Healing the Incest Wound:  
A Treatment Update with Attention to Recovered-Memory Issues

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This article provides an updated treatment model for adults who report having experienced incestuous abuse in childhood. It integrates psychodynamic, traumatic stress, developmental and feminist formulations, accords greater emphasis to object relations and self-psychology perspectives, includes more attention to dissociative reactions, and utilizes more cognitive-behavioral interventions. It is also responsive to issues raised in the recovered/false memory controversy. This holistic model is sequenced, paced, and titrated according to the patient's characterological structure, ego strength, and needs as well as the range and severity of presenting problems and life difficulties. Special consideration is given to issues pertaining to memory and the maintenance of a neutral stance by the therapist, especially in the case of recovered rather than continuous memories and/or suspicions rather than actual knowledge of abuse. Contemporary perspectives regarding some of the unique transference, countertransference, and vicarious traumatization issues with this population and their potential impact on treatment are also discussed.

INTRODUCTION

Throughout the 1970s and 80s, research on incest/child sexual abuse documented an alarmingly high prevalence rate in North America. This research was given extensive media coverage with the result that child sexual abuse was publicly acknowledged as never before in human history. The research also documented the potentially dire personal, interpersonal, and societal consequences of abuse, prompting researchers to call for the development of prevention and intervention initiatives. In response, social service and child welfare professionals developed new models for intervening in contemporaneous sexual abuse and treating child victims and their


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families. Mental health professionals simultaneously developed models for the treatment of adults who reported a history of sexual abuse.

One of the first comprehensive models for the retrospective treatment of adults reporting a history of incestuous abuse was published in Healing the Incest Wound: Adult Survivors in Therapy.\textsuperscript{1} Several other treatment models were also published from the mid-80s to the early 90s, making up a preliminary expert consensus or "first generation" of treatment for past incest/sexual abuse.\textsuperscript{2-11} In general, these models were posttraumatic in perspective and emphasized abuse as an important, although not exclusive, focus of treatment. This orientation was in marked contrast to the predominant therapeutic perspective of the day that dismissed or minimized reports of abuse as either unimportant or as wish or fantasy on the part of the victimized child.

Since that time, considerable refinement has occurred, spurred by increased clinical experience with the population, more sophisticated diagnostic formulations that include an increased recognition of characterological deformations and dissociative responses associated with chronic traumatization during childhood, and the integration of the early models with additional therapeutic orientations. The model has also been significantly shaped, influenced, and buffeted by a number of societal events and issues. Foremost among them: the widespread publicity accorded the new research findings on abuse and other forms of family dysfunction during the 1980s in the print media and in radio and TV reporting (and the "tabloidization" of abuse in some cases); the resultant influx of individuals who sought treatment for "adult child" and abuse related issues, some with trained therapists, others with uncredentialed treaters, and some in self-help programs; the noninclusion of abuse and trauma in professional training programs, a situation that put therapists in the difficult position of "learning by doing" when working with abuse issues; the resurgence of interest in psychological dissociation. Multiple Personality Disorder in particular, and the latter's association with sexual abuse and other major forms of childhood trauma; the acceptance and dissemination of the concept of traumatic memory, including the likelihood of amnesia and delayed/recovered memories of abuse and other trauma; the rise in allegations of ritual forms of abuse, especially among patients diagnosed with multiple personality; the legislative extension of statutes of limitations to allow for delayed discovery of damage from past abuse that opened the option of civil lawsuits; the development of a countermovement spearheaded by the False Memory Syndrome Foundation and academic memory researchers, some of whom were members of the Foundation's professional
advisory board, that challenged the concept of recovered memories and charged that therapists were creating false memories of abuse through the use of suggestive techniques; and, last but not least, the rising influence of managed care.

A more detailed discussion of each of these is beyond the range of this paper; however, the reader should be aware, at the very least, that the incest treatment model described here has developed within a dynamic sociohistorical context. It has been significantly configured by these influences, and ongoing development will continue to be impacted by issues and events within and outside of the clinical arena.

This contribution provides a description of the updated or "second-generation" treatment model for adults who experienced incest in childhood or adolescence. The updated model retains much of its original posttraumatic and abuse-focused orientation but has broadened. It now includes attention to other formative life events, object relations, and characterological issues as they might reinforce or dilute reactions to abuse and as relate to choice-of-treatment strategy.

The sequence of treatment is also more articulated. The model places emphasis on pacing and titration of the treatment process and development of the patient's ego capacities, skills, functioning, and life stability before any direct work with the abuse trauma is undertaken. This model also focuses more on issues of memory and the maintenance of therapeutic neutrality, especially with regard to recovered rather than continuous memories and/or suspicions rather than actual knowledge of abuse. Finally, it reviews contemporary perspectives regarding some of the unique transference, countertransference, and vicarious traumatization issues and their bearing on the successful resolution of the most salient incest-related issues.

We now move to a brief overview of incest as an exceptional traumatic stressor and then to a review of some recent clinical and research findings regarding the consequences of incestuous abuse as they suggest new diagnostic formulations and implications for treatment. The main body of this paper offers a description of major components and issues of the treatment process. It should be noted that research and theory pertaining to trauma, abuse, and dissociation are at a relatively early stage of development and that postabuse treatment is an evolving specialty in clinical practice. As a consequence, the treatment approach described here is, of necessity, based more on clinical hypotheses and strategizing than on empirical substantiation. Outcome studies are needed to test the efficacy of this model in order to direct its continued development and refinement.
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INCEST: CHARACTERISTICS, EFFECTS, AND DIAGNOSTIC FORMULATIONS

Incest is a particularly virulent form of sexual abuse that has the potential for serious psychological sequelae in childhood and adulthood. Defined as sexual contact or behavior occurring between related and quasi-related individuals, incest is considered a form of child abuse when the perpetrator is older, physically bigger and stronger, and/or holds a position of power or authority over the victim. This power differential as well as the victim's age and immaturity preclude informed consent regarding participation.

Incest is a stressor with many traumatizing characteristics that put the victim at risk for a range of initial and long-term effects. Its occurrence in a family context and its perpetration by a relative or someone in close proximity to the child and on whom the child is dependent, is a defining characteristic. Incest often takes place in conjunction with other forms of family abuse, including spousal violence and all forms of child maltreatment from physical and emotional abuse to neglect and abandonment; furthermore, it occurs in interaction with other family problems and pathology, such as chemical dependence, mental illness, and numerous psychosocial stressors. Disturbed family relationships and dynamics, such as parental discord and immaturity, parent-child role reversals and triangulation, boundary violations, double-bind communication, and entrenched patterns of denial, secrecy, rigidity, and shame, are frequently implicated. These aspects are damaging to the victim above and beyond the sexual transgression and, in many cases, may be more damaging.

Certain variables of occurrence have been found to relate to the severity of response. On average, incest results in a more serious aftermath if it begins when a child is either very young or in early puberty; is of longer rather than shorter duration (the average duration is four years); is forceful and violent; involves misrepresentation and coercion; involves "grooming" of the child to be an active participant; is blamed on the child; involves an escalation of sexual behavior over time and a sexualized response on the part of the child; involves physical penetration; occurs sequentially with more than one perpetrator; occurs between parent (or step-parent) and child or between other members of the nuclear family; is observed, acknowledged, or disclosed but not stopped; and when intervention occurs, it is traumatic in its own right and/or is ineffective and the abuse continues.

In the case of chronic, escalating incest without protection or interven-
tion, the child is essentially trapped and powerless and must find ways to cope. Most, if not all, child victims develop negative self-attributions. They conclude that they are bad and, therefore, the cause of the abuse, a conclusion that paradoxically allows them to maintain an image of the abuser as good (a position necessary to maintain a secure, albeit ambivalent, attachment). Denial, blame, disavowal, and nonintervention (especially when incest is disclosed or observed) further consolidate the child’s sense of badness and self-blame. Child victims also cope by emotionally and physically distancing themselves from ongoing abuse. They step outside of themselves in whatever way possible and otherwise dissociate to distort reality and their own physical and emotional responses to accommodate ongoing incest.1,2,36 Evidence is accruing that dissociative responses, such as these, are especially likely when the abuse fits the severity profile described above.37

Studies of child and adult incest victims have found a correlational relationship between an abuse history and patterns of aftereffects. A definitive causal relationship cannot be made at this time using available retrospective self-report and nonexperimental research methodologies; however, the aggregate data are consistent enough to support incest as a major risk factor for a variety of serious aftereffects.38 Although research findings document a host of nonspecific symptoms and effects associated with abuse, a pattern emerges when samples of abused versus nonabused individuals are compared. Abused subjects report more depression and posttraumatic symptoms along with irrational guilt, shame, and self-blame, atypical anxiety reactions, dissociation, somatization, suicidality and self-harm, revictimization, relational disturbances, sexual dysfunction, substance abuse and other addictive-compulsive behaviors, major cognitive distortions, and polarities of behavior than do nonabused subjects.39-42

A listing of symptoms, such as this one, does not give an adequate description of the presentation of the symptoms that adults with an incest history make in a clinical setting. It is worth noting that incest and other forms of sexual abuse have been found to make a significant contribution to the need for clinical services in the first place. Studies of prevalence of abuse and incest in the backgrounds of psychiatric patients document a startlingly high percentage (ranging from 50 to 75%) of adult female patients in both inpatient and outpatient settings.30,43,44 Incest survivors are also overrepresented in a number of other at-risk populations, e.g., the homeless, women in prison, prostitutes, addicts.35

Clinical descriptions have shown a high degree of consistency. Gelin45 provided one of the earliest contemporary descriptions. She found that the
adult incest survivor often presented with a characterological depression with complications and atypical impulsive and dissociative features as well as intense affects, such as shame, excessive responsibility, self-blame, and irrational guilt that underscored and became entangled with the depression. She further observed victims to be prone to a host of anxiety disorders including panic, agoraphobia, and a range of simple phobias (often directly or symbolically related to the original trauma). Self-destructiveness, including suicidality, self-mutilation, and revictimization due to repetition compulsions, reenactments, naivete, personal disregard, and risk-taking, was observed as were addictions and compulsions used to alleviate distress. Gelinas also documented intergenerational family roles and relational patterns that put the child at risk for incestuous abuse.

Gelinas described how this clinical presentation often masked or covered an incest history that went unreported if not directly assessed by the clinician. The “disguised presentation” will be discussed in more detail below in the section devoted to assessment issues.

Russell added another dimension to the clinical description with her identification of the existential crises of incest survivors. Many suffer from extensive damage to identity and self-esteem and, as a result of the betrayal trauma, they experience a generalized mistrust of others whom they expect to use them to meet their own needs or abandon and not protect them. They further experience a profound loss of faith, personal meaning, and safety in the world.

Other researchers described some of the physical effects associated with an incest history. Physical consequences at the neurological and physiological level may result in psychobiological adaptation. An abbreviated list of some of the most common physical symptoms reported in incest survivors include actual physical damage, psychosomatic manifestations, gastrointestinal and genitourinary disorders, headaches and neurological problems, autoimmune disorders, muscular and skeletal pain, sexual and reproductive dysfunction and distress (including sexually transmitted diseases), and the dissociation of various physical sensations. Briere and factored down a set of core effects and issues associated with severe sexual abuse. These include other-directedness/hypervigilance, a chronic perception of danger and an associated need for control, self-hatred and associated feelings of stigmatization, “negative specialness” or a magical-thinking sense of power due to personal badness, conditional reality, including dissociative phenomena and impaired self-reference, and a heightened ability to avoid, deny, and repress abuse-related issues and emotions.
Herman, echoing a description that she originally gave a decade earlier, noted that "Survivors of childhood abuse develop... complex deformations of identity. A malignant sense of the self as contaminated, guilty and evil is widely observed. Fragmentation in the sense of self is also common, reaching its most dramatic extreme in multiple personality disorder." Many of these issues are incorporated in the criteria for the diagnosis of borderline personality disorder and a number of clinicians have speculated about and documented an impressive overlap between a history of childhood abuse and symptoms of borderline personality. Moreover, an overlap between borderline personality and posttraumatic stress disorder is increasingly acknowledged as is a relation to dissociative disorders.

Despite these indices of serious consequences, great variability has also been found in aftereffects and damage attributable to incest. Some victims suffer enormously from what objectively appears to be less serious abuse while others are seemingly less damaged by more serious forms. Russell, on the basis of her landmark study of incest and its consequences, cautioned professionals on a significant aspect of this matter. She documented a wide range of reactions but also found that subjects in her study tended to minimize the severity of both their incest experience and its impact and that approximately 40% experienced very severe consequences. Because of their propensity towards defensive minimization and patterns of masking and dissociation, when patients present with symptoms that match those described above, the clinician might well develop an index of suspicion regarding unreported or unacknowledged abuse in the individual's background. Careful ongoing but nonsuggestive assessment is warranted.

Researchers have also documented factors that can serve to moderate or mediate the effects of abuse. Those that might insulate or "inoculate" the child victim to some degree include his/her personality makeup and personal resilience; perpetrator acknowledgement versus denial; effective intervention when abuse is disclosed or observed with no further recurrence; firm reassurance to the victim that he/she is not to blame; any healthy relationship with, and attachment to, significant others at the time of the abuse or later; trauma-related beliefs; and other family factors or crises.
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In sum, the clinician should not assume that every patient with a reported history of incest or other sexual abuse always experiences major negative consequences. An individualized assessment of each case is necessary. That said, since this article is directed towards the effects of incest that are debilitating enough to require therapeutic intervention, we now move to a discussion of the diagnostic formulations that account for the range of the most serious abuse sequelae.

DIAGNOSTIC FORMULATIONS

Clinicians and researchers have come to understand that reactions resulting from chronic family violence and child abuse and other forms of repeated, prolonged trauma, such as hostage situations and concentration camp internment differ from more circumscribed and time-limited trauma such as rape, accidents, and natural disasters.67 A condition of entrapment, including ongoing contact with, dependency on, and subordination to a captor/perpetrator along with the constant anticipation of recurrence, characterizes the former, resulting in a situation of great emotional complexity. When abuse occurs in a family, a profound role and relationship betrayal is also involved. Paradoxically, the abuser is the source of both safety and danger to the victim who is thus dependent upon the very person who does harm. Spiegel66 has described such a relationship as a “macabre double bind” of love-hate, dependence-terror and dependence-betrayal, a sentiment recently echoed by Freyd in her theory of betrayal-trauma and memory.56

Further compounding the situation in the case of chronic childhood trauma is the fact that the victim is not yet physically or psychologically mature. Research is now identifying neurological and other physiological consequences of traumatic stress that form a physical substrate to psychological symptoms. A child’s physiology may thus be negatively affected by ongoing abuse in ways that compromise later physical and psychological development.57, 58 The child’s sense of self, psychosexual development, and object relations may be destabilized (and in some cases, totally derailed) by ongoing abuse. Wilson59 has described this process as psychobiological adaptation.

Victims of chronic trauma in childhood report an array of initial and long-lasting posttraumatic symptoms above and beyond those encompassed in the diagnosis of posttraumatic stress disorder (PTSD) as currently defined in the DSM-IV.60 The DSM description is based predominantly on symptoms associated with war trauma and discrete traumatic occurrences and on individuals traumatized in adulthood rather than in
childhood. Three broad areas of psychological disturbance that differentiate reactions to chronic trauma from reactions to more circumscribed forms of trauma have been identified:6,7 (1) various Axis I symptoms and dimensions of clinical functioning that are noteworthy for their complexity, diffuseness, and tenacity. These include a range of posttraumatic and dissociative symptoms; (2) characterological and developmental disturbances, those most associated with Axis II personality disorders, borderline personality in particular; (3) reenactments of aspects of the original trauma (including the victimizing of others) and vulnerability to repeated harm (revictimization), whether self-inflicted or perpetrated by others.

Herman6,7 and other clinician-researchers have, on the basis of these additional factors, proposed a new variant of PTSD: “Complex Posttraumatic Stress Disorder” or “Disorders of Extreme Stress, Not Otherwise Specified” (DES-NOS) to differentiate it from “simple” PTSD. Although this new diagnosis is not yet included in the DSM, data from several field trials and other studies have provided substantiation for the triad of distinguishing elements and for the defining criteria of the diagnosis that include alterations in affect regulation, consciousness, self-perception, perceptions of the perpetrator, relations with others, and systems of meanings.61-64 The Complex PTSD formulation is most helpful in providing a conceptual model of the complicated symptom picture presented by the chronically traumatized. It also has great utility in conceptualizing and planning the treatment process.

An additional conceptual model of severe chronic PTSD has recently been proposed to account for the seemingly intractable course of vacillating symptoms observed longitudinally in some combat veterans.65 The model presents a cycle of “stages” of functioning and decompensation, ranging from adaptive to totally dysfunctional, that can be described clinically and that may be distinct physiologically. Core PTSD symptoms and other dimensions of clinical functioning, such as affect regulation, defenses, ego states, interactions with the environment, capacity for self-destruction/suicide and capacity for attachment and insight, are described by stage in this model. The authors further propose that chronic forms of PTSD resulting from prolonged trauma, whether occurring in childhood or adulthood, are usefully conceptualized as dynamic and changing rather than static. A model that addresses cyclical stages of clinical status assists the clinician to expect variability in functioning over time (and in the process, hopefully to offset his/her frustration and exasperation with cyclical decompensations in clinical status) and to adjust and titrate therapeutic interventions accordingly. This model thus adds another dimen-
sion to the “Complex PTSD” formulation that can stimulate innovative perspectives on the treatment of the aftereffects of chronic abuse such as incest.

AN UPDATED MODEL FOR THE TREATMENT OF INCEST

The updated model for the treatment of incest retains much of its original integration of psychodynamic, traumatic stress, developmental and feminist formulations but now includes more emphasis on object relations/attachment and self-psychology perspectives. The model gives additional attention to dissociative phenomena and utilizes more cognitive-behavioral and self-management/skill-building interventions than previously. It has a recommended sequence of therapeutic tasks and issues that are addressed, paced, and titrated according to the phase of treatment and the needs and capacities of the patient. It is also responsive to the most salient issues raised in the recovered memory controversy and stresses work on a wide range of therapeutic issues, not just trauma or trauma memories. The model presented here reflects the standard of care that is evolving for the treatment of trauma-based disorders.

PRINCIPLES AND ETHICS GUIDING TREATMENT

Treatment for the long-term effects of incest differs from more generic therapy by virtue of its posttraumatic perspective and its associated emphasis on treating the abuse directly; nevertheless, the established principles and standards of practice guiding generic psychotherapy remain as the foundation of this treatment. The extant professional ethics also apply and are particularly salient in work with incest survivors. The complex symptom picture and associated characterological and interpersonal deficits and difficulties present significant challenges to the clinician. Often, these include direct and indirect invitations on the part of the patient and urges on the part of the clinician to practice “differently” by stretching or exceeding established boundaries due to the perceived specialness, neediness, complexity, or even coerciveness of the patient. As a consequence, the adherence to established ethical standards and principles takes on additional rather than lessened urgency with this population. Blurred boundaries and dual relationships have the unfortunate effect of replicating abuse dynamics and are, therefore, most damaging to this treatment population.

Therapists must begin by assessing their own professional and emotional competence to treat incestuous abuse. Because trauma (much less incest) and its treatment are topics that are rarely or adequately covered in professional training, therapists must avail themselves of specialized training, consultation, and supervision. They should also institute strategies for
self-care, including systems of personal and professional support and monitoring. It is now well recognized that work with human-induced trauma often causes strong countertransference reactions as well as vicarious traumatization of the helper, something that the therapist should understand and be able to tolerate and manage. Not all therapists can handle the challenges presented by the treatment of incest survivors. Some are not suited by temperament or choice, others by their own personal history of abuse or by other life stresses that make it hard for them to have the emotional resources necessary for the demands of the work. These therapists have an obligation to self-assess and to refer patients as needed. According to Briere, "It is...critically important that the clinician be sufficiently self-aware, psychologically healthy, and under sufficient self-control that he or she does not act out countertransferential issues on the client. Such issues obviously include inappropriate anger, sexual expression or behavior, and physical or psychological boundary violation" (p. 1).

Other especially pertinent issues are confidentiality, boundaries, and informed consent. Patients should be advised about the limits and boundaries inherent in a therapeutic relationship and further informed about the limits of confidentiality in cases of active danger to self or others or if ongoing abuse of minors is disclosed. They also should be informed regarding the course of treatment along with its possible risks, benefits and the potential side-effects of any specialized interventions (e.g., medications, hypnosis, Eye Movement Desensitization and Reprocessing). Only those interventions that meet the evolving standard of care for trauma treatment should be utilized, selected according to the needs and capacities of the patient.

Treatment of incest also involves issues related to the survivor's relationship with the alleged abuser and other family members. Therapists are advised to support patients in examining different courses of action (temporary or more permanent separation from family, family mediation, disclosure, confrontation, reporting, legal action) but to refrain from a predetermined direction, especially one that meets the therapist's rather than the patient's agenda. Therapists must be cognizant that each of these actions may have beneficial as well as detrimental consequences and that complicated ambivalent attachments are often at play. A more conservative but empowering course of action (except where ongoing abuse within the family becomes evident and must be reported or where clear and present danger exists and any contact with abusive family members is inadvisable) is to help the patient learn assertiveness and self-protection when in contact with family members. Issues of delayed and recovered memories further
complicate the matter. The reality of abuse might be in question and therefore require additional caution and conservatism as well as education about the reconstructive nature of human memory and the denial and projected blame characteristic of abusing families.

A Conceptualization of the Treatment Process

At present, a strong consensus is evident among trauma experts with regard to the treatment of complex dissociative posttraumatic conditions. In contrast to the earlier model that placed more emphasis on an abreactive or traumatic resolution approach, this model continues to attend to the trauma but does so with much more attention given to characterological/developmental, personal functioning, and environmental issues. These are defined broadly to encompass issues of self-development and identity stabilization, object relations and attachment style, and cognitive and emotional schema, and attention to other life circumstances, whether from the past or in the present.

Additionally, therapy is directed towards what Kepner has labeled “healing tasks” and Linehan termed cognitive modification and the development of behavioral skills. These include mood and symptom stabilization and self-management skills. Themes and issues related to incestuous trauma and its damaging dynamics and effects are thus treated throughout the process along with other issues. When the incest is worked on directly, it is only when the patient has achieved enough stability, skills, and ego strength and mastered enough healing tasks to be able to manage and tolerate the strong emotions likely to be generated without serious regression and only if such a strategy is needed for therapeutic resolution. The work, whenever possible, must be paced to not exceed the patient’s emotional tolerance and to not precipitate regression or decompensation. McCann & Pearlman labeled this sequenced, progressive strategy as “self work before memory/trauma work.”

In general, the treatment is longer rather than shorter term, although some time-limited interventions (often psychosocially or in focus) have been described, as have episodic, sequenced treatment approaches and packages. Long-term treatment is generally necessary, however, due to the pervasive effects of abuse, the compounding of effects over time, and the complexity, tenacity, and range of symptoms. The development of the therapeutic relationship takes time as does identity consolidation, personal stabilization, cognitive and emotional modification, and skill-building.

A treatment and ethical dilemma of major proportions is being created by the service limitations imposed by managed care; it is not too strong to
say that the longer-term and more intensive treatment requirements of many adult survivors and the limitations imposed by many insurance plans are on a collision course. As a consequence, both therapist and patient must monitor throughout the process and plan accordingly. It goes without saying that the patient is not assisted if treatment is predicated upon resources that are not available and if treatment is prematurely terminated while the patient is in the middle of the work. It is far better to plan episodic, brief and goal-directed treatment in such a circumstance. Clinicians may also need to take on the role of advocates in order to argue for appropriate treatment that meets ethical considerations.

THE SEQUENCE OF TREATMENT

The treatment of adult survivors of incestuous abuse is generally considered to proceed according to sequenced phases. Four phases are considered here: (1) pretreatment assessment; (2) a preliminary phase devoted to alliance-building, safety and stabilization; (3) a middle phase devoted to the de-conditioning and mourning of the incest trauma and its consequences; and (4) a late phase devoted to further integration of the posttraumatic material with self and relationship development. Although these phases are listed here in linear and rather lockstep fashion, they should instead be considered as fluid and dynamic and as a spiral rather than a straight line. Patients progress quite variably within and between the different phases according to their clinical condition, needs, capacities, and tolerances and often need to rework various tasks and skills many times over. Optimally, they achieve mastery of a skill or a task and use it to address a variety of different issues that arise over the course of treatment. Patients also regress to what are “tried and true” but often maladaptive thinking and coping skills during times of stress. Such a relapse is not necessarily a failure; rather, it should be treated as an expectable occurrence in the learning/healing process. It provides additional opportunity for the patient to review or relearn a concept or skill that leads to more sophisticated internalization and application.

Pretreatment Assessment

Following an explanation of the process and informed consent, a broad-based clinical and psychosocial assessment is in order. The clinical assessment includes attention to the individual’s reasons for seeking therapy, the severity and course of current symptoms and any past history of same, the individual’s ability to function and general level of functioning, the type and intensity of psychosocial stressors, any threats of harm to self or others, and a general mental status examination. It also includes a preliminary
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assessment of ego capacities and personality structure. Past treatment history, including previous symptoms and diagnoses, should also be explored. Questions about the patient's family, social, medical, developmental, and occupational history are part of the psychosocial assessment.

Questions about problematic childhood and family experiences and about all forms of violence and trauma (including family violence, sexual abuse, physical abuse, medical trauma, accidents, devastating personal and family losses, and natural disasters) should be included among other questions in the initial history taking. These provide a point of reference for future assessments; moreover, they indicate to the individual seeking treatment that these issues are relevant and open to discussion. All questions should be asked in as neutral and open-ended a way as possible and the therapist strives to neither suggest nor suppress reports of abuse/trauma in the individual's history. When incest (or other abuse) is disclosed either before or during the assessment or when it is not disclosed but is suspected, different clinical strategies are recommended. These are discussed next.

When Incest Is Disclosed

When incest is disclosed, the therapist should record the information factually and objectively as reported. This provides a baseline in the individual's own words and thus provides a counter to the idea of therapist suggestion. A description should be obtained in as much detail as is feasible without overly stressing the individual, including the nature and particulars of the incest occurrence; the identity of and relationship to the perpetrator; the individual's and other family members' role and any actions taken or not taken; the individual's subjective thoughts and feelings about the incest, its occurrence, and its effects; general information about the individual's coping style, ego strength and cognitive functioning at the time of the abuse; and whether there have been memory gaps or lack of memory accessibility.1,77,75

The assessment continues with questions to ascertain posttraumatic reactions, including intrusive reexperiencing, autonomic hyperarousal, numbing of responsiveness and affect (with attention to substance abuse and other addictive/compulsive behaviors), intense emotional states, learning difficulties, memory disturbances and dissociation, medical problems and psychosomatic reactions, interpersonal difficulties, and criminal-justice or legal difficulties. The assessment should also include questions about the individual's current level of safety in terms of self-harm and violence to and from others. It is not uncommon to discover further
victimization and trauma along with suicidality, self-injury, and extreme personal disregard and risk taking. Finally, another important area of inquiry concerns whether the individual has taken or is contemplating any legal action regarding the incest.

The therapist must ask questions in an objective but supportive manner, all the while maintaining an attunement to any toll the questioning is taking. Some individuals have the capacity to respond to such detailed questioning without too much discomfort but others experience intense reactions and need to answer the questions over time. Others show no outward reactions but report delayed or “rebound” responses either in the session or later; and others may dissociate all or part of the assessment and later deny or be confused about their responses to the questions. It is good policy to both forewarn the individual about the possibility and the normalcy of delayed reactions and to offer suggestions for management of any that are distressing.

When Incest Is Not Disclosed but Is Suspected

Incest might not be disclosed due to a variety of circumstances. In one scenario, the incest is known but is deliberately not divulged due to factors such as shame, guilt, self-blame, fear, mistrust, the protection of others, family loyalty, and previous negative experience with disclosure. In another, it is not divulged because it is not known to the individual, or even suspected, due to memory disruption of some sort. And, in a third scenario, it is also not explicitly known but is suspected by the individual. When abuse is suspected but not known, the individual’s expectations in seeking treatment must be assessed and may need to be reworked or even challenged. For example, some are realistic and on target (e.g., “I want help determining if there is any basis to my suspicions” or “I want to determine if something I’m not sure about is causing my symptoms”), others, unrealistic and even potentially dangerous to the individual or the therapist (e.g., “I want you to tell me that I was abused so that I can sue my parents”).

As a general matter, the therapist should not make assumptions regarding the meaning of a lack of disclosure—at its most simple, it means that the individual does not have an abuse/trauma history to report; however, when the individual’s symptom picture is acute and/or has a strong resemblance to the comorbid complex dissociative PTSD formulation presented earlier in this paper or when the therapist observes certain behavioral and response patterns commonly associated with trauma (such as dissociation or microamnesias in the session or a high degree of personal risk-taking,
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chronic self-harm, or a history of revictimization), the possibility of undisclosed or unrecognized abuse or other trauma, or the "disguised presentation" as described by Gelinas should be given consideration. In such a case, the therapist might develop an "index of suspicion" but must also tolerate the patient's not knowing or not disclosing and should not push for closure. In some highly traumatized individuals, the story will only emerge in a disguised and fragmented manner that requires patience and diligence on the part of the therapist.

In situations resembling the third scenario, the therapist must be especially cautious. It is prudent to inquire about how the individual came to suspect incest in the absence of specific memory, to assess possible personal and interpersonal motivations, and any sources of suggestion and misinformation (e.g., social influences, media reports, books, previous suggestive therapeutic activities, etc.). In some cases, it is necessary for the therapist to explain to the individual that his/her memory has been possibly influenced and to urge an open-ended exploratory stance over time. The therapist must also be prepared to correct misinformation about abuse and memory processes and to clarify appropriate goals of treatment (and should explicitly note both the misinformation and the correction in the patient's record). Additional evaluation of other risk factors associated with possible false memory production, such as personal motivation, hypnotizability, interrogatory suggestibility, paranoia, and psychosis, is called for in some cases. It is necessary to underscore, however, that psychotic and posttraumatic symptoms can co-occur and/or that psychotic symptoms might, in reality, be posttraumatic symptoms or adaptations (i.e., flashbacks) of real abuse.

When specific memory is absent, it is crucially important that the therapist not "fill-in" or "confirm" suspicions of a nonremembered abuse history—the individual needs to come to a personal understanding and may need to tolerate considerable uncertainty, especially when corroboration is lacking. The clinician must avoid leading questions and a premature focus on incest/sexual abuse as the only possible explanation of an individual's distress. Alternatively, exploration should not be curtailed with the effect that incest or other trauma is dismissed prematurely. Many survivors "know more than they know they know" but may never have been in an interpersonal context that supported knowing on a consistent basis. Therapy can provide such a context but the establishment of adequate trust and support, of necessity, takes time.
**Diagnosis and Treatment Approach**

It is advisable that the therapist complete all five axes listed in the *Diagnostic and Statistical Manual* when making a diagnosis to account for psychological, characterological, and medical concerns as well as the number and severity of past and current stressors and the individual's level of functioning. As discussed above, survivors of severe abuse tend to have comorbid conditions, making the diagnostic process complicated. The therapist may list diagnoses according to severity and/or priority of treatment. Adjunctive consultation (e.g., medical, psychiatric, neurological) might be considered and a second opinion sought regarding diagnosis and treatment at this juncture or later. Pertinent records of any prior treatment should also be requested and reviewed.

The assignment of a PTSD diagnosis is problematic in the absence of clear memory of the traumatic circumstance, even if the individual exhibits posttraumatic symptomatology. Criterion A, the experiencing or witnessing of a traumatic stressor, is not always a certainty when recollection is lacking. Although this situation is of the “chicken and egg” variety in individuals who do not recall the trauma as part of their posttraumatic response, the therapist can err on the side of caution by not assigning the diagnosis until all criteria are met (or only assigning it provisionally). In a similar vein, the diagnosis of a dissociative disorder must be approached with discretion. Therapists should consider the range of dissociative disorders, not only dissociative identity disorder (DID) and, in particular, should insure that all diagnostic criteria are met before diagnosing DID. A number of questionnaires and screening instruments specific to trauma symptoms and dissociation are now available to supplement more standard psychological assessment batteries and to assist in diagnosis and treatment planning.76-79

A decision regarding treatment approach follows from the assessment and diagnosis. In situations where abuse is suspected but not explicitly remembered and where posttraumatic reactions and symptoms are not in evidence, the treatment should follow a generic rather than posttraumatic model. This strategy can be reversed in the event that memory of abuse or other trauma returns and/or the individual exhibits delayed-onset symptoms of PTSD. We now continue in our discussion of the posttraumatically based incest treatment model.

**Early Phase: Alliance-Building, Safety, and Stabilization**

The establishment of the parameters of treatment, the development of the therapeutic relationship and working alliance, and the maintenance of safety and relative life stability are critical tasks of this phase. In many ways,
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this work resembles that of generic, nontrauma therapy; however, the patient's posttraumatic reactions compound it. For example, the development of the therapeutic alliance, a more or less straightforward process with a nontraumatized patient, is often a daunting challenge with an interpersonally victimized one. The therapist may be perceived as a stand-in for other untrustworthy and abusive authority figures to be feared, challenged, tested, distanced from, raged against, sexualized, etc. or may be perceived as a stand-in for the longed-for good parent or rescuer to be clung to, deferred to, and nurtured by.

The beginning of this phase includes educating the patient about the parameters of psychotherapy and the therapeutic relationship, explaining the assessment and diagnostic findings as related to the philosophy and course of treatment, and establishing a treatment contract and preliminary goals. All contribute to informed consent. A collaborative working relationship that is empowering to the patient is the orientation of choice, however, the therapy process is not laissez-faire and the therapist is clearly the one responsible for its general structure, organization, and pace. Patients have corollary responsibilities to work within the treatment frame and to actively work on the mutually determined goals.

Although these issues are discussed and agreed upon at the outset of treatment, a degree of noncompliance with the plan should be anticipated. Traumatized individuals can be difficult to engage in treatment due to their profound mistrust of others, their characterological issues, and what is often a heightened ability (whether conscious or unconscious) to avoid and otherwise defend against painful material. This problem requires that the therapist engage in a juggling act of adhering to the parameters of the treatment contract while maintaining flexibility and sensitivity. The patient's motivation and capacity to do the work must be constantly assessed. Treatment tasks and pacing can then be titrated accordingly.

The development of a therapeutic relationship is a task and process of crucial importance that occurs over the entire course of treatment. The relationship provides an interpersonal context and foundation for the various treatment tasks and also provides "grist for the mill" about the patient's object relations. As previously discussed, object relations and interpersonal attachments are often seriously compromised by the relational insults of incest. Resulting issues concerning self in relationship to others will be projected onto the therapist providing a form of coded communication about the past. Therapists must expect these projections and strive to analyze and interpret their antecedents and meaning rather
than re-enacting them with the patient. The relational challenges inherent in working with interpersonally victimized individuals are increasingly recognized and a literature addressing these issues is rapidly developing.21,66,81–84 Some of the most common transference and countertransference issues and treatment traps in treating incestuously abused individuals are discussed below in more detail.

The specific tasks and goals of the early phase of treatment are determined according to the patient's unique character structure, defensive patterns, concerns, symptoms, and personal resources, including motivation.5,29,85 On average, patients who meet the criteria of Complex PTSD and who exhibit a borderline ego structure and/or who have a corollary dissociative disorder (i.e., those who lack a stable identity, observing ego, object constancy, relational stability, and the ability to identify, tolerate, and regulate their affective states) need more intensive stabilization and character-building work than patients with more developed ego capacities and ability to relate to others. This contribution is directed towards the less developed patient and should be modified according to the patient's ego structure and character resources.

Early-phase work is generally measured in terms of the mastery of skills and the development of ego resources and personal stability, not time. In fact, it is usually the most lengthy of the three phases encompassing many therapeutic issues, some of which emerge only after the resolution of others.8 Much of this work is focused on self-development (affect recognition, tolerance, and management, identity formation and stabilization, self-esteem and mood regulation, object constancy). The treatment is also continuously focused on issues of personal safety along with symptom stabilization and self-management achieved through cognitive restructuring and skill development.

At this stage, any work with the traumatic or abuse material is cognitive and educational in format, directed towards actively teaching the patient about the process and aftermath of traumatization and about cognitive and emotional schema molded by the abuse in order to normalize this material. The patient is actively cautioned against premature, unplanned work with traumatic material without adequate emotional and coping resources in place. This orientation and structure work against an ambiguous and unfocused treatment format that runs the risk of creating conditions of regression and overdependence on therapy, on the one hand, or flooding/retraumatization and decompensation, on the other. It also works against those conditions that are suggestive or conducive to memory elaboration (as described later in this paper).
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Early in this phase of treatment, it is useful to assess the patient's capacity for self-care and his or her quality of life and to begin the implementation of stress-management and self-regulation strategies as needed. Some of these patients present in a condition of posttraumatic decline due to their chronic PTSD and associated depression and anxiety. They exhibit an array of behavioral and health problems, such as eating and sleeping poorly, patterns of physical and medical neglect, and difficulty functioning and relating to others. All of these issues provide a focus of early therapeutic intervention that might have a cascading impact on others (e.g., adequate sleep might improve personal functioning and lessen interpersonal irritability). Yet, the therapist must understand that even seemingly small and simple self-care issues may have major traumatic associations and may not resolve easily (e.g., poor sleep may be the result of the terror of being abused at night that, in turn, resulted in a long-standing pattern of nocturnal hypervigilance).

Other destabilizing behaviors and symptoms should be given treatment priority. Patients can be taught relaxation and de-escalation skills to manage physical hyperarousal and intrusive symptoms and taught grounding and re-focusing skills to control dissociation. Specific cognitive-behavioral interventions have been recommended as a preliminary strategy in treating mood disturbances. Should such techniques prove inadequate, psychotropic medications can be prescribed to lessen or control debilitating symptoms of depression, anxiety, and other active mental conditions. Specific types of medications are now recommended for PTSD symptoms; however, the therapist must prepare the patient adequately for their use and must simultaneously guard against overmedication, a not uncommon occurrence because of the intensity and complexity of the symptom picture. The ultimate goal of all of these interventions is to stabilize the patient's mood and symptoms sufficiently to relieve distress and improve functioning.

The lives of many of these patients are crisis ridden and chaotic. Of necessity, any ongoing crisis and life-threatening circumstance (including but not limited to suicide attempts, self-mutilation, other forms of major risk-taking and self-harm, revictimizations in the form of violence to and from others, addictions and compulsions, and debilitating degrees of dissociation and reenactment/reenexperiencing) must be addressed early on. Because these behaviors and symptoms may well have developed as ways to cope with the painful effects of the original trauma, lessening or dismantling their use causes the patient to feel what has been avoided. In many cases, this has resulted in relapse to the same or new means of coping and
escape. It is, therefore, important to teach the patient alternative means of
self-management and coping to replace dangerous and addictive behaviors
and practices. Relapse planning is also in order.

Also in this phase, the patient must be encouraged to develop relation-
ship skills and to build a system of support apart from the therapist. Much
therapeutic time must be spent identifying and unlearning the “relational
rules of abuse and victimization” and replacing them with skills and
attitudes necessary for healthy, interdependent connections with support-
ive others. Relational work proceeds slowly and may have many false starts
and stops. Optimally, the therapeutic relationship serves as a model of a
healthy affiliation and provides a safe arena for learning and practicing
skills with others. Group therapy may be an especially useful setting in
which to address these issues; yet, abuse survivors may not be able to
productively participate in a group until much preliminary relational work
has been accomplished. If group involvement is considered at this point in
treatment, a structured psycheducational type organized around specific
themes or issues is far preferable to an unstructured process-oriented
therapy group.1

Clearly, the scope, intensity, and duration of this first phase of the
treatment process varies considerably. Patients with sufficient ego re-
sources and adequate relationship skills may, following the development of
the therapeutic alliance, move through this phase and onto trauma-
resolution work in short order. More compromised patients may require
literally years of stabilization, skill-building, and alliance-building and may
never go any further in the process. Some patients choose to stop treatment
once they have mastered the tasks of this phase. Others discontinue
because they lack the personal, motivational, family, or financial resources
to continue. In all of these cases, the patient who is successful in mastering
the major tasks of this phase leaves therapy with more personal and
interpersonal resources and life stability than when treatment began.

The Middle Phase: De-Conditioning, Mourning and Resolution
of the Incest Trauma

Van der Kolk, McFarlane, & van der Hart2) are most eloquent in
discussing the critical purpose of this phase of treatment:

When patients have gained stability, control, and perspective, treatment can be
terminated. There is no intrinsic value in dredging up past trauma if a patient’s
current life provides gratification... However, if...involuntary emotional,
perceptual, or behavioral intrusions continue to interfere with people’s current
functioning, controlled and predictable exposure to the traumatic memories
can help with regaining mastery... A therapist’s natural proclivity is to help a
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patient avoid experiencing undue pain; however, learning to tolerate the memories of intense emotional experiences is a critical part of recovery. The psychotherapist who understands the nature of trauma can aid the process of integration by staying with the patient through his or her suffering; by providing a perspective that the suffering is meaningful; and by helping in the mastery of trauma through putting the experience into symbolic, communicable form (i.e., through putting perceptions and sensations into words) (p. 428).

The primary goal of the trauma-resolution phase is for the patient to gradually face and make sense of the incest and to experience associated emotions at a pace that is safe and manageable. The work of this phase is not devoted to high-intensity abreactive re-experiencing or “reliving” that retraumatizes and results in decompensation nor does it involve digging for memories. Patients are not encouraged to do this work to foster regressive dependency or to get stuck in a morass of more and more serious trauma, and certainly not to create traumatic memories; rather, the purpose is to allow a gradual emergence and deconditioning of the traumatic material and a restructuring of trauma-related cognitions and schema about self and others in the interest of resolution. The therapist should discuss his/her approach to working with traumatic memories and make explicit that the patient must come to a personal understanding and acceptance about the past and that considerable uncertainty may remain. Free recall and free narrative are strategies of choice. Patients must struggle with ambivalence and what they “know” and “don’t know”—the struggle is theirs and not the therapist’s who is there to offer support and perspective but has no way of knowing what did or did not happen.

Patients and their supportive others should be informed ahead of time about the challenges of this phase. It is likely to be the most painful part of the therapy during which the survivor may appear to be getting worse instead of better. It often helps for patients to understand that facing previously warded-off realities and feeling previously intolerable feelings makes them feel worse in the short run but is in the interest of resolution and ultimately feeling better in the longer term. The therapist must also be personally as well as professionally prepared for the additional demands of this phase. Patients may require much more availability, reassurance, and support as they struggle with the traumatic material and its meaning.

Horowitz suggested that the resolution process involves an approach-avoid strategy that initially mimics the phasic alterations of the posttraumatic response. Over time, the patient is encouraged to increase the approach phase and to tolerate the traumatic material in manageable doses.
while simultaneously lessening avoidance and numbing. In following this strategy, the therapist offsets approach strategies with temporizing ones, modulated according to the patient’s response. Briere and Cornell and Olio have discussed similar titration strategies. Briere discusses the concept of a “therapeutic window” of emotional tolerance within which optimal therapeutic work is done. Undershooting the window keeps the patient from adequately addressing and processing the trauma (and thus maintains avoidance) while overshooting it results in overwhelming the patient’s capacity (and results in re-experiencing and flooding). In a similar vein, Cornell and Olio discuss an “affective edge” where patients are actively encouraged to maintain both cognitive understanding and emotional and bodily awareness without triggering denial and dissociation in the interest of achieving personal integration.

It is the back-and-forth nature of such a free-recall strategy in the context of a therapeutic relationship that produces the gradual reconstruction of the survivor’s story. Patients must be supported as they struggle with their ambivalence and doubt their perceptions and memories. Feelings of shock, rage, anguish, and grief are expressed as the incest story, its betrayals, and lack of protection are faced. An existential crisis of major proportions results as survivors try to understand how and why the incest happened to them. Core issues such as shame and a sense of having deserved the abuse along with irrational guilt and self-blame and “secondary secrets” such as sexual response during the abuse, an enjoyment of a sense of power in the family, or the victimization of others must be addressed. Survivors are often in need of spiritual solace during the difficult work of this phase and may seek out spiritual direction or pastoral care.

Nonverbal as well as verbal strategies can be used most productively at this time. Expressive strategies, such as writing and artistic productions, and physical strategies, such as movement and body work, may provide means to symbolize and communicate what the patient has difficulty to do verbally. Emotional ventilation achieved verbally and nonverbally gives way to assimilation and new meaning over the course of processing the trauma. Once the survivor has faced the incest and experienced the resultant emotions with less denial or dissociation, assimilation occurs as he or she expands personal understanding of what happened in childhood and why and attaches new meaning to the experience and its personal implications. At its most basic, a resolution of issues of self-blame and associated self-hatred is achieved as the patient develops a deeper understanding of
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the incest scenario, including the abuser's motivations and contributory family dynamics and characteristics.

Group therapy specific to sexual abuse trauma is especially useful in this treatment phase. Group participation relieves feelings of emotional isolation and stigmatization by providing a context of support from individuals with similar experiences and reactions. It serves as an interpersonal catalyst and container for the exploration of the incest memories, beliefs, cognitions and emotions and offers a unique forum for grieving. Furthermore, it provides a safe context for the exploring and changing abuse-related interpersonal dynamics. Group members assist and support each other as they struggle with issues of connection, respect, trust, conflict, and intimacy.

Trauma resolution is furthered by addressing any related issues and weighing the need for any specific courses of action. At this point, patients might struggle with such diverse issues as seeking corroboration or outside evidence, disclosing and being open about the incest with selected friends and associates, breaking silence and maintaining assertiveness in the family especially in the face of ongoing responses of denial and scapegoating, attempting mediation and reconciliation with family members, deciding whether or not to forgive family members, developing self-protection strategies when faced with ongoing mistreatment, reporting past or current abuse, and initiating criminal or civil proceedings. Whenever possible, all of these courses of action are best decided after the major trauma work is completed and the patient is in a stable enough emotional state to be able to deal with any repercussions without decompensating.

The Late Phase: Self and Relational Development

The gains achieved over the course of treatment, including development of a self less encumbered by traumatic intrusions and effects and continued development of interpersonal connections, are consolidated in this phase. Attention continues to be directed to personality issues, self and emotional development, mood stability, personal safety, self-care, and personal boundary management; however, a major focus is the reestablishment of secure social connections and an accumulation of restitutive emotional experience with the therapist and trustworthy others.

Not uncommonly, this phase involves additional losses along with substantive gains. Previous relationships (including intimate partnerships, parenting, other family relationships, friendships, and social and work relationships) may need rebalancing to accommodate the patient’s newfound personal and interpersonal maturation and assertiveness. Some
relationships will adaptively grow and change while others will falter and end.

Issues, such as sexual difficulties and dysfunctions and addictions and compulsions, may only become amenable to therapeutic influence during this phase following the resolution of core traumatic issues. Although many standard therapeutic strategies can be used with all of these concerns, they might need modification to account for their traumatic etiology. For example, specialized sex therapy, addictions, and eating disorder models and techniques have been developed for abuse survivors with these concerns.89–92

Finally, survivors may begin to develop aspects of their lives that were attenuated by the trauma and its aftermath, such as educational and occupational endeavors, recreational activities and hobbies, and physical activities and pursuits. Trauma resolution can open many previously foreclosed avenues and the growth and development achieved in this phase of treatment are most gratifying to both therapist and patient.

The final task of treatment is its ending, a most poignant, exhilarating, and difficult endeavor. The therapy relationship is especially significant and restorative for individuals resolving the betrayals inherent in incestuous abuse; therefore, its loss will be profound. Ending the relationship will most likely stir up feelings of abandonment, grief, and fear; thus, sufficient time must be allotted for emotional ventilation and assimilation. Although the aim is for a clearly demarcated termination, a return for additional work in the future should not necessarily be precluded. Because of this possibility, the therapist should scrupulously guard against blurred boundaries or the development of a dual relationship with the survivor after the formal treatment has ended. The patient might need to return for an occasional “tune-up” or “check-in” for more minor concerns. More extensive work might be called for if the survivor experiences a major resurgence of symptoms or period of decompensation. These often result from unanticipated triggers or a crisis of some sort and may involve developmental precipitants. Abuse survivors, more than any other therapeutic population must be assured that the therapeutic relationship is unencumbered by conflicted role relationships, so that a return to the “safe place” is assured if needed.

**Transference and Countertransference Issues**

The treatment of complex dissociative posttraumatic reactions poses a number of challenges, many of which get played out in the therapeutic process and relationship. The survivor is not only likely to reenact relational
issues in the transference but to cause the therapist to experience them in
the countertransference, a process colored by characterological, dissocia-
tive, and posttraumatic reactions and distortions. For example, the ther-
apist is likely to be transferredentially mistrusted as an authority figure, a
common posttraumatic and characterological response. This reaction may
be compounded by dissociative distortions that further cause the patient to
misperceive and fear the therapist as the actual abuser. Needless to say, such
responses can be enormously disconcerting to the therapist (as well as to
the patient) and most difficult to manage.

A literature on the significance of transference and countertransference
reactions in the treatment of posttraumatic conditions, in general, and
incest/child sexual abuse, in particular, has emerged in recent years.
In aggregate, these writings describe the challenges of working with the
interpersonally victimized who, by virtue of their mistreatment by others,
have learned mistrust and maladaptive relational patterns that they bring to
therapy. The survivor patient can be expected to project upon, and reenact
with, the therapist salient relational messages derived from the abuse and
the family atmosphere. Many of these are similar to those identified with
personality disturbances, notably borderline personality. Thus, among
other things, the patient might be superficially compliant and nonassertive,
childlike, passive-aggressive, mistrustful, disillusioned, overdependent and
idealizing, sexualized, rageful, demanding and entitled, shamed, highly
defended, confused, anxious, guilty, fearful, and dissociative. These reac-
tions and reenactments are variable in how they are manifested, from
somewhat modulated to highly intense, and they might also shift dramati-
cally. In fact, Davies and Frawley used the term “kaleidoscopic” to
describe their rapidly shifting presentation and its unsettling effect upon
the therapist.

Traumatized patients play out the “victimization triangle” of victim-
victimizer-rescuer roles that get projected against, and played out with, the
therapist. In general, the therapist must decline the roles of rescuer or
victimizer/passive bystander while also refusing to be victimized by the
survivor and fostering a stance of inquisitiveness about these relational
patterns. Major therapeutic gains are made when the patient has insight
about these roles and is able to function outside of them and hence with
greater degrees of freedom in interpersonal relationships. The therapist
who treats incest survivors is well advised to learn about the most common
role enactments and transference and countertransference issues as well as
strategies for their management. Failure to attend to these can result in
therapeutic blunders, misalliances, and misadventures of major propor-

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tions, as have been documented in the treatment literature. Many of these issues, if caught early and managed sensitively, cause minimal harm and, instead, may offer important learning opportunities while enhancing the therapeutic relationship. On the other hand, the reenactment of abuse dynamics may recapitulate elements of the abuse and its aftermath, causing further damage. The therapist must remain vigilant to the treatment traps and dilemmas with this population and the potential for both very positive and very negative outcomes depending upon their management.

A transference reaction quite common in this population is now labeled “traumatic transference.” It refers to the survivor patient’s projection that the therapist is just like the abuser and, at some point sooner or later, he or she will be gratified by using and abusing the patient in some way. Traumatic transferences are upsetting. They are often accusatory and challenging of the therapist’s very willingness or ability to be beneficent. They may be especially upsetting for the novice and/or the therapist who uses treatment to maintain or bolster feelings of self-esteem or self-worth. In any event, the therapist must have enough observing ego and ego strength to depersonalize these projections and to work with them therapeutically. Repeated interpretation and analysis, along with the challenging of cognitive distortions and the teaching and modeling of new relational skills, are necessary.

Common countertransference issues in response to incest and its aftermath can be organized under the three categories of attraction, avoidance, and attack. The therapist has such responses due to his or her own issues (subjective countertransference) or due to the patient’s transference and other issues (objective countertransference) or both. Pearlman and Saakvitne have extended the definition of countertransference to include the therapist’s feelings about his/her reactions as well as the reactions.

Overidentification, overprotection, and fascination are common to the “attraction” types of countertransference, and are prone to emerge early in treatment and/or with the more inexperienced therapist. Responses of this type tend to occur due to the extreme neediness and instability of the patient and the therapist’s exposure to the patient’s abuse history and psychological pain. In response, the therapist may try to re-parent or indulge the patient to “make up for the incest.” This rescuing or overprotective response results in the therapist giving or doing far too much and encouraging a position of entitlement, overdependence, and helplessness (i.e., the victim role). The loss of appropriate limits can often ensue, along with the development of dual roles and gross boundary violations, including the sexualization of the relationship. At some point in time, the
therapist in this position may come to resent the demands and react with anger. The situation becomes further compounded if the therapist is unable to acknowledge anger directly and instead does so indirectly.

Manifestations of unacknowledged anger vary markedly. Although frank expressions of hostility are not the norm, the therapist may nevertheless express anger through neglect, apathy, or distancing. Or, the therapist may engage in reaction formation and work all the harder to rescue or protect the patient, thereby not allowing or encouraging psychological growth and personal responsibility. Finally, the unacknowledged anger might be projected onto the patient with the therapist feeling entrapped and victimized by the patient’s demands and needs. 16

In the “avoidance” countertransference, the therapist might disbelieve, deny, dismiss, or discourage disclosure of any material that appears to be abuse-related. This position is rather codified in some theoretical orientations that view reports or suspicions of abuse as constituting fantasy or wish rather than possibly as reality. The therapist working with these issues must modify this theoretical stance lest it interfere with the ability to encourage disclosure and exploration.

Avoidance is also implicated when the therapist dreads hearing about incest due to personal horror or other inability to tolerate the material. Such a stance often leads to defensive maneuvering on the part of the therapist who may minimize its importance, change the subject, urge the patient to “put it behind him or her,” transfer the patient to another therapist, and so forth. Some therapists are so personally overwhelmed by the material and the rigors of the treatment that they experience numbing responses not dissimilar to those used by the patients (e.g., denial, dissociation, intellectualization, minimization, detachment, etc.) or they maintain an overly rigid professional stance that causes them to be basically unavailable and unempathetic.

In the third main category of countertransference, “attraction,” the therapist is attracted to, and even aroused by, the abuse description. Incest has historically been taboo. The transgression of such a taboo and the very sexual nature of the abuse and any sexualization of relational patterns may result in a fascination with the sexual dimensions of the patient to the exclusion of other material. The patient is seen as special and exciting due to having been involved in incest or, conversely, is seen as profoundly damaged or “spoiled” by the early sexual involvement. Obviously, obsessive sexual interest and privileged voyeurism repeat the sexual objectification of the survivor patient and are, therefore, retraumatizing rather than healing. The most blatant and damaging countertransference response in this
category occurs when the therapist becomes sexually involved with the patient to "provide a corrective emotional experience" or due to the therapist's own pathology or sadism. Such a response constitutes professional incest, a direct reenactment of the earlier betrayal by someone who is in a position of providing assistance and protection. Unfortunately, research on sexual abuse in the context of psychotherapy has documented that abuse survivors (incest survivors in particular) are the most at risk population for therapist exploitation.  

In sum, many complex treatment traps along with transference, countertransference, and vicarious traumatization issues challenge the therapist working with adult survivors of incest. The very nature of the issues to be treated requires active involvement and attentiveness on the part of the therapist who must maintain the ability to empathize yet not be overwhelmed by the patient's pain, psychological condition, and concomitant life circumstance. An understanding of the relational demands made by individuals whose characterological development has been compromised by abuse and neglect assists the therapist to anticipate, prepare for, and work with them with less anxiety when they arise. Additionally, the critical role of consultation, whether achieved through formal supervision, individual and group collegial support, and ongoing training and education, cannot be overemphasized. Therapists need their own supports to do this work and to maintain perspective. Consultation activities provide support and information, allow the airing and discussion of countertransference responses, and assist the therapist in maintaining perspective in the face of the many difficulties of this treatment.

SUMMARY

This article provides an update of the original incest treatment model first published as Healing the Incest Wound: Adult Survivors in Therapy (Courtois, 1988). The revised model builds upon and expands the diagnostic formulations presented in the original and continues with an integrated psychodynamic, traumatic stress, developmental, and feminist treatment approach; however, it accords more emphasis to object relations and self psychology perspectives, utilizes more cognitive-behavioral interventions, and includes more recognition and treatment of dissociative reactions. It has a more articulated sequence starting with a global psychosocial assessment, encourages more strategic focus and titration directed towards the building and maintenance of functioning, and is responsive to issues raised in the recovered/false memory controversy. Finally, the revised healing model accords increased attention to the relational issues and challenges
inherent in working with severely interpersonally victimized individuals and offers strategies for their successful management and resolution.

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