Complex Couples: Multi-Theoretical Couples Counselling with Traumatised Adults Who have a History of Child Sexual Abuse

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One of the major ways child sexual abuse can have an impact on individuals is in their later ability to have and maintain fulfilling couple relationships. Survivors may experience avoidance behaviours that become problematic in their adult intimate relationships. If couple therapists fail to focus on these traumatic imprints, the therapy may founder. This paper proposes that a multi-theoretical approach enables the couple therapist to deal with the complex problems such couples present including sexuality and intimacy concerns. Such an approach integrates trauma theory, attachment theory, feminist principles, body-oriented psychotherapy, and systemic couple therapy.

Keywords: child sexual abuse, trauma, couples therapy, multi-theoretical approach

A person's experience of childhood sexual abuse can severely diminish their later ability to have and maintain fulfilling couple relationships. Although client and counsellor alike commonly acknowledge this impact, it is often overlooked as a crucial aspect of recovery. Therapists who work in sexual assault centres or practice privately and operate predominantly from trauma frameworks privileging individuals may find it difficult to work effectively with couples when one partner has a history of sexual abuse.

This article describes how a synthesis of frameworks, including trauma theory, feminist theory, systemic concepts, body-oriented psychotherapy[1] and attachment theory can serve as the basis of a *relational model* of counselling, when an individual survivor of childhood abuse, or couple (where one or both are survivors) present to counselling. Using a multi-theoretical approach, therapists attend to the ways childhood sexual abuse may shape aspects of the adult couple's relationship.

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However, because of the nature of sexual abuse services or trauma organisations, when attempting to use new frameworks, therapists may face philosophical or organisational barriers, which need to be navigated carefully. For therapists in settings that are primarily focused on counselling the traumatised individual, the problem is how to deal effectively with both past trauma and current couple problems. A case study is used to show a multi-theoretical approach that favours healing the couple relationship.

Rationale for a Multi-theoretical Approach

Despite the absence of formal treatment guidelines for complex trauma (Courtois, Ford & Cloitre, 2009, p. 84), consensus within the sexual assault sector and current trauma literature accepts that victims of sexual abuse require safe and healing relationships to recover from the impact of abuse (see for instance Courtois, Ford & Cloitre, 2009; Herman, 1992; Allen, 2001; Johnson & Courtois, 2009; Miller & Sutherland, 1999; Solomon & Siegel, 2003, Johnson, 2002, p. 24). This principle is often assumed by many to apply exclusively to the therapeutic relationship and the client's experience of safety within the confines of this connection. When providing counselling to adult victims of child sexual abuse, however, the potential for restorative opportunities afforded by clients' expressed desires to have, or improve, intimate couple relationships should not be overlooked. If 'healing occurs in moments of secure attachment' (Solomon, 2003, p. 343), then recognising and using the relationships where such attachments occur is an important therapeutic intention, and, as Johnson (2002) contends offers an even greater corrective opportunity than the therapeutic relationship (p. 6).

Clients sometimes express dissatisfaction with couple therapists for not considering the impact of past childhood sexual assault. Likewise, clients in individually focused trauma therapy often want help for their current relationships. Therapists who work in organisations primarily servicing victims of sexual assault often face quandaries using a multi-theoretical approach focusing on the couple relationship. Some of these difficulties can be attributed to the philosophical commitments of the organisation, and how these influence choice of intervention approaches.

For instance, responding to the emerging voices of women articulating negative experiences within nuclear family arrangements, the Centres Against Sexual Assault in Victoria have a tradition founded in the feminist movement, which historically viewed families and intimate relationships as examples of oppression and exploitation. Feminist concepts of *empowerment* and *consciousness* are used within the sexual assault sector, necessarily, to disentangle women from conventional family formations, heterosexist couple dynamics, and oppressive relationships. Focusing on the couple relationship within a sexual assault service with a view, instead, to *strengthening* the bonds and preserving the dyad, is thus a philosophical shift from the founding principles of many of these services.

Similarly, couple therapists may neglect to respond to the power dynamics of sexual abuse adequately. Feminist practitioners have criticised the British *Tavistock Centre* model of marital therapy for perpetuating gender inequalities and ignoring power imbalances within families and couple relationships (Knudson-Martin, 2008,

p. 642). Feminist principles informing sexual assault practice emerged, in part, because of the lack of criticism about power shown by psychodynamic and object relations theories of relationship counselling (Daniel, 1985; Ruszczynski, 1993). From here, an unnecessary false dichotomy emerged between sexual assault centres and relationship centres making it difficult for either service to respond within the couple's relationship to childhood sexual abuse, violence and other developmental or attachment traumas.

Currently, the dominant trauma model of counselling used at sexual assault services is oriented toward individuals and their intrapsychic recovery from sexual assault, an approach that clients themselves expect when communicating with these services. However, many sexual assault centres have broadened their focus to provide counselling to non-offending family members, and more recently, offering to counsel couples. The central organising question of *who is the client?* makes this work complex and difficult. The mandate of sexual assault services is to help the primary victim of sexual assault.

However, from the perspective of systems theory, recovery from sexual abuse takes place through reconnection (Dwyer & Miller, 2006, p. 5; Johnson & Courtois, 2009, p. 373; Miller & Sutherland, 1999, p. 99; Upland, Johnson & Williams-Keeler, 1998, p. 3; Johnson, 2002, pp. 3–11). As trauma theorists are beginning to acknowledge, people with complex trauma are particularly vulnerable to having relationship problems, but the benefits of having a partner who offers a 'safe haven . . . [can lead to] . . . interpersonal . . . earned security' (Johnson & Courtois, 2009, pp. 373–374) aiding recovery. Therefore, providing counselling to the significant people in the lives of our clients and subscribing to systemic concepts viewing the relationship as central to trauma therapy, rather than as an adjunct to individual counselling, is important.

Alternatively, when an individual client struggles with the idea of bringing the partner into counselling, it can be because of their experiences of internalised shame resulting from the sexual abuse (Herman, 2007, pp. 12–13). Again, this is another problem created within a system, although an abusive one and its continuing effects of isolation are grist for the mill for systemic oriented practitioners. Although these two hurdles can make it difficult to prioritise couple relationships in counselling, they are not insurmountable. A multi-theoretical approach can offer many possibilities to this client group.

A blend of theories

Attachment theory

Attachment theory accounts for the ways an individual's early childhood experiences influence his or her relational style as an adult (Bowlby, 1988, p. 138) and why childhood attachment disruption leads to re-enacting early relationship patterns in current relationships leading to dissatisfaction and even re-traumatisation (Allen, 2001, p. 44). In sexual assault counselling, attachment theory provides a rationale for exploring traumatic attachment patterns, *internal working models* of self and other, and unconscious traumatic re-enactments that underlie current problems within the relationship. For instance, because of continuing painful and damaging interactions with an abusive parent/relative, many victims of child sexual assault form generalised working models of people as *dangerous* or *potentially harmful*. They might also view

themselves as inherently *bad* or *unlovable*. These types of belief systems are likely to influence and transfer to their adult relationships. However, negative internalised beliefs and attachment schemas are not included in Post-Traumatic Stress Disorder criteria, and are typically excluded from therapy models based on this paradigm.

Alternatively, drawing on attachment theory, the concepts of Complex Trauma and Disorders of Extreme Stress Not Otherwise Specified (DESNOS) (Luxenberg, Spinozzola, van der Kolk, 2001), recognise the entrenched impacts on personality that victims of child sexual assault frequently suffer. These problems may go beyond the difficulties a couple without trauma may face (Solomon, 2003, p. 329; Allen, 2001; Dwyer & Miller, 2006, p. 8). Solomon (2003) notes how traditional couple-systemic treatments aim to modify current dysfunctional behavioural patterns, yet this does not take account of the ways attachment traumas influence the couple dynamics (p. 324). Only through an attachment theory lens, can we capture these types of inscriptions and begin to remodel them. Where childhood sexual assault is part of the picture, a net wider than conventional systems-couple principles and trauma theory must be cast.

Attachment theory encourages therapists to support their clients' adult relationships to strengthen allies and create a secure base from which to explore oneself and the world. The therapeutic benefit of a supportive adult attachment relationship is manifold:

> Isolation and a lack of secure connection to others undermine a person's ability to deal with traumatic experience. Conversely, secure emotional connections with partners offer a powerful antidote to traumatic experience (Johnson, 2002, p. 37).

In recent years, trauma therapists have also become aware of the biological and neurological changes that occur through attachment bonds and failures (see for instance Ford, 2009; Wallin, 2007, pp. 99–112; Siegel, 2003, pp. 1–56), including disrupted affect regulation that results from attachment traumas. The ability of the therapist to attune to their client's attachment needs is crucial with clients who are victims of child sexual abuse experiencing dysregulated emotion and physiological affect.

However, when applying an attachment lens to trauma therapy, caution must also be taken not to reduce clients to an attachment category or pathologise people, instead, of understanding their experiences and learned ways of interacting. Many feminists criticise attachment theory about its potential to blame mothers and regard it as an apolitical and decontextualised theory of personality and parenting (Allan, 2004). Similarly, attachment theory has been criticised for its lack of attention to cultural differences concerning family and couple dynamics (Johnson, 2002, pp. 44–45).

Situating attachment theory within systemic practice requires examination of the social, environmental, cultural and political context besides individual intrapsychic development or parenting styles.

Systemic family therapy

Systems theory posits that individuals exist in relationship and social contexts and that people influence one another. When therapists employ the systems concept of *context*, they explore the connections, links, influences and patterns in the lives of traumatised

clients. Drawing on the systems concept of circularity can help therapists remember that couple dynamics are co-created and maintained (Crawley & Grant, 2008, p. 41; Fisher, 2002, p. 110).

For instance, following the Bowenian concept of differentiation (Bowen, 1978) it is common to find that if one partner has a history of child sexual assault, the other partner will bring to the relationship problems of equal measure, which place both at a similar level of differentiation. The relationship can become tense when one partner becomes more differentiated on their healing path from sexual abuse. When therapists scratch beneath the surface, they will often reveal the ways the non-abused partner relies on the abused partner's *non-coping* to support their own character strategies, particularly the strategy of being someone capable and coping.

By focusing on the relationship, the therapist can observe this binary between functioning / non-functioning and well / unwell, and thus can intervene. This is a powerful way of challenging blaming attitudes that non-abused partners may hold toward their partner and resituating the relationship as central. Therapists view the client holistically, rather than focusing on symptom management.

Yet the principle of circularity is not without limits particularly concerning abuses of power or violence within relationships where, as Goldner argues, the concept can be misused to 'rationalize the status quo' (Goldner, 1985, p. 333 in Fraenkel, 1997, p. 387). Research suggests that many victims of abuse go on to have adult relationships characterised by violence or mimicking the original abuse dynamics (Johnson & Courtois, 2009, p. 374, Allen, 2001; Upland, Johnson & Williams-Keeler, 1998; Briere & Scott, 2006, p. 154). It is therefore crucial to screen for possible violence in our clients' relationships and to maintain a stance that the person enacting the violence is responsible for the violence.

Though many adult victims of sexual abuse dread bringing their partner into counselling they are, nevertheless, extremely eager to get help so they *get it right this time* or to *find someone who loves me.* Couple therapists use systems concepts to help the victim and their partner make connections between current relationship problems and past abuse, interrupting negative patterns. A powerful and restorative experience for an adult victim of child sexual abuse is merely a loving, accepting response of a partner to their internalised shame (Herman, 2007, pp. 12–13, Johnson, 2002, p. 6).

Therefore, the advantage of the therapist using a systemic lens with the couple and of bringing the partner into the counselling room is that the therapist can limit re-traumatisation through relationship re-enactments. Most important, helping partners together respects the desires and goals of clients who like most people, want to experience satisfying relationships.

Nevertheless, there can be difficulties in applying a systemic framework in a sexual assault or trauma setting. For instance, individual clients may be anxious that they will lose the primacy of the therapeutic relationship if their partner attends. Therapists trained in trauma models may also wonder how to balance potential competing needs of two individuals, instead of privileging the traumatic experiences of the victim. Inviting couples into counselling at a sexual assault centre can leave the therapist carrying a tension between focusing on the sexual abuse problems with the possibility of inherently blaming the victim for the couple's problems (Baima & Feldhousen, 2007,

pp. 24–25); or, alternatively, focusing on the couple and decentering the traumas, thereby re-enacting possible abuse dynamics from the past, which devalued the victim of abuse or taught them their needs were not as important as others.

However, when couples attend relationship counselling *without* a focus on trauma and sexual assault there is immense potential to miss crucial information about the ways the relationship is organised around the impact of the abuse (Miller & Sutherland, 1999, p. 102) and thus lost opportunities to heal the individuals and relationship.

Trauma theory

Trauma theory provides the scaffold to understand and unravel the intrusive re-experiencing, avoidance and physiological hyper-arousal that many victims of sexual abuse experience as flashbacks, panic attacks, volatility, or flat affect. By focusing on neurophysiology within a broader counselling framework, trauma theory, offers the most powerful explanation of why the victim of child sexual abuse 'can't get over it' (Matsakis, 1996), as indeed they are frequently implored to do by uninformed or struggling partners. This pearl of information can bring the partner on board to help in recovery rather than inhibit recovery. Psycho-education with the couple about the impact of sexual assault traumas can shed light on some ways the relationship has suffered because of the abuse, often leading to greater compassion toward each other. A couple who have shared knowledge and understanding between them about impacts of child sexual abuse, such as flashbacks or panic attacks, are much more equipped to deal with these stressors.

Although trauma theory enables the therapist to address the symptoms of individuals, it has been criticised for decontextualising people's trauma responses and focusing on symptoms (Briere & Scott, 2006; Courtois, 1999; Herman, 1992). Feminism alternatively focuses on the *aetiology* of sexual violence with the *impact* of sexual abuse on people's lives (Walker, Gilmore & Scott, 1995). Therapists who draw on feminist theories beside trauma concepts need to find non-reductionist ways of using trauma theories, including awareness about bio-physiological and neurological trauma responses. Feminist practitioners often focus on normalising coping mechanisms and recognising skills in surviving overwhelming experiences.

However, the non-traumatised partner may, nevertheless, attribute the relationship problems to the victim of the abuse because of the intrusive impacts on the relationship (Johnson, 2002, p. 24); or have a 'benevolent blaming' (Baima & Feldhousen, 2007, p. 25) attitude, which implicitly holds the traumatised partner responsible. Given women are the principal victims of abuse, in heterosexual relationships this stance reflects the sexist view that women are liable for relationship problems besides the *symptoms* they suffer. It also minimises the role of the perpetrator of the original sexual abuse by focusing, instead, on finding ways to help clients overcome trauma symptoms, inherently problematising the impact of abuse, rather than the abuse itself.

Feminist theory

A multi-theoretical approach that includes feminist knowledge can inform counselling processes and provide strategies for improving the relationships of victims of sexual abuse. For instance, feminist principles of joining with clients in a transparent way, acknowledging power imbalances within the counselling relationship, observing the

role of the therapist in the therapeutic system, as well as respecting the victim's self-knowledge, contribute to therapy becoming a restorative safe and trusting experience.

Using this perspective, the therapist highlights the client's strengths having survived sexual assault and normalises her coping mechanisms, which her partner might have viewed as problematic. Feminist couple's therapists (Papp, 1988; Goldner in Fraenkel, 1997) encourage an examination of the gender arrangements in the relationship that may uphold traditional gender roles (Papp, 1988, pp. 201–202) or prevent the couple from having the relationship they want (Baima & Feldhousen, 2007, pp. 31–32).

Feminist practice also contests limited or narrow definitions of trauma and traumatic events and in doing so has expanded the range of experiences considered by the Diagnostic and Statistical Manual (DSM) (Johnson, 2002, p. 19). Feminist therapists criticised the diagnostic criteria for PTSD as inadequately describing the impacts of child sexual abuse. Instead, feminists highlight the capacity of any relationship, especially the couple relationship to re-traumatise victims of child sexual abuse (ibid, p.19), points that are now embraced within complex trauma theorising.

Using a feminist lens does not mean the therapist automatically sides with the woman, but does mean the therapist identifies and challenges male domination and rigid adherence to traditional gendered roles, which disadvantage the woman. Women and men are indoctrinated into gendered roles and it can be difficult for couples to shift these entrenched and socially reified patterns but a worthy goal.

Body-Oriented Psychotherapy

Given that the body is violated in acts of sexual abuse, it is crucial and logical that trauma counselling with victims of sexual abuse centres on *the body*. According to Hakomi and Sensorimotor psychotherapies, *all* counselling to process trauma should weave among the cognitive, emotional and sensorimotor levels of experience (Ogden, Minton & Pain, 2006, pp. 8–14; Kurtz, 1990, 2–3). Counselling victims of sexual abuse and their partners lends itself to body-oriented psychotherapy where the couple physically interact during counselling sessions (Fisher, 2002, p. xvi; Sotheren, 2007, p. 203). Body-oriented psychotherapists use *experiments* to explore how relationship patterns arise and are maintained (Fisher, 2002, p. 111). The approach aims to enhance clients' self-consciousness and thereby enable trauma survivors to understand how their 'body remembers' traumatic experiences (Rothschild, 2000). This helps with somatic trauma symptoms of pain, frozen states, dissociation, aggression, numbing and fear of physical intimacy. Together with systemic, trauma and attachment concepts, body-oriented psychotherapists look to the ways client's bodies participate and perpetuate negative cycles (Fisher, 2002, p. 113) or enact attachment patterns (Ogden, Minton & Pain, 2006, pp. 46–64).

Body-oriented psychotherapy encourages therapists themselves to be mindful and self-aware during sessions. It is easy to imagine mindfulness as a construct only for clients to practice and ignore how therapists might be reacting in ways that are not helpful, such as becoming defensive or reacting negatively to clients' material. Body-oriented principles encourage therapists to track their own lived experience within counselling sessions. The self-aware therapist can sense fluctuations in emotional tone between the couple and between each person and therapist (Sotheren, 2007, p. 211).

The biggest challenge to using this approach is keeping clients in the here and now. Many victims of abuse are body-phobic, as their body was the original site of pain and danger. Moreover, the false binary between mind and body still prevails in popular psychology and people attending counselling often do not expect to focus on physiological, sensory, or physical experiences. The sexual assault sector seems to face a difficult tension between either ignoring the body or focusing on the client's body and risking replicating the unsafe touch or objectification that occurred during the abuse. However, this fear, which is more than likely a natural counter-transference, inadvertently upholds the false mind / body dichotomy of cognitive 'talk therapies', perhaps not best suited to dealing with problems of sexual assault and trauma (Sykes-Wiley, 2004, p. 35). Even more problematic, it perpetuates the somatic dissociation victims of abuse often suffer.

Body-oriented psychotherapy draws attention to the client's present consciousness and present interactions, thus eliciting the client's wisdom about the nature of the problem. Clients, however, usually expect therapy to be a cognitive, talk-oriented, or directive process, where the therapist offers solutions and makes their partner see the *truth* about their perspective. Body-oriented psychotherapies do not operate from this premise.

Putting it all together

> *'I have the suspicion that I am no longer the person you fell in love with and that because I don't feel like having sex anymore, your love is no longer there for me'*

Therapists often find that therapy with couples where one partner has been sexually abused is challenging. It has to deal with couple problems and individual problems of two people reflecting long-standing traumatic imprints from the past. The multi-theoretical approach described here is well suited to respond to these presentations.

A common problem raised by victims of sexual abuse and their partners in counselling is a fear of intimacy or lack of intimacy or physical closeness in the relationship as illustrated in the following case.[2]

Vanessa began to attend counselling to resolve past abuse problems. A male family member had sexually abused her between the ages of seven and ten. Through counselling, it became apparent that many of her problems revolved around fears and interactions taking place within her current heterosexual relationship. Vanessa described how she does not enjoy sex and wished that her partner, Luke, would leave her alone. She had been dreaming he would leave her to give her relief, as well as fearing this would happen if she did not resolve her sexual reticence. Vanessa said she loved Luke and wanted to stay with him.

When clients raise problems about intimacy in counselling, therapists must be guided by the universal counselling rule of achieving safety, common to all the approaches discussed in this paper. The initial sessions are merely about building a solid and safe therapeutic relationship by being non-judgmental, warm and attuned to the attachment cues demonstrated by the client during sessions. As Vanessa's therapist, I aimed to increase her 'window of tolerance' (Ogden, Minton & Pain, 2006, pp. 26–40) and affect regulation skills rather than exploring the traumatic

details of her past. I looked for ways that I could increase her feelings of safety outside of counselling, specifically within her attachment relationships.

I asked Vanessa if we could invite her partner Luke to attend counselling sessions or hold him in mind when discussing the problems further (systemic counselling). If Vanessa had chosen not to bring Luke into the sessions, his perspective could remain figuratively within each session by asking Vanessa questions that required her to use her internalised knowledge of him. For example *If Luke was here today, how do you think he would speak about what you have described?* Or: *Is Luke aware of how you feel about this matter?*

The therapist observes and selects an interactional sequence that occurs between the couple within the session and uses this to extrapolate on the relationship.

When Vanessa and Luke arrived for their first shared appointment, I noticed who sat first and where, which way they faced and the distance between them. I noticed that Vanessa quietly moved her chair away from Luke but still faced him, while Luke remained stationary, facing directly ahead. I wondered about a dynamic taking place between them where Vanessa *sees* Luke from a distance, but Luke struggles to be aware of Vanessa.

When a couple attends, the therapist can introduce concepts of mindfulness by helping each person describe his or her here-and-now experience (Kurtz, 1990; Fisher, 2002). The therapist's intention is to gain insight into the precise dynamics occurring between them.

Vanessa reported that her parents taught her sex was wrong and that this made her feel guilty about the sexual abuse she experienced. I asked her to describe how she felt now in her body. *Can you feel that guilt now? What does the guilt feel like in your body?* Vanessa said, *it's all over, but mostly tight and painful in my chest.* Similarly, I asked Luke to reflect on his bodily experience in relation to Vanessa: *Luke when Vanessa's chest stills and tightens like now, what happens in your body?*

Using a feminist lens, I explored the gendered arrangements between Vanessa and Luke to determine whether Luke's behaviour reminded Vanessa of the abuser's behaviour, or if his behaviour was controlling, shaming or forceful in any way. Using the trauma lens, it is also important to give the non-abused partner a framework to understand his partner's current choices and reactions about intimacy or physical touch. This means building consciousness about traumatic triggers and uncoupling fear responses that are not relevant now.

We discussed trauma symptoms and the coping mechanisms of flight, fight and freeze, exploring how Vanessa and Luke react to various things, driven by overactive central nervous systems still trying to protect them from events that took place in the past. I drew the connection between Vanessa's experience of sexual abuse and how *flight* and *freeze* were used automatically when things remind her of the abuse, saying:

> *It's reasonable to assume that if Vanessa is triggered by sexual reminders, she may not feel over sensual or want sexual contact, especially given that her body shuts down at these times.*

I explained that this was not an abreaction to trauma, but a normal reaction to physical violation.

When one partner does not want sex but the other does, the low desire partner is commonly viewed by many as having a problem. This problem needs to be viewed

within a systemic lens. Although we live in a society that holds sexual willingness as the norm, constant sexual availability does not equate to normal. An exploration with the couple about the influences of socio-political and gender constructs that pair male sexual desire with male sexual entitlement can enlighten them about negative and prescriptive gender patterns. From a feminist perspective, it is important that therapists do not use their authority to valorise sex above abstinence, but emphasise the freedom to choose and to be authentic within the relationship.

At this point, the therapist introduces the concept of coping mechanisms and normalises the impact of the abuse on the relationship. Victims of sexual abuse sometimes avoid intimacy, while also wanting safe, restorative physical contact. They may enter relationships at times of experiencing dissociation, numbing or other avoidance coping mechanisms and this effects their sexual expression.

Some clients report that they continued to use their bodies in sexual ways in adult relationships, by sexual abuse conditioning, but that this coping mechanism no longer fitted with their growing consciousness or needs.

I talked to Vanessa and Luke about the change in Vanessa's desire for intimacy saying:

> *Some non-abused partners can find it difficult to understand why their partner no longer wants physical intimacy where this was previously part of their relationship, but this is typical at times of stress like during relationship difficulties or recovering from past traumas.*

The therapist can explain to the clients that the abused partner's indifference or withdrawal from sex is a natural defence against hurt. The therapist supports rather than challenges the client's defences resulting in the client having less need to maintain the defence (Kurtz, 1990, pp. 59–60; Fisher, 2002, pp. 97–108). Thinking systemically, the therapist can also teach the non-abused partner how to support his partner's defences as well.

Vanessa sat away from Luke and was startled or withdrew when he tried to touch her. This distressed Luke. *I only want to get close to you*, he said in a rebuking tone. We explored Vanessa's internal sensory experience of this involuntary defensive strategy and she realised that she felt safer when she did it. From here, we explored how Luke could support her withdrawal defence rather than trying to bulldoze through it. Vanessa suggested she would like Luke to tell her if he is going to try to touch her legs. Luke initially found this perplexing but could see the benefits of giving Vanessa this choice.

Another way the male partner in this situation can support his partner's defences, is to help her consciously move backward, or, instead, move backward for her and take over the defensive behaviour to see how and if this alters her experience (Kurtz, 1990, pp. 101–110). With encouragement to track their experiences, partners can increase their awareness of embodied expectations arising from the sexual abuse and past attachment relationships, and how these are re-enacted in the current relationship.

In conceptualising the current dynamic between the partners, therapists can consider how the attachment patterns and family of origin experiences might have led to core beliefs about proximity and distance or being protective and non-protective. With both partners present in counselling, therapists can observe how these