is most convenient for me to call you back?

PP: I don’t think so.
R:  *If you have any questions later, feel free to call me at 616 735 0397 or email me at brian.c.doane@wmich.edu.*

PP:  *Sounds good.*

R:  *Okay. I’ll put those forms in the mail over the next day or two. I look forward to getting them back from you. Take care.*
Appendix C

Second Contact Telephone and Email Response Script
Appendix C: Second Contact Telephone and Email Response Script

Below is a script that will be used to guide the researcher when contacting participants about fully participating in the study.

Researcher (R): *This is Brian Doane from the WMU research team. I wanted to thank you for completing the questionnaires and returning them to me. I was wondering if you and your partner would be willing to talk with me about your relationship. If so, I would be happy to compensate your time with a $10 gift card to Walmart. If not, I can send you a $5 gift card just for your participation with the mailings.*

Potential Participant (PP): *I think that works for us. What do we do next?*

R: *Let me tell you about what would be expected if you want to continue. We would either meet at Western Michigan University’s campus, at your home, or we could interview over Skype. During the interview, I will ask you and your partner together about your relationship and how the both of you have managed any effects of previous childhood sexual abuse on your relationship. If we were to meet at your home or over Skype, it would be important that the conversation be private as I may ask questions that you or your partner wouldn’t want someone else in the home to hear. This interview will be audio recorded. The total time should be about an hour and half to two hours.*

PP: *That sounds fine. Let’s meet at WMU.*

R: *Great. Now, I can give you directions of where we will meet but I can also mail them to you if you like.*

If they want to meet in their home- *Great. Is your address still 123 Research Lane Kalamazoo, MI? What day and time works for you?*

If they want to use Skype- *Great. What is your Skype ID and what would day and time works for you? I will be using the Skype name “WMUTEAM”*
PP: Sure.

R: We will meet at Western Michigan University’s Grand Rapids campus. The address is: 200 Ionia Ave SW Grand Rapids, MI 49503 and their telephone is (616) 771-4171. When you walk into the building, take the elevator to the second floor, and turn left. The room is called the Center for Counseling and Psychological Services. Even though it’s a counseling center, you will not be a client of the center. Just tell the receptionist you are there to participate in the research project with Brian Doane. I am available Monday, Tuesday, and Wednesday evenings. If one of those days work, what time is best for you?

If they are choosing to meet at the Kalamazoo location, I would give them the address and add – You will have to have a parking pass to park in lot 41. I will mail you a parking pass along with the directions to the clinic.

PP: Next Tuesday at 6:00pm would be good for me.

R: Wonderful. Remember that you and your partner both need to come at the same time to be considered for participation.

PP: That sounds great. See you next Tuesday at 6:00pm.

R: Looking forward to meeting you and your partner. Take care.
Appendix D

Consent Form
Appendix D: Consent Form

Western Michigan University
Counselor Education and Counseling Psychology

Principle Investigator: Alan Hovestadt Ed.D.
Student Investigator: Brian C. Doane M.A.
Title of Study: The impact of childhood sexual abuse: An analysis of healthy couples’ perceptions

You have been invited to participate in a research project titled, “The impact of childhood sexual abuse: An analysis of healthy couples’ perceptions”. This project will serve as Brian Doane’s dissertation for the requirements of a doctorate in counseling psychology. This consent document will explain the purpose of this research project and will go over all of the time commitments, the procedures used in the study, and the risks and benefits of participation in this research project. Please read this consent form carefully and completely and please ask any questions if you need more clarification.

What are we trying to find out in this study?
We are trying to find out how childhood sexual abuse affects adult relationships. When someone experiences abuse, it can have a lasting effect into adulthood. Sometimes it can also affect romantic relationships and even make those relationships challenging. We are interested in learning more about how healthy relationships that have this kind of history stay healthy.

Who can participate in this study?
In order to participate in this study both you and your partner must be at least 21 years old. You must have been living together for at least two years. Additionally, one partner must have experienced childhood sexual abuse before the age of 16 and not experienced any childhood physical abuse or neglect. The other partner cannot have experienced any childhood abuse. Neither of you can currently be in individual or couples counseling. Lastly, we are looking for couples that describe their relationship as healthy.

Where will this study take place?
The first part of this study will take place in your own home. The materials included with this informed consent document can be completed wherever you feel comfortable and returned in the mailing envelopes provided.

The second part of this study will take place in one of four different locations 1) Your home 2) Over Skype 3) The Center for Counseling and Psychological Services located at Western Michigan University Grand Rapids 200 Ionia Street, SW Grand Rapids, MI or 4) The Center for Counseling and Psychological Services located at Western Michigan University 3341 Sangren Hall Kalamazoo, MI.

What is the time commitment for participating in this study?
Reviewing this form and filling out the questionnaires will take about 20-35 minutes. If asked to complete the second part of the study, the time required will be about 90 minutes. Total time for full participation is 110-125 minutes.

What will you be asked to do if you choose to participate in this study? If you choose to participate, both partners will be asked to fill out three questionnaires that ask questions about your background and current relationship. That information will be used to determine if you meet all the criteria to participate in the second part of the study. If both of you meet the criteria, you and your partner will be asked to meet in person or over Skype and participate in a 90 minute joint interview where you and your partner together will be asked about your relationship and how previous childhood sexual abuse may have affected it. Even though the researchers are licensed mental health therapists, none of your participation is considered therapy nor will you be considered a client of the therapists.

What information is being measured during the study? We are trying to measure the common issues in a romantic relationship such as time spent together, agreement, and satisfaction. We are also trying to measure how previous childhood sexual abuse may have affected your relationship. Additionally, we are gathering information about your childhood family.

What are the risks of participating in this study and how will these risks be minimized? While there are no known physical risks associated with this study, the content on the questionnaires may invoke new memories or uncomfortable feelings. These feelings may arise during participation or be delayed days or weeks. Included in this mailing packet is a list of mental health resources to help work through any issues should they arise.

What are the benefits of participating in this study? There are no assumed direct benefits to participating but you may find expressing your thoughts and feelings helpful in gaining a new understanding of yourself and your partner. You may also uncover new areas of personal growth. Lastly, your shared experiences may help inform future research on the impact of sexual abuse.

Are there any costs associated with participating in this study? The costs for participating are your time for participation, and if invited to participate in the second part of the study, your cost of traveling to WMU’s campus if you choose to meet there.

Is there any compensation for participating in this study? There will be compensation for your participation. After you and your partner return the fully completed questionnaires in the mail, the couple will receive one $5 Walmart gift card. If you are invited and choose to fully participate in the second part of the study, the couple will receive one $10 Walmart gift card. The total compensation for full participation is $15 in Walmart gifts card for one couple.

Who will have access to the information collected during this study?
Only Dr. Alan Hovestadt, Brian Doane, and Theresa Nutten will have access to any identifying information you offer. All information collected will be processed and your identity will be permanently removed. The content of what you say may be used in publication but no identifying information will be included.

What if you want to stop participating in this study?
You have the right to stop participating at any point in the study for any reason. There will be no penalty for ending your participation at any time but the compensation is only offered after returning the questionnaires and again after completing the interview.

Should you have any questions prior to the study, you can contact the principle investigator, Alan Hovestadt as (269) 387-5117 or Alan.Hovestadt@wmich.edu. The student investigator, Brian Doane at (616) 387-5100 or Brian.C.Doane@wmich.edu. You may also contact the Human Subjects Institutional Review Board at (269) 387-8293 or the Vice President for Research at (269) 387-8298 if questions arise during the course of the study.

This consent document has been approved for use for one year by the Human Subjects Institutional Review Board (HSIRB) as indicated by the stamped date and signature of the board chair in the upper right corner. Do not participate in this study if the stamped date is older than one year.

I have read this informed consent document. The risks and benefits have been explained to me. I agree to take part in this study.

____________________________________________
I have read this informed consent document. The risks and benefits have been explained to me. I agree to take part in this study.

____________________________________________
Please Print Name of Partner #1

____________________________________________
Signature of Participant #1

____________________________________________
Date

____________________________________________
Please Print Name of Partner #2

____________________________________________
Signature of Participant #2

____________________________________________
Date
Appendix E

Demographic Form
Appendix E: Demographic Form

Participant Code: ______

Birth Date: ______ / ______ / ______ Age: ________ Gender: □ Male □ Female □ Other_______

Race___________ Annual Household Income_________ Religion __________________

Marital Status (May check more than one): □ Never Married □ Partnered □ Married □ Separated □ Divorced □ Widowed

How long have you been with your partner? ________________

Ages of any children: __________

Highest grade of education completed ________________

Have you struggled with any of the following at any point in life? (circle)

Depression   Anxiety   Sexual Difficulties   Suicidal Thoughts   Drug/Alcohol Abuse   PTSD   Eating Disorders

If you experienced previous childhood sexual abuse, please circle any of the following behaviors that apply to the sexual abuse. If not, skip to the next question:

Fondling   Sexual Kissing   Oral Sex   Penetration   Exposure to Pornography

Relationship with Partner
When did you first find out about your partner’s abuse OR when did you first tell your partner about the abuse?
______________________________________________________________

When was the abuse talked about the most with your partner? (ex. right away, about a year into the relationship…etc)
______________________________________________________________

On average, how often does the topic of sexual abuse come up in the relationship?
(circle)

Every day    Once/week    Once/month    Couple times a year    Once/year    Every few years    Almost never

When was the last time you discussed the abuse with your partner (Not including any conversation prompted from this study)?
______________________________________________________________

______________________________________________________________
Appendix F

Interview Guide
Appendix F: Interview Guide

Thank you for agreeing to participate in this study about how childhood sexual abuse affects intimate relationships. Researchers are hoping to better understand how couples successfully work with the effects of the abuse. For the purposes of this study, we are only interested in how CSA has affected your relationship with your current partner. Even though I am a licensed mental health therapist, this interview is not therapy and neither of you are my clients.

Please start by telling me about the history of your relationship. You might start with how you met and go from there.

How has the history of childhood sexual abuse affected your relationship?

You see yourselves as a relatively healthy couple. How have you dealt with the history of childhood sexual abuse while maintaining a healthy relationship?

What strengths do you have or things you have done to help keep the sexual abuse in some perspective?

What do you need from your partner to trust and how do you open yourself up to trusting?

How do you keep the communication lines open and how do you work through conflict?

If your relationship involves sex, how do you create healthy sexual experiences?

What might you tell a couple that is struggling to deal with the effects of childhood sexual abuse on their relationship?

Thank you for sharing your experiences with me. Is there anything that I did not ask that you would like to share about this topic?
Appendix G

List of Mental Health Resources
Appendix G: List of Mental Health Resources

1) Visit http://locator.apa.org/ and type in your zip code. You can also add an “area of specialization” for a specific type of provider. Press the “Find a Psychologist” button and a list of licensed mental health providers will appear local to your area. If you need more options, broaden the search area on the previous screen.

2) Visit http://www.aamft.org/imis15/content/directories/Locator_Search_US.aspx and type in your zip code or city and press “Begin Search”. This will provide a list of licensed marriage and family therapists local to your area. If you need more options, broaden the search area on the previous screen.
Appendix H

Thank You Letter
Dear Jane and Mike,

Thank you for participating in our research study. There were many requirements that were necessary to further participate in this study and you do not meet all of them. We appreciate your time and energy and have included a $5 Walmart gift card as a way to show our gratitude. If you have any questions, feel free to contact me at (616) 735-0397 or email me at brian.c.doane@wmich.edu.

Sincerely,

Brian Doane
Student Investigator
Western Michigan University
Appendix I

Mailing Instructions
Appendix I: Mailing Instructions

Please Read First

You are invited to participate in a research study on the impact of childhood sexual abuse on healthy couples. The following packet contains four documents: Two copies of Informed Consent, Demographic Form, Revised Dyadic Adjustment Scale, Family of Origin Scale, and one copy of the List of Mental Health Resources. Both partners must read the document Informed Consent first. If you have any questions about the document, please call or email me before going any further. If both partners have read the Informed Consent document and understand and agree to participate in the study, go ahead and sign at the bottom of one copy. The other copy is for your records. Again, if there is any confusion or you have a question, please call or email me before signing the document.

Please follow the steps below for completing the first part of the study. Any identifying information will be mailed separately from your questionnaires. This is to protect your personal information if something was lost in the mail. Once we receive the envelopes from you and your partner, all information will be kept in a locked box at Western Michigan University’s campus.

Step 1: Sign the Informed Consent document (White paper)
Step 2: Each partner can now fill out their own copy of the Demographic Form (Yellow Paper), Revised Dyadic Adjustment Scale (Blue Paper), and Family of Origin Scale (Tan). Do not put your name on the Demographic Form, Revised Dyadic Adjustment Scale, or Family of Origin Scale.
Step 3: Insert the signed copy of the Informed Consent (White Paper) into one of the self-addressed and stamped envelopes.
Step 4: Insert each partner’s copy of the Demographic Form (Yellow Paper), Revised Dyadic Adjustment Scale (Blue Paper), and Family of Origin Scale (Tan) into the other self-addressed and stamped envelope.
Step 5: The List of Mental Health Resources (Green Paper) is for you to keep.
Step 6: Place the two envelopes in your outgoing mail.

After I receive the two envelopes, I will either mail you a gift card or contact you for further participation in the study.

Thanks for your time,

Brian Doane
(616) 735-0397
brian.c.doane@wmich.edu
Appendix J

Summary of Dyadic Interviews
This Appendix presents a short summary of interviews with all eight couples. To maintain confidentiality of each participant, the names have been changed and are not presented in any order previously used in the demographic tables.

**Bill and Cindy**

Bill is a late forties male and Cindy is an early fifties female. They met through a church while Bill was attending college. Both of them provided a humorous back story in how Cindy asked Bill out several times before he finally said yes. They dated for two years and have now been married for 27. Both of them tended to tell stories together with one person adding details when the other left something out. They clearly enjoyed each other’s company as they often looked at each other and smiled when the other person was speaking. At one point they had a disagreement about an event earlier in the day but laughed together as they hashed it out. The two of them also explained that they have not spoken about the abuse like they did during the interview in years. Bill stated that he felt like participating in the interview created some risk in bringing it back up even though he felt like he has dealt with it at this stage in his life. He also described enjoying talking about his relationship with Cindy and saw it as a positive experience.

When Bill first brought up his history of abuse with Cindy, she indicated that it was “no big deal” and assumed it would not affect them. She stated that her belief changed when she began to want to confront his abusers. This was a pattern throughout the interview in which Cindy was often very protective of Bill. Bill provided an example, “Like she's called my bosses before and said, ‘You’re treating Bill disrespectfully and
you need to stop.’ And I think that's connected because she felt very protective of me then and she still feels protective of me now.” Cindy noted that part of her growth process was learning to let Bill fight his own battles.

They seemed to attribute much of their health to wanting to spend time together each day. Cindy stated, “Yeah we do a lot of stuff together. I think because we actually enjoy each other's company. He is my best friend.” This fit with their lifestyle as Cindy helps Bill while he is working and often travels with him for business. They also seemed to have a bond that has been kept private. Bill stated, “Like we'll talk about anything with anybody but there's another side of life where we're not trustworthy or were not trusting people.” They attributed a lack of trust in others to Bill’s history with abuse and Cindy’s experience being bullied as a child. Neither are very close with their extended family which may have strengthened the closeness within their immediate family.

Cindy and Bill both made a point to speak about the role of religion in their relationship. Both stated that their faith is very important. Cindy stated, “I think that was a big thing. Had we not both been religious, I don't think it would've been quite the same.” While Christianity seemed to be a consistent part of their life, they also indicated that it was something to turn to when life becomes difficult.

**Kim and Joe**

Kim is an early forties female and Joe is a late sixties male. They met at the workplace and were friends for two years before going out on their first date. This was a second marriage for both of them and they have now been married for 14 years. They seemed comfortable with each other. When talking about how they met, Joe would describe how he was enamored with Kim.
When she came and sat in my office I didn't care what she talked about (laughter) she could've talked about the measles for all I was concerned. And she was talking about being in the church choir and I was mesmerized. I think that was pretty much it.

Overall, the two of them seem to be very thoughtful. Instead of looking at the researcher, they would repeatedly look at each other and engage in a back and forth conversation.

During those moments, they frequently pushed each other further in developing an idea. It was clear both of them enjoy each other’s company in creating meaningful conversations.

The disclosure of the abuse was especially important for Joe. He made note of how Kim’s willingness to talk about the abuse was different from his own background.

I know the first impact was on our very first date in 1999. Kim was very open about her history and I was astounded because I was not used to that kind of openness. That honesty was flabbergasting. I was astounded. More often than not my method of operating was to become more closed, secretive, etc. So I was immediately impressed at the openness. That was fascinating. I remember that.

Kim also remembered the disclosure, but indicated their friendship over the previous two years had created enough trust for her to reveal the abuse; something that was not on Joe’s radar at the time. This kind of interaction during the interview was typical in that one member of the couple would describe an event and the other would add his/her perspective to it. Both of them attempted to provide the story of their relationship while adding their own unique frame of reference.

Kim and Joe’s interview provided helpful context in their differing personalities. Kim described herself as quick to anger at times while Joe would often be avoidant.

And so what Joe's avoidance has allowed is that I have to wait and sometimes waiting means I don't feel as angry later and maybe I can hear him better because I’m not angry. And because I'm less angry he can come out. Because I think what happens when I really fiery and upset, and Joe's tendency to avoid, is he goes away because he's afraid.
While this difference may have created some problems with conflict resolution, they make it work. Both of them described how they have had difficulties growing up which created a strong sense of resilience, perhaps more than the average person. When problems have come up, they describe being very intentional in trying to cope with them because “Sometimes the coping is adaptive and sometimes it's maladaptive but you learn how to deal with it.”

**Sue and Andre**

Sue identified as a female and Andre a male. Both are in their late sixties. They reported recently celebrating their 50th wedding anniversary by traveling and meeting with all of their children and grandchildren. They first began dating in high school and married during Andre’s second year of college. Listening to Sue and Andre for just a few minutes, it was clear they have each other figured out. They rarely, if ever, interrupted the other and spoke to their strengths while allowing the other to speak to his or her strengths. Both seemed to talk about the abuse and how it has affected their relationship with relative ease which was surprising given the uneasiness many individuals have with this topic. Their comfort in the conversation may have been aided by their previous work in helping other survivors of abuse find relief. They were clearly passionate about the interview and showed enthusiasm in wanting to contribute to this study.

One notable difference between the two was how they appeared to have a different style of relating to people. Andre presents as a very confident man to the point of conceivably being intimidating to some. He reported previously working as coach for a high school sports team which seemed to fit his personality well. Behind that persona
seemed to be someone who cared deeply for others which was also apparent during the interview. Andre provided an example of his no-nonsense attitude mixed with compassion for other survivors.

The biggest thing that I think leads to a person healing is someone...if it's an adult and child abuse situation...is that the child is never fault. I think a lot of the unhappy marriages that we have become aware of is that there is still some family members, or sometimes a spouse, but particularly family members who blame the child. You know I don't get that one. That's beyond my comprehension how anyone could blame a child when the adult is using the power that they have over that child.

Sue’s personality seemed more outgoing and accommodating but also mixed with gentle empathy. She spoke from her own experience as a survivor, but also included responses as if speaking for all survivors. That may be because of her vast knowledge from helping many survivors and also shows her passion for serving others. She clearly wanted to give those who have been abused and their partners a voice in their experience. While talking about what she needed from Andre to trust, Sue’s energy comes through for helping others.

And don’t question them and say, "Why do you want to know where I’m going?" You have to understand victims don’t have trust. They need that. Instead of saying why do I have to tell you this or that they should offer. Andre will tell me you can call me at the office or you can call me wherever. A lot of men have to learn that their wives are really insecure. Very insecure. And build that trust in the person.

Laura and Ron

Laura is a female in her late forties while Ron is a male in his early fifties. They met as teenagers, were engaged after two months of dating, and married while Laura was in high school. They have been together for 32 years. Laura indicated that she was looking for a Christian man while Ron was looking for someone that showed love and acceptance. They jokingly spoke about how difficult it was to transition into being
married because they, “…didn’t know what [they] were doing.” Ron and Laura both spoke about how they came from different families of origin. Laura came from a family of communicators to the point that, “We talked about so much that it's painful. It's like please stop talking about that thing... It's enough (laughter).” Ron, however, described coming from a family that did not speak about feelings much at all. He stated, “So I learned I couldn't communicate; I couldn't hold a conversation. I don't know how she married me. And so it took a long time to figure out how to communicate and communicate about hard things.”

The interactions between Ron and Laura generated a sense that Laura has really helped Ron open up about his emotions over time. Even during the interview she coaxed him along with some of his responses.

Ron: Yet I was really...I don't know how to describe it... It was really hard.

Interviewer: This may be hard but can you attach a feeling to how it was?

Ron: I was trying to do that but I couldn't think of one (laughter).

Laura: Can I give you some options? Frustrated? Disappointing? Sad?

Ron: Yes. (laughter) I'd say frustrating and disappointing. It would feel like it's my fault and I would try to figure out what I did wrong.

Laura also stated that she was surprised how much Ron did share during the interview. This pattern of helping each other seemed like a theme between the couple as they shared other stories of how Laura has helped Ron open up, particularly around previous grief. This fits with Ron’s “laid-back” personality in that he tends to be easy going but internalizes a lot of feelings. Over time, this can create some “stubbornness” when those feelings become more important but struggle to be communicated.
Laura’s presence during the interview fit very much with her self-described “talkative” personality. This showed a lot of energy and strong sense of humor throughout the interview. She often responded to questions with personal stories that helped lay the context for her experiences. She also noted how important being proactive in recovery from the abuse has been for her.

Ron had said that I was really committed to recover and I really was. I worked hard at it for about three or four years. Even over the years I’ve continued to work on that. I try to make that a part of my life that I will continue to grow. It’s really important to me. So I think that it never occurred to me that I couldn’t succeed at it.

Mike and Jane

Jane is a female in her early thirties while Mike is a male in his mid thirties. They described meeting at a summer camp in 2004 and having a very strong first impression. Jane stated that immediately after she met Mike, she felt a sense of peace in knowing that he was the man she was going to marry. Mike reported a similar feeling a short time later. They married in 2006. The connection Mike and Jane have for each other was evident. They sat together on a couch with their knees touching each other. They called each other “babe.” At one point Jane began crying when talking about how her anxiety had made their relationship difficult. Mike reached over and held her hand until she stopped crying.

Much of the interview was spent talking about the impact of the abuse during their engagement. Jane was much more verbal than Mike during the first half of the interview and provided a lot of the backstory around their experiences. As the questions moved from talking about their relationship in the past, Mike seemed to provide a lot more input. The two of them also showed a lot of respect towards each other. Occasionally either of them would check in with the other to make sure what was being
said fit for the other person. For example, Mike was responding to a question about conflict resolution and stated, “Like not to bring up things from the past like, ’You did this three months ago.’ I don't think we have arguments like that, do we?”

The personality difference between Jane and Mike was less evident watching them during the interview but hinted at with their responses. Mike tended to be thoughtful about what he said while Jane appeared to think while she was speaking. Jane was talking about her family of origin and indicated that yelling was common and she would sometimes repeat that pattern with Mike. This seemed to be different from Mike’s style of conflict resolution. Jane described how the two of them respond when she begins yelling, “Usually he stays calm, but if he starts raising his voice, I realize I need to stop. For his voice to get raised I must really be going overboard because he doesn't do that often.” Their style of conflict resolution seemed to fit the larger dynamic between them. Jane appeared to be the one who brings a little more passion and energy into the relationship while Mike may hold more of the calming and reassuring position.

**Penny and Cody**

Penny is a female in her mid twenties and Cody is a male in his late twenties. They reported meeting while in college and were friends before beginning to date. They described deciding to move in together as more of a matter of convenience rather than feeling as though it was a natural progression.

I wasn't ready to move in when we first did. I was like it's too soon, but I knew we were planning to move away, so I didn't want to move away from all my friends in my support system and my family and a new city where we had nothing but each other.

They have been together for five years and are currently engaged with plans to marry in 2015.
Both Penny and Cody seemed to describe their initial interactions with each other as different from previous relationships. Cody explained how Penny’s disclosure of her abuse was a moment that created a deeper connection, “Like I could share anything with her now that we kind of knew dirt on each other...that we had the trust and respect and we wouldn't use it to hurt each other.” Penny reflected on how getting to know Cody felt unexpectedly safe.

And he didn't freak out or treat me like I was infected or any of the things you imagine or feel yourself. He was just supportive and loving and I felt like it was a...I don't know...I knew that like we were with someone different than we had been before.

This kind of connection they described seemed evident during the interview. They would talk to each other with a feeling that the other person was special or that what they had together was special to them. There was an enthusiasm for the relationship that bubbled to the surface.

There were also notable differences between the two of them. Cody would sometimes engage the interview questions in a more philosophical way, while Penny usually cut right to the point. This kind of balance appeared to work well for them as various perspectives were entertained with their responses. Cody described some of the personality differences between them.

I’m kind of passive person and disorganized and she’s the opposite. So I think we complement each other’s strengths really well. But I will say that it also reminds me that she is unbelievably understanding and helpful and patient when it comes to my school and career.

Penny added to the description of their differing personalities in how that creates a natural fit for the roles she assumes in the relationship.
I think, and I think Cody agrees, that he is his best self when he is with someone who can...I don’t want to say wear the pants on stuff...but I make decisions for us a lot. Like I do a lot of the legwork of our life.

This style seems to fit with their current situation. Cody described being very busy in graduate school while Penny is taking care of issues that he may not have time to be a part of. There was not a sense that either one is overwhelmed by their responsibilities but work well as a team having shared goals.

**Chad and Kate**

Chad is a male in his late twenties and Kate is a female in her mid twenties. They reported meeting in high school and started dating soon after. They explained that they dated for about a year and a half and decided to take a short break from the relationship before coming back together and marrying a few years later. They have been married for four years. Chad indicated that their break in dating was quite meaningful for him. He stated that Kate was in a serious accident while they were separated which shifted his priorities.

So that kind of put me in perspective. I really do care about this person and the grass is not greener on the other side of the fence (laughter). So I should probably see if she'll take me back. That was kind of the switch for me from dating to really looking at marrying someone.

Listening to Chad and Kate speak provided some context for how intense the impact can be on both partners. Kate described how she still experiences night terrors from the abuse and Chad will often try to help her wake up.

Kate: I used to wake up screaming in the middle of the night and that's affected him because we sleep in the same bed. It's been traumatizing for him for me to be screaming in bed and him not being able to wake me up you know, because it’s hard to wake someone up in a nightmare. I guess Chad could talk about what it’s like to witness it.
Chad: So I'm trying to wake her up to get her out of the night terror but she thinks actually I'm the bad guy or her attacker or whatever...causing the harm. It's never lead to any violence. Like she's never hit me or anything. But it's freaky because she really thinks I'm trying to harm her and it's a weird situation.

This passage illustrates the intensity both of them have experienced because of the abuse but also their resilience. It appeared as though the resilience fostered support for each other. Both of them were very quick to provide a compliment or build the other up in some way. A consistent message was the support that they felt. Chad provided a comment on his feelings toward Kate.

Some people can take adversity and channel it into self-improvement and some people can kind of take that adversity and it will burden them or weigh them down or take them down another path you know? So I think Kate has taken some of the challenges she's faced and really rose above the difficulty and done it with quite remarkable resilience although she would probably never admit to it. But I think she's pretty strong.

Another notable theme between the couple was hearing how Kate had a tendency to withhold her stress from others, including Chad. She described having a natural tendency to “bottle up” her emotions, “It's a really hard thing to bring up and so sometimes I think if I just keep it in that it won't affect me, but then it just affects me more if I don't say anything.” Despite the pull to withdraw, Kate continues to push herself in being vulnerable and Chad has responded by learning to listen. Chad described how important it can be for a partner to listen to a survivor, “Because you just don’t know what their experiences are like and you need to hear from them because it’s unique to that person. So I think I’ve learned a lot through listening and it’s really helped us get closer.” Perhaps this speaks again to their resilience as a couple but also illuminates how both of them have learned to adapt to the needs of each other.
Erica and John

Erica is a mid sixties female and John is an early seventies male. Erica explained how when she was walking home from high school, John drove by and asked her if she needed a ride home. She had no idea who he was and declined. He kept asking her each day until her friends who knew John told her he was a nice guy. They married a year later and have been together for 52 years. Part of their back story included purchasing a small home with cash when they were very young and slowly saving up money to build it up over time to avoid any debt. The strong sense of independence and literally building their future together by hand represents their values as a couple. They seem to take pride in hard work, staying busy, and being resourceful.

It is also worth noting the role of John’s family in their marriage. Erica was abused by one of her family members and “…ran away from home by getting married.” She had little awareness of what it was like to feel familial love until she met John’s parents. She explained, “…his mom and dad always treated me like their daughter rather than their daughter-in-law. And I found out what it was to be part of a family that has unconditional love.”

Erica was much more talkative during the interview. She spoke freely about the abuse, her childhood, and a lot about family. It was evident that family and friends are very important to her. She described a care-taking role with many people in her life often in the form of making sure that no one was hungry. When John’s friends came over to work on the house, Erica would work hard to create a sense of community, “I’d fix a big dinner and all the wives would come so that they didn’t miss their husbands when they
were gone all day Saturday and Sunday. We had big dinners there and it was like big family gatherings.”

John was more reserved than Erica. It seemed as though he was content to let her tell their stories, but would chime in with his own perspective when needed. Erica often described John as caring and patient, which was evident in the interview, but he also mixed in a straight-forward demeanor. For example, when asked about what strengths they have in managing the abuse, he stated, “Well I don’t know. It’s just something that I don’t dwell on you know? It’s happened and it’s not Erica’s fault and you know…she’s always been true to me and I’ve been true to her. Phooey on it.”
Appendix K

HSIRB Approval Letter
Appendix K: HSIRB Approval Letter

Date: February 19, 2014

To: Alan Hovestadt, Principal Investigator
    Brian Doane, Student Investigator for dissertation
    Theresa Nutten, Student Investigator

From: Amy Naugle, Ph.D., Chair

Re: HSIRB Project Number 13-12-02

This letter will serve as confirmation that your research project titled “The Impact of Childhood Sexual Abuse: An Analysis of Healthy Couples’ Perceptions” has been approved under the full category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note: This research may only be conducted exactly in the form it was approved. You must seek specific board approval for any changes in this project (e.g., you must request a post approval change to enroll subjects beyond the number stated in your application under “Number of subjects you want to complete the study.” Failure to obtain approval for changes will result in a protocol deviation. In addition, if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

Reapproval of the project is required if it extends beyond the termination date stated below.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: December 18, 2014