Understanding and treating survivors of incest - Counseling Today

Adults with histories of being abused as children present unique challenges for counselors. For instance, these clients often struggle with establishing and maintaining a therapeutic alliance. They may rapidly shift their notion of the counselor from very favorable to very unfavorable in line with concomitant shifts in their emotional states. Furthermore, they may anxiously expect the counselor to abandon them and thus increase pressure on the counselor to prove otherwise. Ironically, attempts at reassurance by the counselor may actually serve to validate these clients' fears of abandonment.

The motivating factor for many of these clients is mistrust of people in general — and often for good reason. This article explores the psychological and interpersonal aspect of child sexual abuse by a parent and its treatment, with a particular focus on its relationship to betrayal trauma, dissociation and complex trauma.

Incest and its effects

Child abuse of any kind by a parent is a particularly negative experience that often affects survivors to varying degrees throughout their lives. However, child sexual abuse committed by a parent or other relative — that is, incest — is associated with particularly severe psychological symptoms and physical injuries for many survivors. For example, survivors of father-daughter incest are more likely to report feeling

depressed, damaged and psychologically injured than are survivors of other types of child abuse. They are also more likely to report being estranged from one or both parents and having been shamed by others when they tried to share their experience. Additional symptoms include low self-esteem, self-loathing, somatization, low self-efficacy, pervasive interpersonal difficulties and feelings of contamination, worthlessness, shame and helplessness.

One particularly damaging result of incest is trauma bonding, in which survivors incorporate the aberrant views of their abusers about the incestuous relationship. As a result, victims frequently associate the abuse with a distorted form of caring and affection that later negatively influences their choice of romantic relationships. This can often lead to entering a series of abusive relationships.

According to Christine Courtois (*Healing the Incest Wound: Adult Survivors in Therapy*) and Richard Kluft ("Ramifications of incest" in *Psychiatric Times*), greater symptom severity for incest survivors is associated with:

- Longer duration of abuse
- Frequent abuse episodes
- Penetration
- High degree of force, coercion and intimidation
- Transgenerational incest
- A male perpetrator
- Closeness of the relationship
- Passive or willing participation
- Having an erotic response
- Self-blame and shame

- Observed or reported incest that continues
- Parental blame and negative judgment
- Failed institutional responses: shaming, blaming, ineffectual effort
- Early childhood onset

Incest that begins at a young age and continues for protracted periods — the average length of incest abuse is four years — often results in avoidance-based coping skills (for example, avoidance of relationships and various dissociative phenomena). These trauma-forged coping skills form the foundation for present and future interpersonal interactions and often become first-line responses to all or most levels of distress-producing circumstances.

More than any other type of child abuse, incest is associated with secrecy, betrayal, powerlessness, guilt, conflicted loyalty, fear of reprisal and self-blame/shame. It is of little surprise then that only 30 percent of incest cases are reported by survivors. The most reliable research suggests that 1 in 20 families with a female child have histories of father-daughter child sexual abuse, whereas 1 in 7 blended families with a female child have experienced stepfather-stepdaughter child sexual abuse (see the revised edition of *The Secret Trauma: Incest in the Lives of Girls and Women* by Diana E. H. Russell, published in 1999).

In 1986, David Finkelhor, known for his work on child sexual abuse, indicated that among males who reported being sexually abused as children, 3 percent reported mother-son incest. However, most incest-related research has focused on father-daughter or stepfather-stepdaughter incest, which is the focus of this article.

Subsequent studies of incest survivors indicated that being eroticized early in life disrupted these individuals' adult sexuality. In comparison

with nonincest controls, survivors experienced sexual intercourse earlier, had more sex partners, were more likely to have casual sex with those outside of their primary relationships and were more likely to engage in sex for money. Thus, survivors of incest are at an increased risk for revictimization, often without a conscious realization that they are being abused. This issue often creates confusion for survivors because the line between involuntary and voluntary participation in sexual behavior is blurred.

An article by Sandra Stroebel and colleagues, published in 2013 in *Sexual Abuse: A Journal of Research and Treatment*, indicates that risk factors for father-daughter incest include the following:

- Exposure to parent verbal or physical violence
- Families that accept father-daughter nudity
- Families in which the mother never kisses or hugs her daughter (overt maternal affection was identified as a protective factor against father-daughter incest)
- Families with an adult male other than the biological father in the home (i.e., a stepfather or substitute father figure)

Finally, some qualitative research notes that in limited cases, mothers with histories of being sexually abused as a child wittingly or unwittingly contribute to the causal chain of events leading to father-daughter incest. Furthermore, in cases in which a mother chooses the abuser over her daughter, the abandonment by the mother may have a greater negative impact on her daughter than did the abuse itself. This rejection not only reinforces the victim's sense of worthlessness and shame but also suggests to her that she somehow "deserved" the abuse. As a result, revictimization often becomes the rule rather than the exception, a self-

fulfilling prophecy that validates the victim's sense of core unworthiness.

Beyond the physical and psychological harm caused by father-daughter incest, Courtois notes that the resulting family dynamics are characterized by:

- Parent conflict
- Contradicting messages
- Triangulation (for example, parents aligned against the child or perpetrator parent-child alignment against the other parent)
- Improper parent-child alliances within an atmosphere of denial and secrecy

Furthermore, victims are lesslikely to receive support and protection due to family denial and loyalty than if the abuser were outside the family or a stranger. Together, these circumstances often create for survivors a distorted sense of self and distorted relationships with self and others. If the incest begins at an early age, survivors often develop an inherent sense of mistrust and danger that pervades and mediates their perceptions of relationships and the world as a whole.

Betrayal trauma theory

Betrayal trauma theory is often associated with incest. Psychologist Jennifer Freyd introduced the concept to explain the effects of trauma perpetrated by someone on whom a child depends. Freyd holds that betrayal trauma is more psychologically harmful than trauma committed or caused by a noncaregiver. "Betrayal trauma theory posits that under certain conditions, betrayals necessitate a 'betrayal blindness' in which the betrayed person does not have conscious awareness or memory of the betrayal," Freyd wrote in her book *Betrayal Trauma: The*

Logic of Forgetting Childhood Abuse.

Betrayal trauma theory is based on attachment theory and is consistent with the view that it is adaptive to block from awareness most or all information about abuse (particularly incest) committed by a caregiver. Otherwise, total awareness of the abuse would acknowledge betrayal information that could endanger the attachment relationship.This "betrayal blindness" can be viewed as an evolutionary and nonpathological adaptive reaction to a threat to the attachment relationship with the abuser that thus explains the underlying dissociative amnesia in survivors of incest. Under these circumstances, survivors often are unaware that they are being abused, or they will justify or even blame themselves for the abuse. In severe cases, victims often have little or no memory of the abuse or complete betrayal blindness. Under such conditions, dissociation is functional for the victim, at least for a time.

Consider the case of "Ann," who had been repeatedly and severely physically and sexually abused by her father from ages 4 to 16. As an adult, Ann had little to no memory of the abuse. As a result of the abuse, she had developed nine alternate identities, two of which contained vivid memories of the sexual and physical abuse. Through counseling, she was able to gain awareness of and access to all nine alternate identities and their functions.

Although Ann expressed revulsion and anger toward her father, she also expressed her love for him. At times, she would lapse into moments of regret for disclosing the abuse, saying that "it wasn't so bad" and that the worst thing that had happened was that she had lost her "daddy." During these moments, Ann minimized the severity of the abuse,

wishing that she had kept the incest secret so that she could still have a relationship with her father. This was an intermittent longing for Ann that occurred throughout counseling and beyond.

Thus, understanding attachment concepts is critical for understanding betrayal traumas such as incest. Otherwise, counselors might be inclined to blame survivors or might feel confused and even repulsed by survivors' behaviors and intentions. For many survivors, the caregiver-abuser represents the best and the worst of her life at various times. She needs empathy and support, not blame.

Dissociation

As defined in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders*, dissociation is "a disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, perception, body representation, motor control and behavior." Depending on the severity of the abuse, dissociative experiences can interfere with psychological functioning across the board. Survivors of incest often experience some of the most severe types of dissociation, such as dissociative identity disorder and dissociative amnesia (the inability to recall autobiographical information). Dissociative experiences often are triggered by perceived threat at a conscious or unconscious level.

As previously noted, betrayal trauma theory holds that for incest survivors, dissociative amnesia serves to maintain connection with an attachment figure by excluding knowledge of the abuse (betrayal blindness). This in turn reduces or eliminates anxiety about the abuse, at least in the short run. Conversely, many survivors of childhood incest report continuous memories of the abuse, as well as the anxiety and felt

terror related to the abuse. Often, these individuals will find a way to leave their homes and abusers. This is less frequently the case for survivors who experience dissociative amnesia or dissociative identity disorder.

Depersonalization and derealization distort the individual's sense of self and her sensory input of the environment through the five senses. For example, clients who have experienced incest often report that their external world, including people, shapes, sizes, colors and intensities of these perceptions, can change quickly and dramatically at times. Furthermore, they may report that they do not recognize themselves in a mirror, causing them to mistrust their own perceptions.

As one 31-year-old incest survivor stated, "For so many years, everything within me and around me felt and looked unreal, dull, dreary, fragmented, distant." This is an example of depersonalization/ derealization. She continued, "This, along with the memory gaps, forgetfulness and inability to recall simple everyday how-tos, like how to drive a car or remember the step-by-step process of getting ready for the day, made me feel crazy. But as I improved in counseling, my perceptions of my inside and outside worlds became clearer, more stable, and brighter and more distinct than before counseling. It all came to make more sense and feel right. It took me years to see the world as I think other people see it. From time to time I still experience that disconnection and confusion, but so much less frequently now than before."

Initially, some real or perceived threat triggers these distorted perceptions of self and outer reality, but eventually they become a preset manner of perceiving the world. Reports such as this one are not

uncommon for survivors of incest and often are exacerbated as these individuals work through the process of remembering and integrating trauma experiences into a coherent life narrative. For many survivors, a sense of coherence and stability is largely a new experience; for some, it can be threatening and trigger additional dissociative experiences. The saying "better a familiar devil than an unfamiliar angel" seems to apply here.

The severity of dissociation for survivors of incest is related to age onset of trauma exposure and a dose-response association, with earlier onset, more types of abuse and greater frequency of abuse associated with more severe impairment across the life span. Incest is associated with the most severe forms of dissociative symptoms such as dissociative identity disorder. Approximately 95 to 97 percent of individuals with dissociative identity disorder report experiencing severe childhood sexual and physical abuse.

Fragmentation in one's sense of self, accompanied by amnesia of abuse memories, is particularly functional when children cannot escape the abuse circumstances. These children are not "present" during the abuse, so they often are not aware of the physical and emotional pain associated with the abuse. Yet this fragmented sense of self contributes to a sense of emptiness and absence, memory problems and dissociative self-states. Many survivors of incest are able to "forget" about the abuse until sometime later in adulthood when memories are triggered by certain events or when the body and mind are no longer able to conceal the memories. The latter results from the cumulative effect of lifelong struggles related to the incest (for example, interpersonal problems and emotional dysregulation). It takes a great deal of psychological and physical resources to "forget" trauma memories.

Dissociation, especially if it involves ongoing changes in perceptions of self and others, different presentations of self and memory problems, may result in difficulty forming and maintaining a therapeutic alliance. Dissociation disrupts the connection between the client and the counselor. It also disrupts clients' connections with their inner experience. If these clients do not perceive themselves and their surroundings as stable, they will mistrust not only their counselors but also their own perceptions, which create ongoing confusion.

Thus, counselors must remain alert to subtle or dramatic fluctuations in survivors' presentation styles, such as changes in eye contact or shifts in facial features from more engaged and animated to flat facial features. Changes in voice tone quality and cadence (from verbally engaged to silent) or in body posture (open versus closed) are other signs of possible dissociative phenomena. Of course, all or none of these changes may be indicators of dissociative phenomena.

Complex trauma

Incest, betrayal trauma and dissociative disorders are often features of a larger diagnostic categorization — complex trauma. Incest survivors rarely experience a single incident of sexual abuse or only sexual abuse. It is more likely that they experience chronic, multiple types of abuse, including sexual, physical, emotional and psychological, within the caregiving system by adults who are expected to provide security and nurturance.

Currently, an official diagnostic category for complex trauma does not exist, but one is expected to be added to the revised *International Classification of Diseases* (*ICD-11*) that is currently in development. Marylene Cloitre, a member of the World Health Organization *ICD-11*

stress and trauma disorders working group, notes that the new complex trauma diagnosis focuses on problems in self-organization resulting from repeated/chronic exposure to traumatic stressors from which one cannot escape, including childhood abuse and domestic violence. Among the criteria she highlighted for complex trauma are:

- Disturbances in emotions: Affect dysregulation, heightened emotional reactivity, violent outbursts, impulsive and reckless behavior, and dissociation.
- Disturbances in self: Defeated/diminished self, marked by feeling diminished, defeated and worthless and having feelings of shame, guilt or despair (extends despair).
- Disturbances in relationships:Interpersonal problems marked by difficulties in feeling close to others and having little interest in relationships or social engagement more generally.
  There may be occasional relationships, but the person has great difficulty maintaining them.

Early onset of incest along with chronic exposure to complex trauma contexts interrupts typical neurological development, often leading to a shift from *learning brain* (prefrontal cortex) to *survival brain* (brainstem)functioning. As explained by Christine Courtois and Julian Ford, survivors experience greater activation of the primitive brain, resulting in a survival mode rather than activation of brain structures that function to make complex adjustments to the current environment. As a result, survivors often exhibit an inclination toward threat avoidance rather than being curious and open to experiences. Complex trauma undermines survivors' ability to fully integrate sensory, emotional and cognitive data into an organized, coherent whole. This lack of a consistent and coherent sense of self and one's surroundings

can create a near ever-present sense of confusion and disconnection from self and others.

Regular or intermittent complex trauma exposure creates an almost continual state of anxiety and hypervigilance and the intrinsic expectation of danger. Incest survivors are at an increased risk for multiple impairments, revictimization and loss of support.

Treatment issues

Although a comprehensive description of treatment is well beyond the scope of this article, I will close with a general overview of treatment concepts. Treatment for incest parallels the treatment approaches for complex trauma, which emphasizes symptom reduction, development of self-capacities (emotional regulation, interpersonal relatedness and identity), trauma processing and the addressing of dissociative experiences.

Compromised self-capacities intensify symptom severity and chronicity. Among these self-capacities, emotional dysregulation is a major symptom cluster that affects other self-capacity components. For example, if a survivor consistently struggles with low frustration tolerance for people and copes by avoiding people, responding defensively, responding in a placating manner or dissociating, she likely will not have the opportunity to develop fulfilling relationships. The following core concepts, published in the May 2005 *Psychiatric Annals*, were suggested by Alexandra Cook and colleagues for consideration when implementing a treatment regimen for complex trauma, including with incest survivors and with adaptations for clients with dissociative identity disorder.

1) Safety: Develop internal and environmental safety procedures.

2) Self-regulation: Enhance the capacity to moderate and rebalance arousal across the areas of affective state, behavior, physiology, cognition, interpersonal relatedness and self-attribution.

3) Self-reflective information processing: Develop the ability to focus attentional processes and executive functioning on the construction of coherent self-narratives, reflecting on past and present experience, anticipation and planning, and decision-making.

4) Traumatic experiences integration: Engage in resolution and integration of traumatic memories and associated symptoms through meaning making, traumatic memory processing, remembrance and mourning of traumatic loss, development of coping skills, and fostering present-oriented thinking and behavior.

5) Relational engagement: Repair, restore or create effective working models of attachment and application of these models to current interpersonal relationships, including the therapeutic alliance. Emphasis should be placed on development of interpersonal skills such as assertiveness, cooperation, perspective taking, boundary and limit setting, reciprocity, social empathy and the capacity for physical and emotional intimacy.

6) Positive affect enhancement: Work on the enhancement of self-worth, self-esteem and positive self-appraisal through the cultivation of personal creativity, imagination, future orientation, achievement, competence, mastery seeking, community building and the capacity to experience pleasure.

Typically, these components are delivered within a three-phase model of counseling that is relationship-based, cognitive behavioral in nature and trauma focused:

- Safety, self-regulation skill development and alliance formation
- Trauma processing
- Consolidation

The relational engagement component is particularly critical because for many survivors, to be attached often has meant to be abused. Furthermore, accompanying feelings of shame, self-loathing and fear of abandonment create a "failure identity" that results in low expectations for change. Additionally, it is important for counselors to attend to client transference issues and counselor countertransference issues. Courtois suggests that ignoring or assuming that such processes are irrelevant to the treatment of survivors can undermine the treatment process and outcome.

In addition, strength-based interventions are critical in each phase to help survivors develop a sense of self-efficacy and self-appreciation for the resources they already possess. A strength-based focus also contributes to client resilience.

For some clients, dissociated self-states or parts will emerge. Counselors should assume that whatever is said to one part will also be heard by the other parts. Therefore, addressing issues in a manner that encourages conversation between parts, including the core self-structure, is critical. It is also important to help parts problem-solve together and support each other. This is not always an easy proposition. A long-term goal would be some form of integration/fusion or accord among alternate identities. Some survivors eventually experience full unification of parts,

whereas others achieve a workable form of integration without ever fully unifying all of their alternate identities (for more, see *Treating Trauma-Related Dissociation: A Practical, Integrative Approach* by Kathy Steele, Suzette Boon and Onno van der Hart).

Finally, it must be mentioned that repeated exposure to horrific stories of incest can overwhelm counselors' capacity to maintain a balanced relationship with clear boundaries. A client's transference can push the boundaries of an ethical and therapeutic client-counselor relationship. Furthermore, the frequent push-pull dynamics between counselor and client can be exhausting, both physically and mentally for counselors. Therefore, it is important for counselors to frequently seek supervision and consultation and to engage in self-care physically, psychologically and spiritually.

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