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Anger and type-related coping resources in the experience of adult survivors of incest

Kathleen M. Giles

College of William & Mary - School of Education

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Giles, Kathleen M., Ed.D.

The College of William and Mary, 1992

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**300 N. Zeeb Rd.
Ann Arbor, MI 48106**

**ANGER AND TYPE RELATED COPING RESOURCES
IN THE EXPERIENCE OF ADULT SURVIVORS OF INCEST**

A Dissertation

Presented to

**The Faculty of the School of Education
The College of William and Mary in Virginia**

In Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

by

Kathleen M. Giles

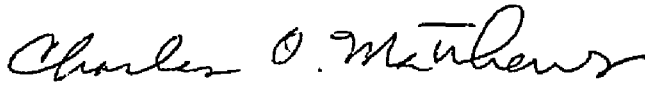
April 1992

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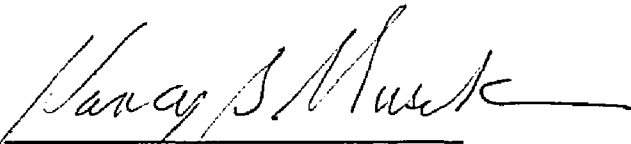
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Fred L. Adair, Ph.D.



Nancy S. Musika, Ed.D.

DEDICATION

To the Tuesday night survivors'support group at CONTACT House, whose courage and persistence has inspired me throughout this study. The poem Margie wrote and shared with us about anger is a symbol of the dedication to healing you have.

When I'm angry,
When rage churns inside of me
I stare into space.
I withdraw from the world.
Then I write.
I share my life with the hungry lines on the paper.
The words spill from my pen like a waterfall.
And when obstructions once again interfere,
I hold my thoughts inside of me,
All my fears and hate.
Until again I find myself drawn to expression.
Frantically I search for pen and paper
So that I may share my intensity.

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Gail Robertson and the Board of Directors of CONTACT Peninsula, Inc., made a flexible work environment available to me where it was possible to oversee the Sexual Assault Services Program as well as pursue this research. From them I learned that a

climate for learning could be transferred from the academic world to the work place and that support and good cheer were available and were freely given from sources other than family and friends.

In the academic world, the faculty and students in the Counseling Program in The School of Education of The College of William and Mary have been my teachers from our first association. Chas Matthews, chair of my dissertation committee, affirmed my interest in Jung and guided my wanderings as a developing counselor well before he agreed to oversee this project. His model of congruence and of a therapist who has done his own work stays with me at all times. Fred Adair taught me the value of precision in reporting research data and the value of reliable measurement. I have tried to absorb his ability to extravert his thinking function with only limited success. Nancy Musika taught me the possibility of being a therapist/scholar. She modeled an approach to treatment planning for her clients that incorporates the best spirit of scientific inquiry, and she provided a spark of interest in studying the outcome of treatment of incest survivors that was valuable to me in the early stages of planning this project. Dixie Sheild was my first supervisor in the field of sexual assault services, and she shared with me her passion for ending victimization. It was through her efforts that I became connected with the women of courage who are part of the VAASA network of staff and volunteers and who work daily for social change in the field of sexual assault services.

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ANGER AND TYPE RELATED COPING RESOURCES IN THE EXPERIENCE OF ADULT SURVIVORS OF INCEST

ABSTRACT

The purpose of this study was to determine from a group of ending stage or post-treatment incest survivors their experience with anger before therapy, during therapy, and at present, using semi-structured interviews and the following objective measures: STAXI--*State-Trait Anger Expression Inventory* (Spielberger, 1988), CRI--*Coping Resources Inventory* (Hammer and Marting, 1988), MBTI--*Myers-Briggs Type Indicator* (Myers and McCaulley, 1985), a researcher- constructed outcome measure (a visual analog scale of awareness of feelings and symptom improvement) and a researcher-constructed Type-Related Anger questionnaire. Subjects who volunteered to participate in the study were 45 adult female (average 38 years old) survivors of childhood incest where incest was defined to include any sexual contact by a blood relative or by someone who is in a caretaking role and their 25 referring outpatient therapists, identified as experts in their communities by local rape crisis centers. Survivors had worked with an average of 3.6 therapists per person and had been in therapy for an average of 32 months with their current therapists.

STAXI results showed that these survivors had much more State and Trait Anger and had repressed much more anger before therapy than at present. They were not significantly more expressive with their anger prior to therapy than at present. When compared to the norm groups on the objective measures, these survivors at present had equal total coping resources, equal repressed anger, and more expressed anger. There were no differences between therapist assessment and client report of current repressed or expressed anger. Further study is needed to determine whether these scores represent

survivor norms or whether they are specific to this sample. These scores, taken together with (1) survivors' enthusiastic reports in the interviews of the value of therapy in their lives, and (2) therapist and client assessment of symptom improvement (75-79 on a 100 point scale, n.s.) and overall improvement (78-91 on a 100 point scale, $p < .001$), imply that a successful outcome of therapy has occurred.

Specific coping resources had some type-related similarities, but the small sample size in this study made all type results inconclusive. Strategies, tasks, and rituals for working through anger were suggested by both survivors and therapists and could be classified by type preference and by coping resource preference.

Results from therapists showed client anger in a positive frame, an essential element of client empowerment, contrary to the notion that anger is "maladaptive." Two patterns of anger presentation were observed by therapists: (1) Anger-In clients where anger has been repressed and therapy consists of access, identification, and acceptance of anger, and (2) Anger-Out clients where excessive amounts of anger are constantly present and therapy consists of directing the anger toward the abusers and accessing and accepting other emotions.

Further research is needed on what constitutes effective treatment of survivors and on how to train more therapists to meet the need for mental health services to survivors of childhood sexual abuse.

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**ANGER AND TYPE-RELATED COPING RESOURCES IN
THE EXPERIENCE OF ADULT SURVIVORS OF INCEST**

CHAPTER 1

INTRODUCTION

Statement of the Problem

The problem of this study concerns the issue of anger as part of the recovery process for adult survivors of incest and the extent to which each person's psychological type explains the coping resources favored by each survivor. Some questions which motivated this study are as follows:

1. How do post-treatment incest survivors describe their experience with anger before, during, and after treatment?
2. How do experienced therapists conceptualize anger as an element of their treatment of incest survivors?
3. Is there a difference between self-report and therapist report about the extent to which therapy helps a survivor deal with anger?
4. Are the choices of coping resources made by incest survivors related to their psychological type?
5. What techniques do both therapists and clients report as being helpful for incest survivors' dealing with their anger?
6. Are there type-related features of the therapy experience that survivors and therapists can identify whether or not they have used type theory directly in their work together?

Justification

The plight of adult survivors of childhood sexual abuse has received increased attention in the treatment community, in the news and entertainment media, and in the sexual assault crisis services agencies in Virginia during the past two years. There are 21 sexual assault crisis centers currently in the state coalition Virginians Aligned Against Sexual Assault (VAASA), and those centers report a 30-50% increase in requests for services from adults who were molested as children in the time period of 1987-1989 (Groot, 1990). Accurate records about the relationship of the assailant to the survivor have not been kept until fiscal year 1990-91 in VAASA centers, so estimates of incidence of requests for services from adults who were molested as children are based on an informal survey of center staffs. Of the 3,615 victims of sexual assault served by VAASA centers in 1989, it is estimated that about half of them were survivors of childhood molestation.

Wyatt's (1985) multi-stage stratified probability sample of 248 African-American and white-American women in the Los Angeles area indicated that 62% reported at least one incident of sexual abuse prior to age 18. Russell's (1983, 1986) prevalence report of childhood sexual molestation by a relative in a randomly selected community sample in the San Francisco area indicates that 16% of all women may be survivors of incest. Prevalence studies regarding sexual abuse of males are just beginning to be done, and estimates vary according to definition of sexual abuse and method of data collection. Urquiza and Capra (1990) reviewed recent studies and found estimates ranging from 11% of adult males in a random telephone survey in Minnesota to 17% of male college students in Washington state who have had some sort of abusive sexual contact before age 18. Finkelhor, Hotelling, Lewis, and Smith (1990) found that 16% of the adult males in a national randomly generated sample of residential phone

owners had been sexually victimized. If these prevalence numbers happened to be true also in Virginia, then VAASA centers, which serve about 60% of the geographical area of the state and 72% of the population, can be seen to be serving only a fraction of the possible 1.8 million adults in Virginia who were sexually abused when they were children. An obvious conclusion is that there are still women and men who need the crisis intervention and support services of the VAASA centers as well as mental health services from practitioners in their communities in order to recover from their childhood sexual abuse.

A concern expressed by VAASA center staffs has been that relatively few mental health practitioners in their communities specialize in treating sexual assault survivors in general and survivors of childhood sexual abuse in particular. Some of the persons seeking services from VAASA centers have been casualties of treatment, people who were not helped to heal from the abuse in their childhoods, even though they had been in therapy with licensed professionals. The complexities of attributing a cause to these negative outcomes of therapy have not been addressed systematically by VAASA centers, but the prevailing wisdom is that more practitioners need education in specific issues of recovery from sexual assault and sexual abuse (Groot, 1990).

The concerns expressed by sexual assault crisis service providers in Virginia were also expressed by a nationally known research team (Finkelhor, Hotaling, and Yllo, 1988) who surveyed approximately fifty experts in the fields of family violence research and treatment to set an agenda for research priorities in the 1990s. They limited their consideration to research on physical abuse of children, child sexual abuse, and spouse abuse. A high priority that emerged from their think tank about research in the future was further study about the long term impact of and recovery from the trauma of sexual abuse. They criticized research designs that focus solely on impairment suffered

by survivors of child sexual abuse, and they strongly endorsed the need for "studies that demonstrate how recovery occurs" (Finkelhor, Hotaling, and Yllo, 1988, p. 68). They envisioned a follow-up study that would identify victims of child sexual abuse 5 - 10 years after their abuse and would include the following goals:

- The study should obtain extensive information about current functioning, problems, and symptoms.
- The study should gather extensive information on factors that may have been important in the recovery process: professional helpers, important relationships, positive life experiences, attitudes that the victim took toward the abuse.
- The study should elicit specific opinions from victims about what they found the most helpful. Toward this end, some of the interviews should be in-depth rather than simply survey format. By accounting for factors that may have aided in the recovery process, this study could markedly improve the guidance that professionals give to victims of sexual abuse (Finkelhor, Hotaling, and Yllo, 1988, p. 69).

The study that Finkelhor and his colleagues imagined would take 2 to 3 years and would have a budget of \$300,000 which is clearly beyond the scope of this project. However, the motivation to study some aspect of the recovery process in a way that collects objective data from survivors as well as collects some qualitative data in an interview format is something that this investigator shares with Finkelhor's team.

The issue of anger as part of the process of healing from childhood sexual abuse is well known among clinicians who specialize in working with incest survivors (Steele and Colrain, 1990; Calof, 1988a, 1988b; Courtois, 1988; Gil, 1988; McCann, Pearlman, Sakheim, and Abrahamson, 1988; Sgroi and Bunk, 1988; Briere and Runtz, 1987; Maltz and Holman, 1987). Problems in dealing with anger are also well documented in the anecdotal literature from survivors themselves (Wood and Hatton, 1988; Wischild, 1988; Bass and Thornton, 1983; McNaron and Morgan, 1982; Allen, 1980). The place where there has been no help for clinicians and by implication for survivors has been in the research literature on anger. The focus of research efforts on anger have been in describing offender populations instead of victim populations

(Hoshmand, 1987; Maiuro, et al., 1987; Stermac, 1986; Wilfley, et al., 1986); toward establishing a link between medical problems and unexpressed anger (Julius, et al. 1985; Manuck, et al., 1985; Rosenman, 1985); and toward establishing ways to get rid of anger in treatment (Sharkin, 1988; Hazaleus and Deffenbacher, 1986; Hecker and Lunde, 1985; Novaco, 1985; Alschuler and Alschuler, 1984; Crumrine, 1980). The character of these studies has not included a recognition of the appropriateness of anger as a result of sexual abuse. Novaco (1985) mentioned different causes for anger but discussed modifying anger in treatment without differentiating between trauma-induced anger and other examples of anger. Hecker and Lunde (1985) noted that "the etiology of chronic hostility is largely unknown" (p. 228). Chesney (1985) raised the ethical issue of the appropriateness of anger. Her point was that in situations of social injustice where anger responses are not only justified but also are appropriate, it is the social situation that should be the object of the intervention for modification rather than the subject's anger response. Despite this recognition from anger researchers that the etiology of anger may be important, no study to date has explored anger as a result of victimization with a victimized population. The label "maladaptive" has been used to describe a person's anger without consideration of the context in which the anger was generated.

The purpose of this study is to investigate incest survivors' experience with anger before, during, and after treatment and to determine whether the coping resources preferred by survivors relate to the personality variable of psychological type. The intention is that because this specific treatment issue has never before been the focus of an empirical study, the results will be of interest to experienced clinicians who are familiar with treating incest survivors and will also give other clinicians some useful tools for treating individuals in what for them may be a new population.

Theoretical Rationale

An important antecedent to the current attention in the incest treatment literature toward individualizing treatment of incest survivors (Courtois, 1990; McCann and Pearlman, 1990; Sgroi, 1989a, 1989b; McCann, et. al., 1988; Sgroi and Bunk, 1988; Courtois and Watts, 1982) is Carl Jung's theory of psychological type. At the end of his career as an analyst, Jung spoke with clarity about the value of individualizing treatment.

Psychotherapy and analysis are as varied as are human individuals. I treat every patient as individually as possible, because the solution to the problem is always an individual one. . . . To my mind, in dealing with individuals, only individual understanding will do. We need a different language for every patient (Jung, 1961, p. 131).

Jung began his work on articulating differences between people in response to his own urge to understand the differences between the psychology of Freud and the psychology of Adler (Jung, 1917/1926/1943; 1957; 1961) and "to find my own bearings" (Jung, 1959, p. 435). He continued to make observations about personality differences from his clinical practice, and over a ten year period of time he developed a classification system for the differences he observed (Jung, 1936). He believed that type in no way discounted individual uniqueness.

The individual attitudes are certainly as inexhaustible as the variations of crystals, which may nevertheless be recognized as belonging to one or another system. But just as crystals show basic uniformities which are relatively simple, these attitudes show certain fundamental peculiarities which allow us to assign them to definite groups (Jung, 1921, p. 531).

His intention was to bring order to what he had observed as "the enormous diversity of human individuals" (Jung, 1936), "not in any sense to stick labels on people at first sight" (Jung, 1921, p. xiv).

Jung called *Introversion* and *Extraversion* the two basic types, which he defined based on the flow of a person's psychic energy:

The introvert's attitude is an abstracting one; at bottom, he is always intent on withdrawing libido from the object, as though he had to prevent the object from gaining power

over him. The extravert, on the contrary, has a positive relation to the object. He affirms its importance to such an extent that his subjective attitude is constantly related to and oriented by the object. The object can never have enough value for him, and its importance must always be increased" (Jung, 1921, p. 330).

He believed those two types represented two kinds of biological adaptation that would encourage perpetuation of the species:

There are in nature two fundamentally different modes of adaptation which ensure the continued existence of the living organism. The one consists in a high rate of fertility, with low powers of defence and short duration of life for the single individual; the other consists in equipping the individual with numerous means of self-preservation plus a low fertility rate. This biological difference, it seems to me, is not merely analogous to, but is the actual foundation of our two psychological modes of adaptation. I must content myself with this broad hint. It is sufficient to note that the peculiar nature of the extravert constantly urges him to expend and propagate himself in every way, while the tendency of the introvert is to defend himself against all demands from outside, to conserve his energy by withdrawing it from objects, thereby consolidating his own position (Jung, 1921, pp. 331-332).

Jung believed that type differentiation begins very early in life and that it is proper to speak of type as "innate" (Jung, 1923). He observed that in addition to the basic attitude types of extraversion and introversion there were in addition the four psychic functions of the conscious mind: *Sensation, Intuition, Thinking, and Feeling*.

Under sensation I include all perceptions by means of the sense organs; by thinking I mean the function of intellectual cognition and the forming of logical conclusions; feeling is a function of subjective valuation; intuition I take as perception by way of the unconscious, or perception of unconscious contents.

So far as my experience goes, these four basic functions seem to me sufficient to express and represent the various modes of conscious orientation. For complete orientation all four functions should contribute equally: thinking should facilitate cognition and judgment, feeling should tell us how and to what extent a thing is important or unimportant for us, sensation should convey concrete reality to us through seeing, hearing, tasting, etc., and intuition should enable us to divine the hidden possibilities in the background, since these too belong to the complete picture of a given situation. In reality however, these basic functions are seldom or never uniformly differentiated and equally at our disposal. As a rule one or the other function occupies the foreground, while the rest remain undifferentiated in the background. Thus there are many people who restrict themselves to the simple perception of concrete reality, without thinking about it or taking feeling values into account. They bother just as little about the possibilities hidden in a situation. I describe such people as *sensation types*. Others are exclusively oriented by what they think, and simply cannot adapt to a situation which they are unable to understand intellectually. I call such people *thinking types*. Others, again, are guided in everything entirely by feeling. They merely ask themselves whether a thing is pleasant or unpleasant, and orient themselves by their feeling impressions. These are the *feeling types*. Finally, the *intuitives* concern themselves neither with ideas nor with feeling reactions, nor yet with the reality of things, but surrender themselves wholly to the lure of

possibilities, and abandon every situation in which no further possibilities can be scented. Each of these types represents a different kind of one-sidedness but one which is linked up with and complicated in a peculiar way by the introverted or extraverted attitude (Jung, 1923, pp 518-519).

The one-sidedness in function preference Jung came to call the primary or dominant function with a secondary or auxiliary function serving to balance the conscious orientation of the dominant function:

For all the types met with in practice the rule holds good that besides the conscious, primary function there is a relatively unconscious auxiliary function which is in every respect different from the nature of the primary function. The resulting combinations present the familiar picture of, for instance, practical thinking allied with sensation, speculative thinking forging ahead with intuition, artistic intuition selecting and presenting its images with the help of feeling-values, philosophical intuition systematizing its vision into comprehensible thought by means of a powerful intellect, and so on (Jung, 1921, p. 406).

The eight types named by Jung are Extraverted Thinking, Introverted Thinking, Extraverted Sensing, Introverted Sensing, Extraverted Feeling, Introverted Feeling, Extraverted Intuitive, and Introverted Intuitive.

Isabel Myers began her work operationalizing Jung's theory of psychological type in 1942, after being taught Jung's system by her mother, Katharine Briggs, and after over twenty years of observing the behavior of family and friends through the lens of type (McCaulley, 1981). Her contribution to the theory of psychological type was that she emphasized the importance of the auxiliary function in the conscious mind and she believed that introverts extraverted their auxiliary function during the course of daily living (Myers, 1962/1970/1976/1980/1987; 1980; Myers and McCaulley, 1985). The process of developing the Myers-Briggs Type Indicator (MBTI) included the use of a criterion group of known types, friends and family members of Isabel Myers, and a particular effort to phrase items designed to measure a particular function in the language that would be natural for a person with that particular preference to use. The assumption of the existence of a "true type" as well as the notion that the Indicator should sort rather than measure was fundamental to its development:

Myers and Briggs assumed that in each individual "true preferences" on each of the Jungian dichotomies actually exist, and the task of the MBTI is to give an individual the opportunity to report them. They further assumed that individuals can report on the behaviors and attitudes postulated to result from type preferences and that true preference can be inferred from these reports (McCaulley, 1981, p. 308)

Keeping the scales independent, rejecting items that correlated well on more than one scale, setting the division point on each scale, and making sure that the scale differentiated well at the mid-point in addition to the extremes were issues that Isabel Myers addressed with her patience, her commitment to the Indicator, and her hand calculator! (Lawrence, 1986). Her final published version of the MBTI included four dichotomous scales which could be combined into sixteen type categories:

Extravert with Sensing dominant	and introverted thinking as auxiliary	ESTP
	and introverted feeling as auxiliary	ESFP
Extravert with Intuition dominant	and introverted thinking as auxiliary	ENTP
	and introverted feeling as auxiliary	ENFP
Extravert with Thinking dominant	and introverted sensing as auxiliary	ESTJ
	and introverted intuition as auxiliary	ENTJ
Extravert with Feeling dominant	and introverted sensing as auxiliary	ESFJ
	and introverted intuition as auxiliary	ENFJ
Introvert with Sensing dominant	and extraverted thinking as auxiliary	ISTJ
	and extraverted feeling as auxiliary	ISFJ
Introvert with Intuition dominant	and extraverted thinking as auxiliary	INTJ
	and extraverted feeling as auxiliary	INFJ
Introvert with Thinking dominant	and extraverted sensing as auxiliary	ISTP
	and extraverted intuition as auxiliary	INTP
Introvert with Feeling dominant	and extraverted sensing as auxiliary	ISFP
	and extraverted intuition as auxiliary	INFP

(McCaulley, 1981, p. 304)

Another theoretical contribution of Jung's is his position that perception is paramount and that a person's perception is informed by his or her psychological type. "The book on types yielded the insight that every judgment made by an individual is conditioned by his personality type and that every point of view is necessarily relative" (Jung, 1961, p. 207). Jung made the point that perception can influence an individual's reaction to a traumatic event:

This failure to react to an apparent shock can frequently be observed. Hence it necessarily follows that the intensity of a trauma has very little pathogenic significance in itself, but it must have a special significance for the patient. That is to say, it is not the shock as such that has a pathogenic effect under all circumstances, but, in order to have an effect, it must impinge on a special psychic disposition, which may, in certain circumstances consist in the patient's unconsciously attributing a specific significance to the shock (Jung 1917/1926/1943, p. 14).

Regarding the influence of type on the diagnosis and prediction of mental illness, Jung stopped short of claiming that type solved the choice of neurosis question: "Why in a neurotic family, does one child react with hysteria, another with a compulsion neurosis, the third with a psychosis, and the fourth apparently not at all?" (Jung, 1931, p. 530). He believed that asking that question was premature but that a lot could be learned about human behavior by understanding the type-based, largely unconscious decision-making processes that people have available to them. The more relevant question, he believed, was "How does a person react to an obstacle?" (Jung, 1931, p. 530).

The link between type and treatment was fundamental to Jung's theory. His theory developed from the observations he made during the course of treatment in his clinical practice:

Critics commonly fall into the error of assuming that the types were, so to speak, fancy free and were forcibly imposed on the empirical material. In face of this assumption I must emphasize that my typology is the result of many years of practical experience—experience that remains completely closed to the academic psychologist. I am first and foremost a doctor and practising (sic) psychotherapist, and all my psychological formulations are based on the experiences gained in the hard course of my daily professional work. What I have to say in this book, there fore, has, sentence by sentence, been tested a hundredfold in the practical treatment of the sick and originated with them in the first place. (Jung, 1921, p. xiii, Foreword to the Seventh Swiss Edition, 1937)

He wrote about the usefulness of attending to each individual client and about the usefulness to the therapist of examining his or her own type in order to avoid projecting inappropriately on the client. He also noted with some humor that every psychological theory which depends on a uniform human psychology instead of the diversity explained by type theory represents a projection of the theory maker's own type (Jung, 1921). He was willing to answer questions about his own type, but he was unwilling to speculate about Freud's (Jung, 1955). Commenting on his own type in an interview with BBC television, Jung said,

I most certainly was characterized by thinking. I always thought, from early childhood on, and I had a great deal of intuition too. And I had a definite difficulty with feeling, and my relation to reality was not particularly brilliant. I was often at variance with the reality of things. Now that gives you all the necessary data for a diagnosis! (Jung 1960, p. 436).

He put forth the type theory as a practical tool to help the research community and practicing psychotherapists, and he considered it a hypothesis, not dogma (von Franz, 1971). The practical implications of the theory for this study are the applications of psychological type to the treatment of incest survivors, in particular, what information can be learned empirically about the relationship between type and coping resources and between type and anger as a treatment issue for this population. The intriguing questions raised by Jung about awareness of type as an aid to a therapist in treatment and about treatment as a projection of therapist type are beyond the scope of this study.

Definition of Terms

Anger is defined here as "an emotional state that consists of feelings that vary in intensity from mild irritation or annoyance to fury and rage" (Spielberger, et al., 1985, p. 7). When a state of anger is experienced frequently over time, a person may be said to have anger as a personality trait (Spielberger, 1988). Spielberger's contribution to the anger research literature has been to clarify the overlapping concepts of anger, hostility, and aggression by defining and measuring the emotional state and personality trait of anger and by distinguishing the experience of anger from its expression.

Incest is defined here as any sexual contact including fondling and ogling by anyone who is a blood relative or who is in a caretaker role. This definition is more inclusive than that used by some researchers, and it was chosen specifically in agreement with Wyatt and Peters (1986a) and Finkelhor (1986) who noted that data can be restricted for comparison if needed, but it cannot be recovered later if it is not collected initially. Another statement of definition of incest that meets the broad criteria is Blume's (1990):

"the imposition of sexually inappropriate acts, or acts with sexual overtones, by--or any use of a minor child to meet the sexual or sexual/emotional needs of--one or more persons who derive authority through ongoing emotional bonding with that child" (p. 4).

Gelinas (1983) made the point that despite the variations in legal definitions of incest from one state to the next, "for *clinical* purposes, incest can be defined by two criteria: sexual contact and a *preexisting* relationship between adult and child" (p. 313).

Post-traumatic stress disorder is "the clinical manifestation of problems associated with trauma induced during the catastrophe and represented by the post-traumatic stress reactions" (Figley, 1985, p. xix).

Post-traumatic stress reactions are "the subsequent ripples which may last long after the pebble penetrates the surface of the pond" (Figley, 1985, p. xix).

Survivor is anyone, female or male, who has endured childhood sexual abuse. In this study, *survivor* specifically refers to those who have experienced incest. The researcher supports the case made by Hunter and Gerber (1990) for precision in nomenclature in the treatment of victims of sexual abuse and for the progress during therapy from victim to survivor and beyond. "The ultimate goal of therapy ought to be to transcend survivorship and remove the abuse experience as an issue of identity" (Hunter and Gerber, 1990, p. 83). For the purposes of this study, the term *survivor* is intended to convey respect for the strength of the person to overcome the effects of the abusive past they have experienced and is used for convenience instead of *victim* for uniformity.

Trauma is defined in Figley's (1985) terms as "an emotional state of discomfort and stress resulting from memories of an extraordinary, catastrophic experience which shattered the survivor's sense of invulnerability to harm" (p. xviii).

Traumatic stress reactions are "the first indication of the presence of a trauma. They occur in the initial wake of a traumatic event or catastrophe. It is like the initial wake created by casting a pebble into a pond" (Figley, 1985, p. xix).

Research Hypotheses

1. Incest survivors will exhibit significantly more repressed anger than an age-matched sample of the general population.
2. Incest survivors will exhibit significantly fewer total coping resources than a sample of the general population.
3. There will be trends toward type and coping interactions that will indicate a pattern of high use of specific coping resources by specific psychological types.
4. The therapists' reports about their clients dealing with anger will be more optimistic than the incest survivors' self-reports.

Description of the Sample

Finkelhor (1984) has noted that "sexual abuse treatment and research have grown up outside academic institutions, i.e., social service agencies, prosecutor's offices, and rape crisis centers" (p. 222). Volunteers from among the incest survivors treated by the experienced therapists who are on the referral lists of VAASA centers across the state were studied here as the best available source on the healing process. The incest survivors were recruited from nominations of their therapists of those clients who either are in the ending phase of treatment or have successfully terminated therapy within the past three years. They were voluntary participants in the research. The willingness of their therapists to nominate clients and to participate themselves in the study was encouraged by the recognition of their expertise based on the referral network from the VAASA centers in their communities and by the availability of funding to pay for a clinical hour from each of them at their present fee. Those therapists who declined the fee were honored instead by a donation to VAASA made on their behalf. The invitation to participate in research was issued uniformly to all the therapists in the VAASA center

referral network, a total of 195 therapists. A total of 45 incest survivors volunteered to participate after being contacted by 25 of the referring therapists. The rationale for selecting therapists in the VAASA center referral network was that they have been judged by others to have skills in treatment of incest survivors, an important criterion indicative of positive outcome in therapy (Luborsky, et. al., 1988). The rationale for selecting incest survivors who were nearly finished with or had finished therapy for this study was to use their experiences as a data bank of successful treatment from which therapists may infer helpful interventions for other incest survivors newly seeking treatment. Utilizing all the therapists who agreed to be part of this study was expected to be reinforcing of the referral relationship that supports the skills of the therapists in providing high quality treatment in the communities. It was the goal of the researcher to be mindful of the impact of the research study itself as an intervention in these communities.

Limitations of the Study

An important limitation of the study is that it finally surveyed only adult female survivors of incest. The need for research on male survivors far exceeds the availability of male subjects who first of all report their sexual abuse and second of all seek treatment. Finkelhor, Hotaling, Lewis, and Smith (1990) found that 16% of the men and 27% of the women in their randomly generated national sample of residential phone owners had been sexually victimized. There was no significant gender difference between the 1,145 men and the 1,481 women surveyed in the percentage of experiences lasting more than a year (8% for boys and 11% for girls); however, boys were somewhat more likely (42% vs. 33%) never to have disclosed the experience to anyone. Male survivors were underrepresented in this study as predicted by the literature.

Possible reasons for that happening, the literature would suggest, are (a) their abuse may never have been disclosed, and (b) they may never have sought treatment. This researcher concurs with others who have mentioned the need for further study of male survivors of childhood sexual abuse (Kluft, 1990; Dimock, 1988; Lew, 1988; Risin and Koss, 1987; Finkelhor, 1979).

The interview data was collected retrospectively and is therefore subject to distortions of time lapse and imperfections in memory. The three year time limit within which therapy must have been terminated was intended to minimize this limitation.

The sample was taken from the entire state of Virginia, so it has some geographical diversity. The sample has the limitation that it may not represent uniformly the ethnic, racial, educational, and socioeconomic profile of women in the state and also the limitation that other states would not have the same demographic profile as Virginia. It is a volunteer sample and as such will have the limitations of all forms of volunteer bias. There is no way to guarantee that these incest survivors are indeed the set of most successfully treated people in the state. Therapists should note carefully the demographic summary of the survivors to determine whether some of the usual correlations with positive outcome are also present in this group: more education, higher socioeconomic status (Luborsky, et. al., 1988). Therapists should also note whether the demographics of treatment such as duration, frequency, and modality match their own practices before generalizing the results to other incest survivors seeking treatment.

CHAPTER 2

REVIEW OF THE LITERATURE

Research on Psychological Type

Much research has been generated by the Myers-Briggs Type Indicator (MBTI) in recent years. The Center for the Application of Psychological Type (CAPT) bibliography of studies and papers using the MBTI included 1,675 entries as of September 1990. Many of the articles have been validity studies to test the type descriptions, to describe various populations as predicted by the theory, and to verify the individual scales (Giles, 1987). A few studies are relevant to the issue of individualizing therapy, a few studies have found a relationship between type and stress, and a few studies have involved psychiatric populations.

MBTI and individualized therapy. In Carskadon's (1979) review of the literature on counseling applications of the MBTI, he recommended systematically gathering clinical "folklore" concerning counseling different types that "would tap a wealth of experience and provide extremely useful hypotheses to test in further research" (p. 17). He also recommended research on the question of whether certain therapies are differentially effective on clients of different types. Two findings (Mendelsohn and Geller, 1963; Galvin, 1975) in the literature prior to 1979 were that counselors are generally intuitive as opposed to sensing and that counseling lasts longer (more sessions) when counselors and clients were similar in type. This study will not address the issue of client/counselor similarity or type of counselor. However, this study will gather

specific treatment information about counseling different types of incest survivors.

Jones and Sherman (1979) and Newman (1979) provided a handbook for therapists based on their own experience attending to type directly in their work with their clients. Jones and Sherman found the MBTI relevant in educational, academic, personal, relationship, family, and therapeutic counseling settings. Newman reviewed each scale as it applies to strengths of therapists and expectations of clients of each type. Provost's (1984) casebook provides further detail including specific case descriptions utilizing the MBTI in counseling with clients of each of the sixteen types. These resources represent anecdotal data establishing the utility of the MBTI in a clinical setting. The present study will gather information about type-related treatment of anger and type-related coping resources of adult survivors of incest, a clinical population that has not been addressed in the type literature.

Witzig (1978) sought to classify psychotherapies according to dominant function addressed by the therapy:

Thinking = *Informational/cognitive*; includes psychoanalytic, rational-emotive, educational, and transactional approaches to psychotherapy.

Intuition = *Symbolic/intuitive*; includes those approaches to psychotherapy which emphasise phantasy (sic), meditation, brainstorming, or any other technique that attempts to transcend the rules of reason or sensory input.

Sensation = *Sensory/experiential*; includes most occupational, Gestalt, bio-energetic, and behaviour modification therapies.

Feeling = *Confrontation/conative*; includes encounter and T-group modalities, classical supportive-ventilative procedures, and the client-centered approaches of Carl Rogers (pp. 320-322).

Witzig surveyed 102 professional therapists in practice in mental health clinics in Oregon. He described one client as an introvert and one client as an extravert and then asked the therapists to assign the two clients to either individual or group therapy.

Group therapy was the treatment of choice for both introverted and extraverted clients. The therapists seemed to take a compensatory attitude toward the introverted clients by assigning even more of them to group therapy than they did the extraverted clients.

The second task Witzig planned was for the therapists to assign each of four hypothetical cases (a thinking dominant client, an intuitive, a sensor, and a feeling dominant client) to the four categories of therapies: (1) informational/cognitive; (2) symbolic/intuitive; (3) sensory/experiential; and (4) confrontational/conative. There was no stipulation to use all four categories. He made no mention of Jung or psychological types on any part of the questionnaire. After assignment of cases to therapies, therapists were asked to rank order the four case descriptions according to the one most to least like themselves. Of the 102 therapists, only 4% assigned all four types of clients to just one approach, 8% selected only two modes, while 44% elected to use three approaches and 44% selectively assigned the hypothetical clients to all four of the proposed modalities of psychotherapy (p. 326). In the actual assignment of clients, therapists assigned significant numbers of thinking types to the informational/cognitive mode (43%) and intuitive types to the symbolic/intuitive mode (42%), but neither sensation nor feeling type clients were assigned in significant numbers to their respective hypothesized modalities. He stated:

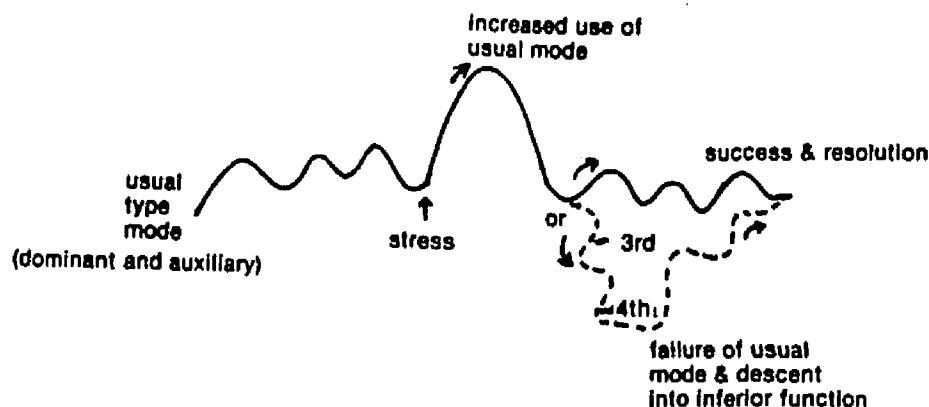
This investigation in general suggests that responding subjects were supportive of clients in terms of function type, compensatory with regards attitudinal type, yet not particularly dominating of therapy with their personal typological bias (Witzig, 1978, p. 327).

Witzig speculated that a considerable part of therapeutic failure is due to the mismatch of the patient's dominant function with the orientation emphasized in the psychotherapy used. If the converse were also true, that successful therapy usually constitutes a match between client type and class of therapy, then therapists of incest survivors in this study would be expected to have used methods of treating client anger and facilitating client

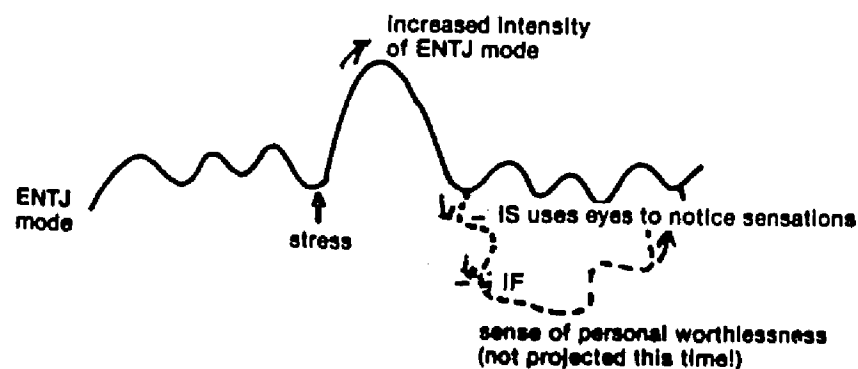
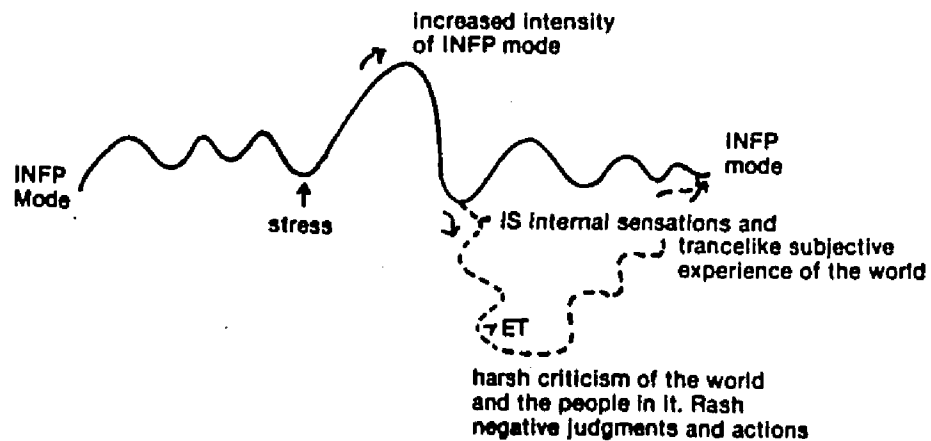
coping that would match the dominant functions of their individual clients without specific knowledge of Jung's theory of psychological type.

On the other hand, Allen (1985) found that there may be a tendency for individuals to prefer a mode of therapy which encourages the use of the opposites of the most frequently used preferences. She surveyed 34 former clients of college counseling centers about their perception of the effectiveness of counseling and their therapists regarding which of the following modes of therapy was used as the primary approach with each client: depth, perceptual, or behavioral. Significant interactions ($p < .05$) were found between type and therapeutic approach in two separate analyses. The results must be treated with caution because of the uneven distribution of types and therapies and the small number of subjects in some of the cells. However, it is possible that anger treatment strategies that incest survivors found to be effective will match their least favored function rather than their dominant function.

Dopson (1986) reported on the process of the clients in his practice of psychiatry. He observed that they try first their dominant function when confronted by a stressful circumstance, and if that does not result in resolution, that they descend through the functions, as diagrammed below:



Specific cases of the process for an INFP client and an ENTJ client are as follows:



Dopson's recommendation for therapy with anyone in stress is to be able to facilitate their work with their dominant function and to be able to help them stretch to make better use of their inferior function, should the inferior function be needed to resolve the conflict.

In the stretching process, the introvert, of any type, will ultimately need to practice the fourth function in an extraverted manner. Extraverts will need to use theirs in a quiet, reflective manner for growth. P's can accomplish tasks for growth and play for support. The J's can organize for support and learn to be playful for growth (Dopson, 1986, p. 34).

His specific catalog of what has worked for him follows:

	Support	Stretch
SENSING	Here-and now techniques Gathering facts either internally or externally Validation of sensory data Pleasant guided imagery of places or events they have known, coupled with slow abdominal breathing can help get them out of their negative intuition with its dark foreboding ES--noticing reality IS--pleasant memory	The act of struggling to catch the pattern in what has appeared to be random data Diagrams Keeping diaries of experience to piece together Encourage small risks based on their hunches Encourage wild guesses about another person in a group Art therapy and psychodrama can help sensing types put "2 and 2 together" experientially
INTUITION	Two-chair Gestalt work Any therapy that seeks patterns: psychoanalysis, TA, RET, Gestalt, dream work, guided imagery	Sensory work creates amazement Discovering principles of simplicity and enjoying the face value of anything = rebirth Grief therapy for saying goodbye to myths and romances about life to get on toward living the realities of the world
THINKING	Logical reflection and problem-solving Cognitive explanations will remind them of cause-and-effect and of their competence	Simple unritualized touch Complimenting self and others Group therapy for feeling work
FEELING	Validation that their values are important Regular compliments, words of support Warm, caring, and understanding therapist	Slow, careful examination of their logical sequencing of cause and effect Assertiveness training Learning the art of constructive criticism

This study will collect data about recovering from a severely stressful event and may provide some further empirical verification of Dopson's observations.

MBTI correlations with stress. Spencer, Carskadon, and Thorne (1986) tested over 1,000 college students for Type A-B behavior patterns using the Jenkins Activity Survey and found J's to be significantly overrepresented among males but not females and T's to be significantly overrepresented among both males and females. Type A's were significantly more likely to be ESTJ and ENTP, and Type B's were significantly more likely to be ISFP, ESFP, and INFP. The authors were cautious about generalizing their results to other age groups, but they were respectful of the research that links Type A behavior with coronary heart disease. They wondered if the MBTI can be a useful predictor of people at risk for coronary heart disease.

Fyfe, Carskadon, and Thorne (1986) surveyed a group of coronary heart disease patients, some of whom were members of The Mended Hearts, Inc., a support group for heart disease patients. They compared the heart disease patients with the Myers high school samples (the most widely used simulation of a national stratified random sample) and with an age-matched sample of 939 subjects constructed from the CAPT data bank. ISTJs and ISFJs were clearly overrepresented among the patient group, while ESTPs, Es, Ns, INs and ESs were clearly underrepresented when compared with the high school samples. In the comparison with the age-matched group, the patients who were ISTJ, ISFJ, ISTP, ESFP, SF and IS were significantly overrepresented, while INTJ, ENTJ, NF, NJ, and Ns were significantly underrepresented. The authors see the current popularity of the MBTI as a powerful screening device to prevent heart disease, the number one cause of death among adult Americans. They recommend education for prevention of risk factors such as smoking, drinking, inappropriate diet, inadequate exercise, mental stress as well as medical supervision for *all* types who want to avoid heart problems, and for IS-Js in particular. Darnell and Hammer (1987) also found an overrepresentation of SJs in a sample of men who had

been identified as high risk for heart disease. ISTJs accounted for 32% of the sample.

Roberts and Roberts (1988) administered the MBTI eight weeks after surgery to 121 individuals who had undergone coronary bypass surgery for the treatment of coronary heart disease. They compared the distribution of types with the Myers high school samples and also with a sample of 596 healthy, age-matched subjects. SJs were overrepresented and Ns were underrepresented among the heart patients, regardless of gender. The following four types accounted for 67% of the total sample of heart patients: ISTJ, ISFJ, ESFJ, and ESTJ. The authors found their results consistent with those of Fyfe, Carskadon, and Thorne (1986). They advocated prevention in the form of type development; "...the intent of any intervention should be to assist the individual in learning how to assert the non-preferred attitudes and functions so as to avoid stresses associated with excessive or rigid reliance on the preferred ones" (p. 12).

Miller and Cooley (1981) used the MBTI, health locus of control, and optimal stimulation level to measure moderator variables for the relationship between life change and the occurrence of disorders. They used a college sample of graduate and undergraduate psychology students at Oregon College of Education. Between number of events and number of disorders, the correlations were significant for I, T, F, and J and for the combined scales ET and IF. This study is methodologically flawed because the authors do not consider all combinations of type scales systematically. They compared rational with irrational functions and developed a rationale for rational functions as moderator variables, but they did not address either the practical consideration that the T/F scale selects every subject in their sample or the implications for treatment of their findings.

Schneider (1988) attempted to build on the research that accepts the notion that personality factors interact with social support to influence how effectively an individual

utilizes the supports available. She administered the MBTI, the Rotter Internal-External Scale, the Tennessee Self Concept Scale, Revised, and the IPAT Anxiety Scale. She used the natural stress of entering doctoral level graduate study in Clinical Psychology for 36 graduate students at the Florida Institute of Technology rather than manipulating an analog of situational stress, and her results showed that locus of control was more closely related to anxiety and self-concept than psychological type was, although in general, the Introverts had lower anxiety and higher self-concept than the Extraverts.

Perhaps the most important study on type and stress was done by Hammer (1989). He attempted to identify those types who might be more vulnerable to the negative outcomes associated with stress by focusing on antecedent variables. He used the MBTI and the Coping Resources Inventory (Hammer and Marting, 1988) to collect data from 4 groups: 61 counselors and peer counselors from a midwestern university counseling center; 112 Danforth Associates, who are university faculty, and their spouses; 27 MBA students in a leadership class at a large urban university on the West coast; and 21 adults from a MBTI workshop. Hammer's results found significant correlations between Extraversion and Social, Emotional, and Total resources, and between Feeling and Social, Emotional, and Total resources. There were no significant correlations of resources with SN or JP scores in any of the samples, although there was a trend toward Js scoring higher on Spiritual/philosophical resources in three of the samples. The type table of Hammer's sample groups [Table 1], the chart of relationships between Coping Resources and MBTI continuous scores [Table 2], the rank ordering by dominant functions by mean Total resource score [Table 3] and the rank ordering of individual types of the associates sample by mean Total resource score [Table 4] and the summary of resources by type table [Table 5] are shown below in **Appendix A.**

Hammer did not assume generalizability of his results, but the consistency among three of the four samples lead him to advocate the use of type/coping resource associations to counsel people for increased coping with stress.

The results have implications for helping individuals in coping with stress. In general, special attention may need to be directed toward identifying Introverts who may not be coping well and in helping them develop effective coping strategies and resources. This may be especially true for the INTPs and the ISTJs, who ranked the lowest on Total resources. Thinking types in general ranked low on resources compared to Feeling types. Using the coping resources model, clinical experience has suggested that interventions aimed at helping individuals deal with stress be directed toward helping them identify and bring into use their high resources. In general, beginning with the lowest resources first may prove ineffective and frustrating and therefore add to the stress. (Hammer, 1989, p. 9)

The current study will extend the use of the Coping Resources Inventory and the MBTI to the population of adult incest survivors. Results should show either confirmation or disconfirmation of Hammer's rank ordering and of Hammer's summary type table of preferred coping resources for each type. It is also expected that evidence of reinforcing preferred coping resources will be found in the reports of therapists about their treatment models for addressing the anger of their clients. If there were instances where therapists tried to encourage low preference resources and thereby induced more stress or more anger in their clients, it is expected that those instances would be reported anecdotally in the interviews with survivors.

MBTI and psychiatric populations. Bisbee, Mullaly, and Osmond (1982) administered the MBTI to 372 psychiatric inpatients who were diagnosed as depressed, schizophrenic, substance abusing, or bipolar-manic. The inventory results were obtained during early hospitalization in the relatively acute phases of the illnesses. Compared with the Myers high school samples and a sample of high school juniors and seniors from the CAPT data bank, the authors found the following types overrepresented in each of the patient groups:

	<i>N</i>	<i>Type</i>
Total Patient Group	372	ISTJ, ISFJ, ISFP overrepresented
Depressed Patients	198	ISTJ, ISFJ, ISFP overrepresented
Schizophrenics	110	ISTJ, ISFJ, ISFP overrepresented
Substance Abusers	35	ISFJ, SJ overrepresented
Bipolar-manics	29	INFP, ENTP, ESFJ overrepresented

Implicit in this study is the assumption that MBTI results are meaningful when collected from an unstable population as opposed to a healthy population on which the instrument was normed. The present study avoids the risk of that assumption by administering the MBTI to a post-treatment sample. An implication for the present study from the Bisbee, Mullaly, and Osmond (1982) work is that the MBTI questions are not harmful to a psychiatric population and can be ethically administered to a post-treatment group without expected ill effects.

Luzader (1984) administered the MBTI to 359 substance abusers and 237 family members of substance abusers in a 4 week outpatient program in Austin, Texas. The MBTI is a part of the educational program for both patients and family members, focusing on the constructive use of differences. In this group, comparisons were made between patients and the Myers high school samples, between family members and the Myers high school samples, and between patients and family members. Male patients were more likely to be IN, IJ, IS, and IP with ISTJ, ISFJ, INFJ, INTJ, ISTP, INFP, and INTP overrepresented. Female patients were more likely to be IN, and NP with INFP, INTP, and ENTP overrepresented. Male family members who were ISTJ and INFJ were overrepresented. Female family members who were ISTJ, INFJ, INTJ, INTP, and ENTJ were overrepresented. Luzader did not imply that her results may

reflect types in the actual substance abusing population. She was more enthusiastic about using the MBTI as a tool for treatment, encouraging communication with family members and self understanding. She quoted two patients who reflected on their learnings about type: "When I'm in a conflict situation, I internalize my feelings. When I could not handle the pain that resulted, I would drink." "It's the inner world that chemicals change" (Luzander, 1984, p. 61).

Emanuel and Harsham (1989) reported MBTI results from another sample of 342 substance abusers voluntarily in treatment in an inpatient program in Dayton, Ohio. ISTJ, ISFJ, ISTP, and ISTP patients were overrepresented. The authors did not answer their initial question, "Is there an addictive personality?" However, they pointed out that Alcoholics Anonymous and all 12-Step recovery programs require a great deal of Extraversion and Judging behavior. They also counseled using the MBTI for understanding of differences, and they advocated further research on possible correlations between patient's type and chemical of choice.

These studies on type profiles of substance abusers are illustrative of clinicians making adaptations of treatment to fit the type of the individual as well as using knowledge about type as a teaching tool for the patients and their families. The present study does *not* ask the question, "Is there an incestuous personality?" Determining frequencies for some sort of comparison with the general population frequency estimates would require a much larger sample of incest survivors than this study will collect. The present study will go beyond the substance abuse studies in investigating a specific treatment issue (anger) and the type-related coping resources of each survivor.

Research on Adult Incest Survivors

Historically, the early research on adult survivors of incest first focused on demographic descriptions of the survivors and characteristics of the abuse (Herman and Hirshman, 1981; Courtois, 1979; Meiselman, 1978). Next, efforts were made to counter arguments that the abuse had no effect (Fromuth and Burkhart, 1989; Gregory-Bills, 1989; Roland, et al., 1989; Briere and Runtz, 1988; Lance, 1988; Wheeler and Walton, 1987; Fromuth, 1986; Scott and Stone, 1986; McCord, 1985; Tsai, et al., 1979). These researchers established overwhelmingly the link between the experience of abuse and a variety of negative consequences requiring clinical intervention. Research on treatment of incest survivors is nearly nonexistent.

The effectiveness of treatment has not been demonstrated extensively. There is a single published outcome study of a treatment program in Canada (Jehu et al., 1988); a single study on the effectiveness of woman-centered rituals for female victims of incest, rape and battering (Jacobs, 1989); and a single unpublished dissertation with non-significant results attempting to show the effectiveness of an eight-week structured group treatment for adult survivors of child sexual abuse (Davis, 1988). There is no research on anger as a treatment issue. In her thorough review of the incest literature, Warner (1986) found no empirical support for the clinical wisdom that anger is a problem for incest survivors:

While anger is mentioned in case reports and clinical lore asserts anger as a common symptom in child and adult incest victims, there is little empirical evidence to support the presence of anger in adults. Anger does seem to be a problem for some incest victims, as it is mentioned in case reports. However, the actual prevalence of this problem and its association with incest remains unknown (Warner, 1986, p. 28).

Research and clinical literature on incest that has a bearing on the present study is summarized below. Relevant studies have demonstrated that incest survivors tolerate

without negative effects participating in research that involves the use of objective measures and face-to-face interviews. Some documentation can be found since Warner's work that anger is indeed a problem for incest survivors. Because there are so few research studies, the published clinical literature and some anecdotal reports of incest survivors will be summarized as well.

This study will be the first attempt in the incest research literature to provide empirical data from objective measures and interviews about the experience incest survivors have coping with anger before, during, and after treatment. In her theoretical article on coping with victimization, Wortman (1983) defined coping to include a variety of dimensions: (1) absence of psychiatric symptomology or extreme emotional distress; (2) the presence of positive emotions and well-being; (3) good physical health; (4) effective functioning; (5) global or general quality of life; and (6) effective coping as defined by the victim (i.e., the extent to which the victim feels that he or she has recovered from the crisis). She noted that researchers have found it difficult to evaluate how well a victim is coping by applying specific criteria such as "freedom from emotional distress" and suggests an alternative method. She suggests creating victim norms and then comparing a person's response with the normative data indicating how others react when they are exposed to the same crisis (p. 216). It is the intent of this study to do just that. There are no incest survivor norms on the STAXI or the CRI, and having these results for comparison may be more useful to clinicians than having the information about incest survivors' results compared to the "normal" norm groups on the instruments.

Methodology using interviews and objective measures. There is some support gained from interviewing survivors for the notion that better trained mental health professionals are needed. Armsworth (1989) found from interviews with 30 adult

female incest survivors from a midwestern urban area who were solicited through private practitioners, a women's agency, and community groups that they had sought help from 113 professionals and spent an average of 36 sessions (9 months) in these helping relationships. Professionals included school counselors, agency counselors, psychiatrists, psychologists, social workers, ministers and priests, pastoral counselors, peer counselors and support group and therapy group facilitators. The women, who reported 45 separate abusers with 10 women reporting multiple abusers, rated as harmful the following practices or attitudes of the professionals they had seen: (1) blaming the victim; (2) lack of validation; (3) negative or rejecting responses; and (4) exploitation or victimization of the client. Sexual involvement with the person in the helping role was reported by 23% of the sample.

Frenken and Van Stolk (1990) reported the results of interviews lasting approximately two hours of 130 professionals and 50 adult women who had been abused by a member of their family, either nuclear or extended, in The Netherlands. Professionals included social workers, clinical psychologists, psychiatrists, pediatricians, child protection agents, general practitioners, and volunteer counselors of women's self-help groups. The women were volunteers recruited from articles in each of two national Dutch newspapers. Beginning with the first professional to whom the victim mentioned openly for the first time her incest history, 38 of the 50 women consulted a second professional; 29 a third; 21 a fourth; 12 a fifth, 7 a sixth, and so on up to one woman who reported she had seen 9 professionals. These women had consulted an average of 3.5 professionals over their treatment history, which the authors call the "long march through the consultation rooms". By the third professional, incest had become the most important presenting complaint for 21 of the 29 women and psychosomatic presenting complaints disappeared altogether. The authors found about

half of these women to have had satisfactory therapeutic contact eventually. A major complaint was that over half of the professionals they consulted did not delve further into the issue of incest once it was explicitly mentioned by the women. 10 percent of the women mentioned spontaneously during the interview that they had experienced either actual sexual abuse by a professional or explicit attempts toward sexual abuse. During the three years prior to the study the 130 professionals had seen a total of 790 adult victims who had been abused in their childhood. In only 10 percent of the cases was the incest experience the presenting complaint. 75 percent of the professionals recognized shortcomings in their therapeutic knowledge about incest treatment and 67 percent recognized a skill deficit. Four categories of disturbing emotions were reported by the therapists: (1) Anger towards the perpetrator; (2) Embarrassment and disgust; (3) Strong identification with the victim; and (4) General feelings of being powerless and overwhelmed. The authors do not suggest that their results generalize to other countries. They present their findings as an opportunity for professionals in the international treatment community to do self-assessment. Implications for the present study are (a) that interviews with a volunteer sample adult incest survivors can be productive and (b) that information from interviews with therapists can provide a learning opportunity for other therapists.

Peters, Wyatt, and Finkelhor (1986) recommended face-to-face interviews for data collection from sexual abuse survivors. Wyatt and Peters (1986b) believed that the interview method was effective because face-to-face interviews prevent underreporting in prevalence studies and because the rapport building process in an interview facilitates the comfort and well-being of the survivor when discussing his or her victimization. They further liked the opportunity within the interview format to clarify misperceptions subjects might have and to pursue attributional idiosyncracies of the subjects that might

distort the data. They preferred that care be given to choice of location for the interview and that subjects have the assurance that they will be given a private and nonjudgmental setting. It is the intention of the present study to follow their recommendations.

Courtois (1988) found the interview process to be of therapeutic benefit to the incest survivors she interviewed. They "expressed relief at having discussed their incest in a structured interview format," and they felt understood in the "various dimensions and complexities" of their experience because of the informed questions that were asked (Courtois, 1988, p. 147). Courtois' "Incest History Questionnaire" was consulted when devising the demographic questions for the survivors in this study.

The fact that adult incest survivors can tolerate objective measures that address somewhat sensitive subjects was demonstrated by Cole and Woolger (1989). They recruited 40 female sexual abuse survivors, who were mothers, through local media. Twenty-one of the women were abused by their fathers (17 natural and 4 step), and 19 were abused by men who were unrelated. The women were asked to complete an interview on the demographics of their sexual abuse and the construction of their family of origin and three objective measures: (1) The Children's Report of Parental Behavior Inventory, which consists of 48 items for each parent which the subject rates on a three point scale as like or not like the parent; (2) The Parental Attitudes Research Instrument, a 78-item questionnaire in which respondents agree or disagree on a four point scale with statements about child rearing; (3) The Marital Satisfaction Inventory, a 280-item questionnaire which reports scores for 9 scales--Affective Communication, Problem-Solving Communication, Time Together, Disagreement About Finances, Sexual Dissatisfaction, Role Orientation, Family History of Distress, Dissatisfaction With Children, and Conflict Over Child Rearing. Results from this volunteer community sample showed that the incest and nonincest groups did not differ on the

scales reflecting marital discord about parenting. Incest survivors had more negative perceptions of their parents and supported more autonomy in their own children than the nonincest child sexual abuse survivors. The authors claim that their sample "has the advantage of not being skewed toward maladjustment as do clinical samples" (p. 411). They discovered that half (52.6%) of the women in their sample had been to therapy. In the present study, the safety factor of being linked with a therapist in their community already will put these volunteers less at risk than the Cole and Woolger sample, even if it were argued that these volunteers are potentially less stable because they are all formerly a clinical sample. The test items on the MBTI, the STAXI, and the CRI do not appear to be any more traumatizing than questions about parents, children, and marital satisfaction.

A study of 43 adult female survivors of incest in a clinical sample was conducted by Armsworth (1984). She wanted to assess the utility of the Post-Traumatic Stress Disorder (PTSD) diagnosis on this population. The women completed an incest history questionnaire, the Impact of Event Scale, the Coping Inventory, and the Beck Depression Inventory as well as an original research instrument, the Themes Following Stressful Events Questionnaire. The Impact of Event Scale and the Coping Inventory were administered for three time frames: (a) immediately after the incest ended; (b) prior to seeking help or therapy; and (c) during the past seven days. Results showed that the incest survivors in this study did fit the diagnostic criteria for PTSD. The four common themes that received the highest endorsement from the subjects were feelings of vulnerability, rage, loss, and fear of loss of control over aggressive impulses. These subjects were able to own feelings of rage and aggression and comment on their depression and coping strategies, tasks that compare to what is being asked of subjects in the present study.

Anger described by anecdotes from survivors. Incest survivors themselves are eloquent in articulating their feelings of anger. They have identified anger as a problem and have experienced focusing the anger on their abusers as a positive step in recovery. The following quotations are from published accounts in the self-help and clinical case study literature:

I was very angry, cried all the time, was extremely impatient and felt like I was going to explode all the time. There were days when I thought the top of my head was going to blow off (Vicki, in Donaldson, 1983, p. 24).

My fury circles back inside of me, hitting me with myself. I take it out on my body, slashing and pushing, unable to be gentle. The anger crowds out softness, making me rough and hard (Wisecchild, 1988, p.122).

During recess, huddled in some sheltered corner of the schoolyard, out of the wind, I'd nurse the big bubble of anger that seemed to fill my chest completely; I visualized acts of revenge and bitterly relished images of myself brandishing a knife or a gun, seeing my father cowed and fearful; seeing myself take the big bread knife from the kitchen to stab him to death. I experienced an overwhelming sense of relief at the projections of this image, a powerful rightness to the act. I wanted him dead. Or I wanted him to turn into a father and love me (Allen, 1980, p. 83).

It left me with huge stores of anger which all too often were randomly vented on the world around me (McNaron and Morgan, 1982, p. 13).

Our anger is a healthy and valid response. It means we have finally placed responsibility for the abuse on the abuser. We begin to respond to it by talking more about what we can do for ourselves. This is a subtle change from passive (victim) to active (empowered). Ironically, we get our real power when we accept that we were powerless over our abusers and focus our powers on ourselves. This is the start of healing. In all of nature, the phenomenon of healing is the same; it is literally new growth. There is no shortcut to this process. The growth, the change happens as a response to the pain and anger we experience (Bronson, 1989, pp. 305-306).

I started to rage and the whole mental health department of Napa heard me, because I raised the roof. Everything came up. All the obscenities and everything were connected. The male assaults of me and my kids all went together. I had been intellectually angry at my father before, but this time I just blew. I just screamed my fury all over the place. I threw my glasses against the wall. I was just beside myself. I can't say that it felt good, but it was a turning point. It was so clear where the rage was coming from. It was the beginning of me not blaming myself (Barbara Hamilton, in Bass and Davis, 1988, p. 129).

It is the intent of this study to collect systematically from a broad sample of post-treatment incest survivors both anecdotal and objective information about their experience with anger before, during, and after treatment.

Conceptualizations of anger and treatment by clinicians. Three assumptions underlying successful treatment of incest survivors have been articulated by Gelinas (1983), p. 328: (1) *Whenever there is sexual contact between an adult and a child, it is always the adult's responsibility.* (2) *A child is intensely loyal to his or her parents, and that loyalty must be explicitly supported in treatment.* (3) *The adult is held accountable for the incest, but the therapist must never scapegoat, nor allow scapegoating.* These assumptions will be used as a basis for interviewing the clinicians in this study about their conceptualizations of anger as a treatment issue for incest survivors. Clinicians will be asked to agree or disagree with the assumptions about treating this population in general, and then they will be asked to add any other axioms of treatment with respect to anger in the recovery process for their clients.

In handbooks and articles about treatment of adult survivors of childhood sexual abuse clinicians have endorsed the notion that anger is an issue of treatment. Acknowledging the hate and anger toward one's abuser comes *before* forgiveness and is a necessary step in healing from abuse according to Alice Miller (1983).

Hatred is a normal human *feeling*, and a feeling has never killed anyone. Is there a more appropriate reaction than anger or even hatred in response to the abuse of children, the rape of women, the torture of the innocent--especially if the perpetrator's motives remain hidden? A person who has had the good fortune from the beginning to be allowed to react to frustration with rage will internalize his empathic parents and will later be able to deal with all his feelings, including hatred, without need for analysis. I don't know if such people exist; I have never met one (Miller, 1983, p. 261).

Bass and Davis (1988) labeled anger "the backbone of healing." They saw as symptomatic of repressed and unfocused anger either a survivor turning anger inward in bouts of depression and self-destruction or a survivor lashing out in anger against

partners, lovers, friends, co-workers, and children. They recommended to survivors directing their anger where it belongs, overcoming fear of anger, and practicing safe expressions of anger. They offered an extensive catalog of suggestions for expressing anger positively:

- Speak out.
 - Write letters (either to send or purely for the chance to get your feelings out).
 - Pound on the bed with a tennis racket.
 - Break old dishes.
 - Scream (get a friend to scream with you).
 - Create an anger ritual (burn an effigy on the beach).
 - Take a course in martial arts.
 - Visualize punching and kicking the abuser when you do aerobics.
 - Organize a survivors' march
 - Volunteer at a recycling center and smash glass.
 - Dance an anger dance.
- (Bass and Davis, 1988, p. 129)

Abusive anger and the potential for violence were addressed by Bass and Davis. Steele and Colrain (1990) were also respectful of the violent potential in their clients:

It is useful to assess the ways in which the client generally manages anger within the context of his or her life and to build on appropriate management skills. If the client has a history of violence, the therapist should be aware that rage reactions may be especially intense, and issues that trigger anger should be approached slowly and with caution. Clients often fear their own anger; it feels overwhelming and bad. These issues must be addressed cognitively as well as experientially in the context of the therapeutic relationship. The therapist must give permission for the client to be angry, while setting limits on destructive behavior toward self, others, or property. Appropriate limit-setting will be reassuring to clients who fear their own rage (Steele and Colrain, 1990, p. 35).

Forward and Buck (1978) saw anger as the first essential stage of treatment and suggested psychodrama as an effective way to externalize anger during treatment. Courtois and Leehan (1982) found group process to lend itself to teaching safe expression of anger for the groups of formerly abused college students they described. Agosta and Loring (1988) had a treatment goal not to get rid of anger but instead to accept strong emotions as part of oneself and to find safe ways to vent it. They saw the therapy group as a safe place to practice expressing anger, and they also suggested self defense training and wilderness therapy as adjuncts during the treatment process. Maltz and Holman (1987) also endorsed constructive expression of anger as a treatment goal

but spent more time in their book talking about the anger of the partner of the victim than the victim's own anger. Mayer (1983) stated that anger catharsis was a major therapeutic goal for adolescent and adult survivors of incest, but she offered only one suggestion for working anger through (writing an angry letter to the abuser) in her list of over sixty activities and exercises for therapy with survivors.

Two presentations with respect to anger were observed by Leehan and Wilson (1985) in their experiences with support groups for the "grown up abused children" they treated. Either the survivors denied their ability to feel anger, or they became immobilized from their consciousness of their anger. "They believe that if they were ever to begin to express the deep feelings of anger, resentment, and hatred, they would never be able to stop. They feel the emotion so strongly that they believe the only way to be safe is to totally suppress it, to remain rigidly, adamantly in control" (Leehan and Wilson, 1985, p. 17).

Assessing the presence of anger as a diagnostic aid to reveal undisclosed incest was mentioned by Blume (1990). She included anger on her assessment tool "The Incest Survivors' Aftereffects Checklist," a 34 item checklist she put together to help her clients become aware of childhood sexual abuse when none is remembered. The anger item is "Anger issues: inability to recognize, own, or express anger; fear of actual or imagined rage; constant anger; intense hostility toward entire gender or ethnic group of the perpetrator" (Blume, 1990, p. xvii). Donaldson and Gardner (1983) wrote seven items dealing directly with anger to assess "reaction to the perpetrator" and "anger and betrayal" as themes of incest in their 52-item "Responses to Childhood Incest: A Tool for Self Assessment" questionnaire. Their assessment tool was intended to help focus on which themes of incest recovery and which post-traumatic stress symptoms were most troublesome to their clients presenting for treatment. Their seven anger items are as

follows:

- When I think about the incest I feel very angry.
- I feel so angry about the incest I would like to hurt the one who abused me.
- I feel angry toward men.
- I feel there is so much anger inside of me that I could explode.
- I feel angry that someone didn't help me sooner regarding the incest.
- I feel angry about the incest and blame my mother for not protecting me.
- I feel angry about the incest and blame the man who abused me.

The items were designed to be administered to female victims of male perpetrators and are untested as a measure of treatment outcome (Edwards and Donaldson, 1989) so will not be used in the present study.

Physical symptoms indicating the presence of unresolved anger were listed by Tower (1988): headaches, stomach problems, skin rashes, asthma, eating disorders, alcohol dependency, and drug addiction. Tower's suggestions for safe ways to deal with anger follow: meditation, running, handball, tennis, screaming into a pillow, jogging in place, karate, assertiveness training, stress management techniques, and relaxation techniques. Sargent (1989) also saw evidence of internalized anger in self-hatred and self destructive behaviors such as substance addiction, eating disorders, prostitution, and suicide attempts. Schetky (1990) found in her review of the literature of long-term effects of childhood sexual abuse two to seven times as many suicide attempts made by adult survivors of incest than by non-abused controls in clinical populations. She also noted a gender difference in how the abuse is handled: "It has been noted that females tend to suppress their anger and turn it inward, whereas male victims may direct their anger toward others or identify with the abuser" (Schetky, 1990, p. 48).

Other conceptualizations of anger as a treatment issue include the functional use of anger by survivors as a distancing technique to avoid the vulnerability of intimacy as

noted by Sgroi and Bunk (1988). McCann and colleagues recommended a cognitive treatment of anger by challenging a survivor's negative schemata and teaching, "I can trust myself or my feelings" (McCann, et. al., 1988, p. 98). Gelinas (1988) cautioned therapists against siding with the survivor's anger:

Underneath all those legitimately angry statements lies loyalty, and heaven help the therapist who, in a mistaken attempt to gain rapport or to ignite an accusation from a depressed, dispirited victim, has sided with the victim's anger toward, or repudiation of, the offender. The inevitable result will be that the victim will rush to defend the abuser and will lose confidence in the therapist (Gelinas, 1988, p. 35).

Courtois (1988) made a case for therapists and survivors developing creative and individualized methods for dealing with anger:

For example, one of my clients likes to break pencils or shred magazines during sessions when she experiences a lot of anger. She selected these methods because she likes the sounds they make (Courtois, 1988, p. 209).

Courtois also discussed at length the issue of transference and countertransference with respect to anger during treatment. She recognized the temptation of the therapist to distance from the survivor when rage emerged during therapy:

Because women are more likely than men to inwardly focus their anger, it is commonly expressed in disguised forms, such as passive-aggressive behavior, depression, manipulateness, anxiety, and somatic complaints. Quite often, the survivor vents it against herself through self-blame, self-contempt, and self-defeating and self-abusive behavior. This containment and misdirection of anger can lead to frighteningly intense rage with explosive potential, accompanied by anxiety and panic about discharging and controlling the feelings. Rage of explosive proportions is frightening for the therapist, who might respond with distancing and rejection. A more therapeutic strategy is first to accept and legitimize the anger and then to assist the survivor to regain some control and to discharge the anger in nonharmful ways (Courtois, 1988, p. 229).

She also recognized that a mishandled transference of rage can result in premature termination of therapy, an essential revictimization of the survivor:

Any projection of rage and other negative emotions onto the therapist either through the transference or as a challenge to the therapist's caring, may elicit fear and rage reactions in response. She may be enraged at being identified as an authority figure to be challenged and as a potential abuser to be feared, especially if she has made exceptional efforts to engage the

client and to prove trustworthiness. In some instances, the intensity of the survivor's rage may be overwhelming for both client and therapist. The therapist's inability to tolerate the client's projected rage and negative transference reactions or to understand and cope with his/her own can ultimately lead to a distancing from and rejection of the client and a premature termination of the therapy (Courtois, 1988, p. 234).

Blume (1990) described four distortions of anger that occur during the incest survivor's probable long term process of dissociating anger from the events that caused it: (1) the inability to recognize, own, or express anger; (2) constant anger; (3) displaced anger; and (4) disproportionate anger. She conceptualizes anger as healthy when the energy of anger is used to create change:

Anger is healthy, although a critical, attacking, demanding person is not dealing with anger properly, and a person who lashes out in rage is not. But in anger is power, and with power can come change, energy, and strength. The first step toward a healthy attitude about anger is for the incest survivor to recognize when she is angry. She needs to be able to say, "I'm mad," to *feel* anger and attach a label to it (Blume, 1990, p. 142).

The next step in learning to deal with anger, in Blume's opinion, is facing anger in the past; connecting current anger to its cause is the third step; and finally, learning from one's anger by taking note of angry reactions and probing the meaning of such events complete the process. "Emotional health is being able to deal with the gray areas, even in relation to feeling wronged" (Blume, 1990, p. 144). Blume pointed out that there have been few good role models for healthy, non-abusive anger expression for most people and that socialization does not reinforce openness about anger. Her point has been supported by Lynch (1991), Lerner (1985), and Kaplan (1976), who hold that comfort with one's anger may be a particular challenge for women, given the cultural stereotypical role expectation for accommodation and non-assertiveness.

These conceptualizations about anger in the clinical/case study literature were helpful in formulating the interview questions for the clinicians in this study. This study goes beyond each individual published account above because the data base for those handbooks and articles was the person's own case load. This study will summarize data

from survivors who were part of many different therapists' case loads, focusing on anger as a treatment issue during the course of therapy for the incest.

Anger experienced by survivors and reported in research studies.

Donaldson and Gardner (1985) surveyed 27 women who were incest survivors in a clinical sample of convenience and found that 70% of them felt angry when they thought about the incest; 65% felt fearful that they would get so angry they would not be able to control their actions; and 45% felt guilty that they were so angry about the incest.

Briere and Runtz (1987) found that 44% of the 152 women they studied who requested crisis counseling appointments at a local community health center had experienced self-reported sexual contact initiated by someone five or more years older than she was before the age of 15. They compared the abused women with those who had no history of childhood sexual abuse and found that the abused group to be significantly more angry, more dissociative, more tense, and to have more sleep disturbances and sexual difficulties than the non-abused group, based on a factor analysis of the Crisis Symptom Checklist, an earlier version of the Trauma Symptom Checklist (TSC-33) constructed by the authors. The authors and their colleagues administered the TSC-33 to 40 male and 40 female crisis center clients half of whom had a self-reported history of childhood sexual abuse and half of whom had no abuse history (Briere, et al., 1988). They found abused clients to have significantly more anger, dissociation, anxiety, depression, and sleep disturbance than the non-abused group, without significant differences between genders, despite the fact that females reported more extensive and more extended abuse than did males. Both abused males and abused females reported 50% incest and the same number of suicide attempts. The authors concluded with caution about the extent of generalizability that the effects of childhood sexual victimization appear to be the same for male and female survivors regardless of

any reported differences in severity or duration between genders.

Rieker and Carmen (1986) studied retrospective records of all psychiatric inpatients discharged during an 18 month period from an inpatient psychiatric unit in a university teaching hospital and evaluated them regarding length of stay in the hospital, type of abuse, and anger-aggression coping style. They found that "victims who were both physically and sexually abused were most likely to direct aggression against themselves in an uncontrolled manner (30.4%); victims who were sexually abused were next (10.0%); followed by victims of physical abuse (14.3%) and the nonabused patients (10.2%). Female victims, victims of sexual abuse, and patients abused by family members, all of whom were likely to turn their anger and aggression inward, had longer hospital stays than male victims, victims of physical abuse, and patients who were abused by people outside their families" (Reiker and Carmen, 1986, p. 362).

Clinical outpatients and inpatients who had histories of childhood sexual abuse, then were judged in these studies to have more problems with experience and expression of anger than non-abused clinical controls. The status of anger as a problem for community samples has mixed results.

Briere and Runtz (1990) found a correlation between reports of anger and aggression and physical abuse histories rather than sexual abuse or psychological abuse histories among the 277 undergraduate females they surveyed to determine differential symptomology. They found little overlap between physical and sexual abuse after controlling for psychological abuse in this non-clinical sample, and they cautioned that physical and sexual abuse may overlap more in clinical than non-clinical groups. The primary symptom they found for the psychological abuse victims was low self-esteem and the correlate for sexual abuse was dysfunctional sexual behavior as primary symptom.

On the other hand, Murphy et al. (1988) found that the adolescent sexual assault, adult sexual assault, and multiple sexual assault groups scored significantly higher on the hostility scale of the SCL-90-R than did non-sexual assault victim groups. The subject pool for this study was 391 female residents of Charleston County, South Carolina, who had been randomly selected in a telephone survey and who gave permission for follow-up contact and an interview.

These studies have found evidence that anger is related to sexual victimization, although none of them have pursued the extent to which anger impacts treatment. The present study extends current knowledge by measuring anger experience and expression on the most sophisticated instrument available (Spielberger's State Trait Anger Expression Inventory--STAXI) and by collecting data about type-related coping resources as well as the natural history of their experience with anger during treatment for each of the survivors.

Other Relevant Research on Anger

Andersen (1985) found that all current research on anger treatment looked at anger as maladaptive and that multifaceted treatment programs consisting of desensitization or relaxation training, stress inoculation and social skills/problem solving training were most effective. She also found that there was a need for more research on anger with clinical populations. This study will look at anger as a justified reaction to victimization and not necessarily maladaptive and will investigate that justified anger with an outpatient clinical population.

Schlosser (1986) studied the relationship between anger, crying, and health among two age groups of undergraduate females (90 17-19 year olds and 87 25-40 year olds) using Spielberger's Anger Expression Scale (measuring Anger-In and Anger-Out)

and also measures of State Anger, Trait Anger on an earlier version of what is now the STAXI. Schlosser found that there was a slight difference in Anger-In between age groups, consistent with Spielberger's norms that show less repressed anger as age increases. Schlosser was surprised to find no correlation of Anger-Out with any measure of adjustment. It does not appear that directing anger outward enhances health. Anger-In, on the other hand, was positively correlated with depression. "But if holding anger in is harmful and expressing it is not helpful, what is one to do?" (Schlosser, 1986, p. 6). Schlosser found a personality variable, hardiness, (based on Kobasa's, 1979, research defining hardiness to be composed of commitment to self, internal locus of control and a comfort with challenge and change) to moderate the effect of negative life events for his subjects and to moderate the effect of crying as well. "For example, hardy persons who cry feel worse, whereas less hardy persons who cry feel better (in terms of depression and well-being)" (Schlosser, 1986, p. 7). The present study investigates psychological type as a moderator variable in coping with anger in the recovery from childhood incest. It will be interesting to see whether Anger-Out has any positive influence in that recovery as reported by survivors and therapists and whether Anger-In is associated anecdotally with blocks to recovery.

CHAPTER 3

COLLECTION OF DATA

Sample Population

Selection criteria for incest survivors: Any adult male or female survivor of childhood incest (prior to age 18) who has received mental health treatment from a licensed professional therapist and is either (a) in the final phases of treatment and will be terminating therapy by mutual agreement with the therapist within the next few months, or (b) has terminated therapy by mutual agreement within the past three years.

Selection criteria for therapists: All therapists who are recommended by one of the 21 VAASA sexual assault crisis centers in Virginia because of their known skills in empowering women and men who have been sexually victimized as measured by positive feedback from clients as reported informally to VAASA center staff and volunteers. In some instances the therapist identified was the contact person for the practice. All therapists in the practice deemed expert in treating adult incest survivors were then included on the list of community identified experts.

This sample population represents a geographically diverse (rural and urban) mixture of people who have been successfully treated for childhood incest by community identified experts in treatment. They constitute a volunteer clinical sample and the data collected from them will be subject to the limitations in generalizability that might be expected from that sample.

Data Gathering

A battery of objective measures were administered to each subject prior to the semi-structured interview. The following order was chosen to proceed from less sensitive to more sensitive content and to prevent contamination from the early measures in subsequent measures: MBTI, CRI, STAXI-now, Outcome Measure, STAXI-before therapy, Type-Related Anger Questions. Incest survivors self-reported on the paper and pencil inventories and during the structured interview. Therapists first filled out objective measures about each of their clients and then reported demographic data about themselves, the extent of their training and experience working with incest survivors, and answered questions about their conceptualization of anger during therapy for incest survivors in general during their semi-structured interview. Interviews were tape recorded so as to be available for post hoc analysis of patterns and trends.

Instrumentation

Researcher constructed measures .

1. Semi-Structured Interview for clients including demographic data about incest and treatment.
2. Semi-Structured Interview for therapists including training and conceptualizations about treating anger in incest survivors.
3. Visual analog scale measuring subjective assessment of treatment outcome (same form completed by client and by therapist for each client). Each line on the scale is 100 mm. in length, and the marks made by both therapists and clients were measured to determine a numerical score for comparison purposes.
4. Type-Related Anger Questions (same form completed by client and by therapist for each client).

Standardized measures .

1. The Myers-Briggs Type Indicator (MBTI), form G, consists of 126 forced choice answers with an instruction set that does not demand answering every item. Items are scored into four discrete bipolar scales measuring (1) Direction of energy flow--*Introversion/Extraversion*; (2) Data-gathering method--*Sensing/Intuition*; (3) Decision-making method--*Thinking/Feeling*; and (4) Behavior seen by others as primarily data-gathering or primarily decision-making--*Judging/Perceiving*. Individuals receive a 4-letter indication of their psychological type based on their particular combination of preferences on each of the four scales. There are 16 possible type categories, arranged by convention in the following array:

MBTI Type Preferences

ISTJ	ISFJ	INFJ	INTJ
ISTP	ISFP	INFP	INTP
ESTP	ESFP	ENFP	ENTP
ESTJ	ESFJ	ENFJ	ENTJ

Internal consistency coefficients estimated by coefficient alpha for the MBTI data bank of $N = 9,216$ (288 of each type) are .83 for E/I; .83 for S/N; .76 for T/F; and .80 for J/P (Myers and McCauley, 1986, p. 169). Test/retest reliabilities are given in the manual for

intervals of 5 weeks to 6 years and are typically in the .75-.90 range for individual scales. The manual's range for all categories unchanged on retest is from 24% to 61% when retest ranges from 5 weeks to 6 years. Validity for the MBTI has been deemed acceptable after repeated reviews (Murray, 1990; Wiggins, 1989; DeVito, 1985; Carlson, 1985; Carskadon and Cook, 1982; Carlyn, 1977). Estimated time for administering the MBTI is 45 minutes. An eighth grade reading level is required.

2. The research edition of the State and Trait Anger Expression Inventory (STAXI) contains 44 items, each scored on a 4-point scale (*Almost never; Sometimes; Often; Almost Always* or *Not at all; Somewhat; Moderately so; Very much so*). Six scales and two subscales are formed to assess the following components of anger:

- State Anger (S-Anger): A 10-item scale which measures the intensity of angry feelings at a particular time.
- Trait Anger (T-Anger): A 10-item scale which measures individual differences in the disposition to experience anger.
 - Angry Temperament (T-Anger/T): A 4-item subscale which measures a general propensity to experience and express anger without specific provocation.
 - Angry Reaction (T-Anger/R): A 4-item subscale which measures individual differences in the disposition to express anger when criticized or treated unfairly by other individuals.
- Anger-In (AX/In): An 8-item anger expression scale which measures the frequency with which angry feelings are held in or suppressed.
- Anger-Out (AX/Out): An 8-item anger expression scale which measures how often an individual expresses anger toward other people or objects in the environment.

- Anger Control AX/Con): An 8-item scale which measures the frequency with which an individual attempts to control the expression of anger.

- Anger Expression (AX/EX): A research scale based on the responses to the 24 items of the AX/In, AX/Out, and AX/Con scales which provides a general index of the frequency that anger is expressed, regardless of the direction of expression.

Adult population norms for the STAXI were composed of 2,546 males and 845 females for the S-Anger scale and 2,880 males and 1,182 females for the T-Anger scales. A limitation of the instrument is that there are currently no adult female norms for the AX/Con scale or for the AX/EX scale. Spielberger found no significant gender differences in his norm groups on any of the scales, but the mean scores did differ by age group (lower scores as age increases for both males and females). He recommends that users interpret scores with specific attention to age of respondent, and he has divided the norm group by age for convenience in doing so. The reliability coefficient alpha ranges from .69-.91 for the adult normative population. Validity studies on the STAXI have verified the Spielberger's definitions of the constructs (Spielberger, 1988, pp. 12-14), and research continues at present on this "research edition" of the STAXI. Estimated administration time for the STAXI is 15 minutes, and a fifth grade reading level is required.

3. The research edition of the Coping Resources Inventory (CRI) is a 60 item questionnaire with each item scored on a 4-point scale to indicate how often the responder has engaged in the behavior described during the past six months (*Never or rarely; Sometimes; Often; or Always or almost always*). The directions emphasize the importance of answering every question. Items load on one of 5 scales identifying different resource domains that might be available to a person to mediate between

stressors and psychological and physical outcomes. The authors distinguish between coping strategies ("the things people *do* in reaction to a specific stressor occurring in a specific context") and coping resources ("precursors of behavior," "background factors," "those resources inherent in individuals that enable them to handle stressors more effectively") (Hammer and Marting, 1988, p. 2). Scales are defined as follows:

- COGNITIVE:** The extent to which individuals maintain a positive sense of self-worth, a positive outlook toward others, and optimism about life in general.
A representative item: "I feel as worthwhile as anyone else."
- SOCIAL:** The degree to which individuals are imbedded in social networks that are able to provide support in times of stress.
A representative item: "I am part of a group, other than my family, that cares about me."
- EMOTIONAL:** The degree to which individuals are able to accept and express a range of affect, based on the premise that a range of emotional response aids in ameliorating long-term negative consequences of stress.
A representative item: "I can cry when sad."
- SPIRITUAL/
PHILOSOPHICAL:** The degree to which actions of individuals are guided by stable and consistent values derived from religious, familial, or cultural tradition or from personal philosophy. Such values might serve to define the meaning of potentially stressful events and to prescribe strategies for responding effectively. The content domain for this scale is broader than traditional western religious definitions of spirituality.
A representative item: "I know what is important in life."
- PHYSICAL:** The degree to which individuals enact health-promoting behaviors believed to contribute to increased physical well-being. Physical well-being is thought to decrease the level of negative response to stress and to enable faster recovery. It may also help to attenuate potentially chronic stress-illness cycles resulting from negative physical responses to stressors that themselves become major stressors.
A representative item: "I exercise vigorously 3-4 times a week."
 (Hammer and Marting, 1988, p. 3)

Raw scores are converted to standard scores having a mean of 50 and a standard deviation of 10 points. Interpretation of the CRI profile can be either ipsative, where the

individual's own high and low resources are identified and affirmed or improved, or normative, where the individual's scores are compared to those of the norm groups. Hammer and Marting found that gender differences especially on the Social and Physical scales occurred, so they provided separate profiles and conversion tables for men and for women. Coefficients of internal consistency range from .71-.84, while test-retest reliabilities for a group of high school students after six weeks range from .60-.78 on the various scales. Satisfactory validity studies have been conducted (Hammer and Marting, 1988, pp.13-23), and further studies are in process because the CRI is still published as a "research edition." Estimated time for administration is 10 minutes. The CRI is not recommended for persons younger than 14 because of concepts in the Spiritual/Philosophical domain. A reading level requirement is not specified.

The clients in the sample self-reported on all three standardized measures. The therapists reported a rank ordering of the 5 coping resource categories for each client as part of the interview process as a means of verifying the CRI results for each individual. Clients self reported on the STAXI for two instruction sets: (1) "Yourself before therapy for the incest;" (2) "Yourself at present." Therapists reported on the 24-item Anger Expression Scale for each client under the instruction set: "When angry or furious, your client . . ."

See **Appendix B** for copies of the protocols of researcher constructed instruments used for both survivors and therapists.

Research Design

This study was designed to be descriptive in nature and to rely on retrospective self-report data from clients and therapists. The combination of semi-structured interview questions and objective measures were used to take advantage of the strength

of an interview situation, which allows for as much depth as the participant is willing to offer on the sensitive subject of treatment of the effects of incest, and also to limit the weaknesses of the interview format. Borg and Gall (1983) have stated,

The flexibility, adaptability and human interaction that are unique strengths of the interview also allow subjectivity and possible bias that in some research situations are its greatest weakness. The interactions between the respondent and the interviewer are subject to bias from many sources. Eagerness of the respondent to please the interviewer, a vague antagonism that sometimes arises between interviewer and respondent, or the tendency of the interviewer to seek out answers that support his preconceived notions are but a few of the factors that may contribute to biasing of data obtained from the interview (pp. 437-438).

The opportunity for comparison of interview data with objective data was intended to reduce the risk of bias in the interview process.

Specific Research Hypotheses

The following null hypotheses were tested:

1. There will be no difference between the amount of repressed anger reported by incest survivors and the amount of repressed anger reported by the norm group as representative of the general population as measured by the STAXI.
2. There will be no difference between the total coping resources scores of incest survivors and the total coping resources scores of the male and female adult norm groups as representative of the general population as measured by the CRI.
3. There will be no difference between the rank ordering of coping resources by type among incest survivors and the rank ordering of coping resources by type among other population samples as measured by the MBTI and the CRI.
4. There will be no difference between therapist report and self-report of incest survivors about the outcome of therapy as measured by the visual analog outcome scale.

Data Analysis

- Reports of frequency distributions of survivors in this study using the usual demographic categories were made using percents of the sample.

- MBTI type table distribution of survivors was prepared.

- Rank orderings of coping resources by type for this population sample were compared with the rank orderings found by Hammer (1989).

- A comparison of therapist report on the visual analog outcome measure with the outcome measure reported by clients was made by converting the measured distance in millimeters to numerical scores. A t-test was then used to determine whether a significant difference exists between the two measures.

- Comparison STAXI results with norm group results were made using t-tests. The State Anger before therapy scores were compared with the State Anger at present scores for the survivors, as were the Trait Anger scores for both time frames. Only the Anger-In and Anger-Out scores were compared with therapist report.

- CRI total coping resources results were compared with results from the norm group using a t-test.

- Type-Related Anger Questions were scored by type profile and were related to MBTI type profile for each individual to determine whether anger processing is more a function of dominant function or inferior function and to see whether patterns emerge regarding any of the dominant function groups or individual type groups.

- A list of suggestions for working with anger endorsed by both therapists and clients was compiled, and anecdotal comments from both clients and therapists relevant for increasing the knowledge of a therapist untrained in issues of incest treatment were included.

Ethical Considerations

The study was undertaken with fully informed consent of both therapists and clients. Incest survivors could elect to end their participation at any time. Efforts were made to protect the privacy and confidentiality of the incest survivors who participated in the study. The research data for each individual was assigned a code such that therapist/client pairs could be identified but such that people's names would not be visible on the test materials. The tape recorded interviews were identified by the same code as the written data. The availability of the counseling services of their therapists was intended to protect them should they have an emotional reaction to participating in the study itself. The researcher and her dissertation chair are both Licensed Professional Counselors and were available for emergency consultation to both clients and therapists during and following the data collection for the study. The mechanism of therapist nomination of client preserved confidentiality during the decision-making process about whether to volunteer to participate in the study.

The proposal was reviewed and approved prior to collection of data by the Committee on Research with Human Subjects in the School of Education at The College of William and Mary. The study was also supported in principle by the Board of Directors of Virginians Aligned Against Sexual Assault (VAASA). Sample letter to therapist, cover letter from therapist to client, letter to client explaining research, and mail back consent form and release form are shown in **Appendix C**.

CHAPTER 4

ANALYSIS OF RESULTS

Data collected from the semi-structured interviews of the client group covered demographic information, facts about the incest they experienced, a description of their experience with anger before they entered therapy for the incest, during therapy for the incest and at present, and suggestions they would have for other survivors just beginning to work through their anger about the incest. Data collected from the semi-structured interviews of the therapist group covered demographic information about their training and experience working with incest survivors, information about their assumptions about treatment of incest survivors and about their concept of anger as a component of treatment, information about countertransference they have experienced working with incest survivors, and finally, unanswered questions they have about treatment and directions they would like to see research on incest survivors take in the future. All interview data were analyzed for frequency in the demographic categories and for identifiable trends in the open-ended categories. Quotations were included to clarify and to convey an accurate sense of how the survivors and the therapists described their feelings and experiences. Data collected from both survivors and therapists on the objective measures were scored and compared for significant difference to test the stated research hypotheses.

Demographic Data

Therapist Demographics

In December of 1991 in Virginia there were 940 licensed clinical psychologists, 492 licensed counseling psychologists, 1,365 licensed professional counselors, and 1,641 licensed clinical social workers listed in the Quarterly Licensing Report of the Department of Health Professions. Of those 4,438 licensed mental health professionals in Virginia, 195 clinicians (43 male and 152 female) were referred to this study by the Virginians Aligned Against Sexual Assault (VAASA) sexual assault centers in the state. These community-identified experts in treating adult survivors of childhood sexual abuse were invited to participate in the study and to nominate their clients who had finished treatment or who were in the ending phases of treatment for incest to participate as well. A group of 25 therapists and 47 clients volunteered within the time boundaries of the study. Two clients could not be reached, so the subject groups consist of 25 therapists and 45 clients.

Therapists (4 men and 21 women) range in age from 36-60, with a mean age of 45. Their ethnic backgrounds include a Japanese adopted parent with European birth parents, a first generation Russian-American, a person who was born and raised in Germany, two people with Native American heritage, one African-American, and the rest a mixture of European and British Isles descent. Their professional backgrounds include social work (eight therapists), professional counseling (seven therapists), and psychology (six therapists), as well as one psychiatrist, one creative arts therapist, and one specialist in family and child development. Three of the therapists expressed that they had received some training in working with sexual abuse survivors in their graduate programs. The rest had received specialized training from their clients ("Clients are my best teachers.") and through their own efforts to read and attend workshops and

seminars on topics related to incest survivors. They mentioned significant learning from the following presenters: Richard Kluft, Ellen Bass, David Calof, Suzanne Sgroi, Ann Burgess, and Nicholas Groth. One clinician had received extensive training in hypnosis and one had done extensive post-graduate work in trauma theory and described herself as a "traumatologist." Three clinicians had had extensive experience working with battered women. One therapist had been the director of a child abuse program before entering private practice, and one had started a rape crisis center on a college campus. Five of the therapists also had extensive training in working with children and adolescents and had worked with child victims of sexual abuse as well as adult survivors.

When asked about the theoretical orientation of their graduate program or mentor, the twenty-five clinicians named the following: eight said their programs were psychoanalytic; five said their programs were eclectic; three said their programs focused on the dynamics of family systems and three said their programs were cognitive/behavioral; four said their programs were humanistic; one individual learned from a mentor who was an expert in adult learning, and one individual was trained in Christian Existentialism. The therapists currently adhere to a somewhat larger variety of theoretical orientations than those into which they were originally trained; they generally put themselves in more than one category. The nine who used the term "eclectic" meant it to designate their way of being pragmatic with their clients, using whatever works. Nine therapists have a psychodynamic orientation. Seven described themselves as cognitive/behavioral. Seven are proponents of systems theory, both general systems and family systems. Three use object relations extensively; three are primarily humanistic. Two described themselves as feminist. Two described themselves as transpersonal and talked extensively about the connection between mind and body in the work they do.

Individuals also gave credit to Gestalt, Transactional Analysis and R. E. T. as informing their current theoretical foundation. Four therapists talked about the importance of the spiritual development of their clients as part of their own theory base.

The therapists had been in practice an average of 14 years, ranging from 4 years to 23 years. They had been treating adult sexual abuse survivors an average of 8 years, ranging from 3 years to 17 years. They have treated in individual psychotherapy an estimated 1,375 adult survivors of incest over the years collectively, an average of 55 clients each. Sixteen therapists also provide group therapy for adult incest survivors. The groups sometimes focus on issues of healing for Adults Molested As Children (AMAC Groups, *The Courage to Heal* Groups) and sometimes on generic issues (e.g.: Weight Control Group, Women's Burnout Group, Adult Child of a Dysfunctional Family Group, Family of Origin Group) and may not be exclusively for survivors of childhood sexual abuse. The groups include both structured, time-limited psycho-educational groups and unstructured ongoing therapy groups, where new members join only when an opening is created in the group by a member's leaving the group and moving on. Three therapists focus on body work in the group format, including bio-energetics and breath work. These therapists specifically work on release of repressed feelings during their group sessions and structure group meeting times and sites considering safety and privacy for their group members. Those therapists who do group treatment have treated an estimated 2,656 adults who were molested as children in the group format. Adults who were molested as children constitute an average of 53 percent of the current case loads of all twenty-five therapists who participated in the study. The distribution of current case loads is shown in Table 1.

Table 1
Percent of Current Case Load Adults Molested As Children

Percent	Number of therapists
Less than 20	5
20-39	6
40-59	5
60-79	7
More than 80	2

These therapists, as a group, were well-trained and experienced in working with adult incest survivors. They were modest about the label "expert" and seemed surprised in about half the cases that they might have more knowledge about treating adult incest survivors than many of their colleagues.

Demographics of Treatment

The 45 survivors were experienced mental health services consumers by the time they reached their current therapists. They have each received treatment from a range of 1-9 different therapists, an average of 3.6 therapists per person. As a group they have worked since adolescence with a total of 164 separate therapists. Some of the changes were geographic. One survivor said she spent several years "coping by geography." She moved 23 times in 11 years. Most of the moves for the other

survivors were job related. Some of the changes involved starting and then dropping therapy, a matter of readiness for dealing with the traumatic past. Of the fifteen negative experiences in therapy (all involving a conscious choice to change therapists) reasons for the change were (1) lack of rapport, "She said it over and over--how did that make you feel?--like a robot," "I mentioned the incest; he blew it off," (2) lack of training, "I was doing more reading than she was," "He patted my hand a lot and gave me a lot of drugs," (3) victim-blaming, "He told me I was promiscuous," "He implied that I liked it," (4) sexualizing the relationship (there were three different experiences, involving two of the survivors). Both of the survivors received support from subsequent therapists pressing charges and removing from their jobs two of the male therapists who treated them inappropriately. The third experience went unreported for fifteen years.

All survivors expressed satisfaction with their current therapists. "She must be the most patient woman in the world," said one. "She is not directive. She empowers the client, leads in a very subtle way. I was obedient. If she had said, 'Do this now,' I would have. For me, it was best she didn't do that," said another, and another reflected,

I think I've been lucky to have a really good therapist. Intentions are everything and his intentions come from the heart. There is a Shamanic principle: to have intentions for the good of the planet. No matter what you do or say in your human frailties if you have intentions for the good of the person which is for the good of the planet then things will work out. I don't even remember any therapy horror stories where he would say, 'You're wrong and besides that you're ugly and your mother dresses you funny.' And he had to listen to a lot of crap for a lot of years.

One survivor spoke about how painful the process of shopping for a therapist was, even though she endorsed the personal interview of the therapist as the best way to be selective: "That was a very hurtful process for me, having to tell my story over and over and crying each time and having the person say, 'I understand' and feeling, 'Yeah, right!' You'll know when you've found the right person."

Obstacles to their work in therapy that they mentioned in the present therapy relationship were (1) transferences--wanting to be friends with their therapists, falling in love with their therapists, anger toward their therapists when they refuse to answer questions about their personal lives; (2) time limits--

You knew you were going to have to stop in that hour, so you really had to condense what you were saying and feeling. That was one obstacle. Because I felt that if I let loose then I didn't know how long it would last, how long I would cough, or how long I would vocalize or how angry I would get, if I would throw her a pillow or hit her over the head. I didn't know what my depth was, so I didn't want to show it. I didn't want to be cut off, so I didn't show anything at all. I don't window shop;

(3) financial limits--"The economics of it is tough --my copayment was \$50 per hour;"
 (4) physical constraints--"I wanted her office to be soundproof. I never felt it was a safe physical environment to express myself. I know I consciously controlled myself."

Of the 45 survivors, 24 had completed their therapy, and 21 were in the ending stages of treatment. They had spent an average of 32 months in treatment with their current therapists. They had met for an average of 122 sessions each, or 3.8 sessions per month, on the average. Jehu (1988) noted that the presenting problems of the 51 adult sexual abuse survivors at the University of Manitoba Psychological Services Center fell into three categories: (1) mood disturbances, including feelings of guilt, low self-esteem, and depression; (2) interpersonal difficulties, including themes of isolation, insecurity, discord, and inadequacy; and (3) sexual dysfunctions, including phobias, aversions and sexual dissatisfaction. The survivors in this study also named symptoms that brought them to therapy with their current therapists that fit into those categories and some additional symptoms as well. The distribution of symptoms is listed in Table 2.

Table 2
Survivor Symptoms at Beginning of Current Therapy

Symptoms	Number of survivors	Percent
Mood disturbances	29	64
Interpersonal difficulties	13	29
Sexual dysfunctions	6	13
Dreams, flashbacks, feelings about the incest	6	13
Eating disorders	4	9
Anger	4	9
Alcohol/drug abuse	2	4
Child's sexual abuse	2	4
Somatic complaints	2	4
Self-mutilation	2	4
Agoraphobia	1	2
Battering	1	2
Acquaintance rape	1	2
Child abuse (her own children)	1	2

These presenting problems were confirmed by the therapists from their treatment notes. They also noted symptoms of intrusive thoughts and numbed feelings, amnesias for parts of childhood, guilt about the incest, tendencies for passive behavior, over-

protectiveness toward children, conflicted feelings about parents, over-responsible care taking behavior, an overreaction to any illness, and a person who consistently gags when brushing her teeth. Diagnoses with current therapists are listed in Table 3.

Table 3
DSM III-R Diagnoses Applied to the 45 Survivors by the 25 Therapists

Diagnosis	Number of survivors	Percent
Post Traumatic Stress Disorder	32	71
Major Depression	9	20
Dysthymia	6	13
Adjustment Disorder	4	9
Dissociative Disorder NOS	3	7
Agoraphobia	2	4
Multiple Personality Disorder	2	4
Psychoactive Substance Use	2	4
Anorexia	1	2
Obsessive/Compulsive Disorder	1	2

In some cases the Post-Traumatic Stress Disorder diagnosis was added as information about the childhood sexual victimization was revealed during the course of treatment.

Choice of therapist was made by a variety of referral sources. Three survivors credit divine intervention with leading them to this therapist, although only earthly referral sources are listed in Table 4.

Table 4
How Survivors Were Referred to Current Therapists

Referral source	Number of survivors	Percent
Had met him/her previously	9	20
Recommended by another therapist	8	18
Recommended by a friend	8	18
Rape Crisis Center referral	6	13
Military fam. service/ins. referral	5	11
Priest, professor, medical referral	4	9
Alcohol rehab., AA referral	2	4
Met at hospital after suicide attempt	2	4
Parents United/Parents Anon. referral	1	2

Client Demographics

The 45 survivors in the study were female, which demonstrated the rarity of male survivors who have completed treatment and who are willing to be interviewed about their experience. The survivor group ranged in age from 22-54 years old, with an

average age of 38. The age distribution of the survivors is presented in Table 5.

Table 5
Age Distribution of the 45 Survivors

Age in years	Number of survivors	Percent
20 - 24	2	4
25 - 29	4	9
30 - 34	8	18
35 - 39	11	24
40 - 44	13	29
45 - 49	4	9
50 - 54	3	7

The ethnicity of the family unit during childhood was as follows: 35 survivors grew up in a European-American family, where European includes the British Isles. Six survivors had a Native-American and European-American background, and 4 survivors were of African-American and Island heritage. Two survivors were adopted. No information is available about the biological parents of one; the other one was European-American. Both were raised in European-American adopted families. One survivor was raised by a Holocaust survivor parent and one survivor was raised by a parent who left the country just before the Holocaust. Thirty-eight survivors are

currently employed. Their occupations include 18 professionals, 8 skilled service providers, 7 receptionist/office managers, and 5 in sales. They rate their average liking for their jobs as 2.5 on a three point scale where 1 is *not much*, 2 is *O.K.*, and 3 is *a lot*. Four of the survivors are not currently employed and three are full time students. Their level of education is summarized in Table 6.

Table 6
Survivors' Level of Education

Education received	Number of survivors	Percent
Less than high school	1	2
High school graduate	10	22
Some college	12	27
College graduate	16	36
Graduate degree	6	13

Most of the survivors are primarily self-supporting or contributing significantly to the family income. Most of the survivors who are not currently working are staying home by choice to raise children. Twenty-nine of the survivors are in one-income families; sixteen of them are in two-income families. Twelve of them (twenty-seven percent) classify their economic status as upper-middle class; twenty-two of them (forty-nine percent) classify their economic status as middle class; six of the (thirteen

percent) say they are lower-middle class; and five (eleven percent) say they are lower class, economically. Thirty-one (sixty-nine percent) of the survivors are parents. The current marital status of the survivors is summarized in Table 7.

Table 7
Current Marital Status of Survivors

Current marital status	Number of survivors	Percent
Single, never married	11	24
First marriage	14	31
Second marriage	7	16
Third marriage	3	7
Separated/divorced		
One divorce	5	11
Two divorces	3	7
Three divorces	2	4

The demographic facts about this group of therapists and survivors and the conditions of therapy which include a high level of experience by therapists and a high level of therapist skill as judged by others, a high number of sessions, a long duration of treatment, a high level of education by clients, a good level of occupational adjustment by clients, and a relatively high socioeconomic status of clients are the same

demographic facts that Luborsky, et. al. (1988) found to be related to better outcome in therapy. Luborsky, et. al. (1988) found age, gender, race, previous psychotherapy, and marital adjustment unrelated to outcome of therapy.

Facts About the Abuse

All of the survivors in this sample were abused initially prior to reaching the age of 13. The ages at which the incest began are summarized in Table 8.

Table 8
Age at Which Incest Began

Age at which incest began	Number of survivors	Percent
≤ 5	27	60
6 - 9	12	27
10 - 12	6	13

The incest lasted four or more years for thirty-seven (eighty-two percent) of these survivors. For many of them the associations with the ending of the abuse are when they learned to drive or when they left home after high school. One woman's comment about the abuse ending when she was nine years old was, "I started my period then. The control lasted much longer." The ages at which the incest ended are summarized in Table 9 and the duration of the incest is summarized in Table 10.

Table 9
Age at Which Incest Ended

Age at which incest ended	Number of survivors	Percent
< 10	9	20
10 - 12	9	20
13 - 15	10	22
16 - 18	12	27
≥ 19	5	11

Table 10
Duration of Incest

Duration of incest in years	Number of survivors	Percent
< 1	4	9
1 - 3	4	9
4 - 6	10	22
7 - 9	11	24
10 - 12	9	20
≥ 13	7	16

The type of sexual contact described included everything from leering to rape and often included more than one type per survivor. The different abusive acts are summarized in Table 11.

Table 11
Type of Sexual Contact Experienced by The 45 Survivors

Sexual act	Number of survivors	Percent
Touching breasts/body	24	53
Vaginal and/or anal penetration	21	47
Hands on/in genitals, finger penetration and/or mutual or indiv. masturbation	19	42
Penis forced into her mouth	19	42
His mouth on her genitals	6	13
Simulated intercourse (rubbing)	6	13
Watching her dress, urinate	5	11
Attempted intercourse	4	9
Object penetration of vagina/anus	3	7
Ritual abuse	2	4
Bestiality	2	4
Photography	1	2

When describing the abuse, survivors were often unclear about the quantity of the abuse. They remembered "every time he could get his hands on me," and "several times in a row and then not for a month, depending on the access." One survivor said, "I still don't have clear memories. I wish I could remember like what I had for breakfast. That aided in my denial for a long time." Approximate frequency as reported by the survivors is summarized in Table 12.

Table 12
Frequency of Sexual Contact Experienced by the 45 Survivors

Frequency	Number of survivors	Percent
Daily	7	16
2 - 3 times/week	8	18
Weekly	6	13
1 - 2 times/month	6	13
Occasional	5	11
< 10 times	7	16
Uncertain	6	13

The survivors in this sample experienced abuse from 150 separate abusers, 83 who were either blood relatives or caretakers under the qualifying definition of incest,

and 67 who were friends of their parents, acquaintances, or strangers with opportunity. A summary of the abusers and the numbers of survivors abused by each are listed in Table 13.

Table 13
The Abusers

Identity of abuser	Number of survivors	Percent
Incest abusers:		
Father	28	62
Brother	14	31
Male cousin	10	22
Uncle	8	18
Grandfather	7	16
Stepfather/foster father	6	13
Mother's boyfriend	3	7
Aunt, female cousin, godsister	3	7
Mother	2	4
Caretaking neighbor (male)	2	4
Other abusers:		
Acquaintance rape	31	69
Parents' friends, employers, employees	16	36
Neighbor kids, friends of siblings	11	24
Medical doctors they went to as patients	3	7
Strangers with opportunity	3	7
Gang rape, high sch. or college	2	4
Marital rape	1	2

A total of five survivors (eleven percent) were sexually abused by females. Among the abusive incidents, those five represent six percent of the incestuous abuse experienced by these survivors.

Results of Objective Measures

STAXI Results

The first hypothesis to be tested was that there would be no difference between the amount of repressed anger reported by the survivors and the amount of repressed anger reported by the norm group on the STAXI, as representative of the general population. Repressed anger is measured by the Anger-In scale on the STAXI, and the rationale for choosing that scale was that the clarity in the literature about the effects of childhood sexual abuse and its damage to self esteem would lead to the expectation that therapy might not be effective in freeing up the repressed anger survivors might harbor. The STAXI was administered under two instruction sets. First, survivors answered the questions on the STAXI as they feel at present, then the survivors answered the questions as they remembered feeling before receiving therapy for the incest. Scores on the STAXI-now were then compared to the scores for the age-matched norm group on the STAXI as a control group, representative of the general population of women, to the extent that the validity of the STAXI has been tested. Therapists also answered the questions on the STAXI regarding Anger-In and Anger-Out, and their results were compared to the results reported by the survivors. Therapists were asked to make judgments about their clients only on the Anger-In and Anger-Out scales because it did not seem feasible or valid for them to predict their client's State and Trait anger based on their experience with their clients in the therapy frame. Scores for the STAXI norm group are reported as *T* scores that have a mean of 50 and a standard deviation of 10.

Standardized scores for the survivors are reported and the means and standard deviations of the survivor distribution are calculated. Summaries of the STAXI scores are listed separately for each scale, beginning with Table 14 - Table 17.

Table 14
STAXI State-Anger Scale Scores

Subject group/instruction set	Mean score	sd	t	Significance
Survivors as they felt before therapy	70.2	7.19		
Survivors as they feel now	53.3	5.64	12.38	p <<.001
Survivors as they felt before therapy	70.2	7.19		
STAXI norm group	50.0	10.00	10.98	p <<.001
Survivors as they feel now	53.3	5.64		
STAXI norm group	50.0	10.00	1.93	n.s.

Table 15
STAXI Trait-Anger Scale Scores

Subject group/instruction set	Mean score	sd	t	Significance
Survivors as they felt before therapy	63.1	14.12		
Survivors as they feel now	53.2	10.42	3.81	p < .001
Survivors as they felt before therapy	63.1	14.12		
STAXI norm group	50.0	10.00	5.09	p << .001
Survivors as they feel now	53.2	10.42		
STAXI norm group	50.0	10.00	1.47	n.s.

Table 16
STAXI Anger-In Scale Scores

Subject group/instruction set	Mean score	sd	t	Significance
Survivors as they felt before therapy	74.1	5.10		
Survivors as they feel now	52.6	9.99	12.86	p << .001
Survivors as they felt before therapy	74.1	5.10		
STAXI norm group	50.0	10.00	14.44	p << .001
Survivors as they feel now	52.6	9.99		
STAXI norm group	50.0	10.00	1.25	n.s.
Survivors as they feel now	52.6	9.99		
Therapist prediction	49.9	11.76	1.19	n.s.

Table 17
STAXI Anger-Out Scale Scores

Subject group/instruction set	Mean score	sd	t	Significance
Survivors as they felt before therapy	59.1	15.16		
Survivors as they feel now	56.1	8.85	1.15	n.s.
Survivors as they felt before therapy	59.1	15.16		
STAXI norm group	50.0	10.00	3.37	p << .001
Survivors as they feel now	56.1	8.85		
STAXI norm group	50.0	10.00	3.07	p < .01
Survivors as they feel now	56.1	8.85		
Therapist prediction	57.3	6.12	.38	n.s.

The null hypothesis for repressed anger, that there is no difference, other than that which might be expected by chance, between the scores of the survivors as they feel now and the scores of the STAXI norm group, then is true.

Coping Resources Inventory Results

The second hypothesis to be tested is that there would be no difference between the total coping resources scores of the incest survivors and the total coping resources scores of the female norm group on the Coping Resources Inventory (CRI), as representative of the general population. CRI scores are standardized to a mean of 50 and a standard deviation of 10 for the norm group. "Thus, approximately 95 percent of individuals will have standard scores that fall between 30 and 70" (Hammer and Marting, 1988, p. 5). Results of the CRI total coping scores are shown in Table 18.

Table 18
Coping Resources Inventory Total Scores

Subject group/instruction set	Mean score	sd	t	Significance
Survivors	49.9	10.70		
CRI norm group	50.0	10.00	.05	n.s.

The null hypothesis, that there is no difference between the total coping resources scores for the survivors compared with the CRI norm group, other than that which would be expected by chance, is true.

The third hypothesis, that there would be no difference between the rank ordering of the coping resources by type among incest survivors and the rank ordering of coping resources by type among other population samples (Hammer, 1989), was tested using the Myers Briggs Type Indicator (MBTI) type table and comparing, by inspection, that type table with the results in Hammer's study. The MBTI results are listed in Table 19.

Table 19
MBTI Results for the Survivor Sample

ISTJ n = 6	ISFJ n = 9	INFJ n = 5	INTJ n = 0
ISTP n = 0	ISFP n = 1	INFP n = 6	INTP n = 1
ESTP n = 1	ESFP n = 2	ENFP n = 3	ENTP n = 3
ESTJ n = 1	ESFJ n = 2	ENFJ n = 4	ENTJ n = 1

Individual scale frequencies are as follows: E = 17, I = 28; S = 22, N = 23; T = 13, F = 32; J = 28, P = 17. Dominant function frequencies are as follows: S = 18; N = 11; T = 3; F = 13. For purposes of comparing the rank orderings on the CRI by type with Hammer's sample, only those types which have more than one person per cell were used. The small sample size of survivors makes the results in Table 20 obviously incomplete.

Table 20
Top Coping Resources for Each Type in Survivor Sample

ISTJ Physical (3) Spir/Phil (6) Cognitive (8)	ISFJ Spir/Phil (4) Cognitive (4) Physical (3)	INFJ Spir/Phil (3) Social (4) Physical (2)	INTJ
ISTP	ISFP	INFP Spir/Phil (5) Cognitive (5) Social (5)	INTP
ESTP	ESFP Social (2) Physical (1) Spir/Phil (3)	ENFP Spir/Phil (2) Emotional (1) Cognitive (1)	ENTP Social (3) Emot. (5) Spir/Phil (7)
ESTJ	ESFJ Social (1) Emotional (2) Cognitive (5)	ENFJ Spir/Phil (1) Cognitive (3)* Social (3)*	ENTJ

*Tie scores

Comparison of these results with Hammer's Table 5, see **Appendix A**, shows the only like ordering is in the first choice of Spiritual/Philosophical coping resources for INFJ and INFP types. Extraverts and Feeling types have the highest scores in all five coping resources. ENFPs have the highest average total coping resources scores for this sample. Results of total coping scores by type are given in Table 21.

Table 21
Total CRI Scores by Type for the Survivor Sample

ISTJ 47	ISFJ 49	INFJ 53	INTJ 0
ISTP 0	ISFP 0	INFP 46	INTP 0
ESTP 0	ESFP 56	ENFP 59	ENTP 45
ESTJ 0	ESFJ 54	ENFJ 53	ENTJ 0

By inspection, the null hypothesis that there would be no difference between the rank ordering of coping resources by type among incest survivors and the rank ordering of coping resources by type among the other populations samples Hammer presented is

false. Therapist assessment about rank orderings of coping resources were that four therapists chose all three of the top three coping resources chosen by their clients; thirty-one therapists chose two of the top three coping resources chosen by their clients; and ten therapists chose one of the top three coping resources chosen by their clients. The therapists confirmed at least two of the three top choices by the clients in 78 percent of the cases.

Outcome Measure Results

Hypothesis four, that there would be no difference between therapist report and self-report of incest survivors about the outcome of therapy as measured by the visual analog outcome scale, was tested by measuring the visual analog scale in millimeters and constructing a distribution of scores from the survivor self-report and from the therapist assessment on the same instrument. The outcome measure looked at awareness of feelings in general before therapy, during therapy, and at present; at awareness of feelings of anger in particular before therapy, during therapy, and at present; at symptom improvement; and at overall improvement during therapy as an outcome of therapy. Comparisons were made between survivors' mean scores for each time frame, between therapists' mean scores for each time frame, and between therapist and survivor assessment for the same time frame. Both therapists and survivors reported significant increases in awareness throughout the course of therapy. The only differences between therapist and survivor report was that therapists credited survivors with more awareness of their feelings in general than the survivors did for themselves at the beginning of the therapy process. The results of those scores are summarized in Table 22.

Table 22
Awareness of Feelings Before Therapy, During Therapy, At Present

Subject group/instruction set	Mean score	sd	t	Significance
Survivors--feeling awareness before	15.8	20.28		
Survivors--feeling awareness during	63.3	25.14	9.88	p << .001
Survivors--feeling awareness during	63.3	25.14		
Survivors--feeling awareness now	84.8	16.05	4.84	p << .001
Survivors--feeling awareness before	15.8	20.28		
Therapist assessment before	28.8	23.66	2.80	p < .01
Survivors--feeling awareness during	63.3	25.14		
Therapist assessment during	59.7	20.10	.08	n.s.
Survivors--feeling awareness now	84.8	16.01		
Therapist assessment now	78.8	13.54	1.92	n.s.
Therapist assessment before	28.8	23.66		
Therapist assessment during	59.7	20.10	6.67	p << .001
Therapist assessment during	59.7	20.10		
Therapist assessment now	78.8	13.54	5.29	p << .001

Both therapists and survivors reported significant increases in awareness of feeling angry throughout the course of therapy. One survivor explained that her awareness during the course of therapy changed from one end of the continuum to the other:

For a long time in therapy, I dealt with issues other than incest, which initially I did not remember. When I first began dealing with incest, it frightened me and I was completely unaware of feelings of anger with regards to childhood experiences. First, I learned to deal with anger on "adult issues" and finally on "child issues." The anger awareness during therapy, then, ran the full continuum: from unaware to extremely aware.

There were no differences between therapist report and survivor report on the anger awareness measure. The same summary of awareness of feeling angry is given in Table 23. Both survivors and therapists reported the same levels of symptom improvement, and the survivors were more optimistic about the overall improvement than their therapists were. The symptom improvement and over-all improvement mean scores for both survivors and therapists are reported in Table 24.

Table 23
Awareness of Anger Before Therapy, During Therapy, At Present

Subject group/instruction set	Mean score	sd	t	Significance
Survivors--anger awareness before	25.8	32.86		
Survivors--anger awareness during	72.4	28.94	7.15	p << .001
Survivors--anger awareness during	72.4	28.94		
Survivors--anger awareness now	81.6	23.30	1.66	n.s.
Survivors--anger awareness before	25.8	32.86		
Therapist assessment before	30.2	25.51	.71	n.s.
Survivors--anger awareness during	72.4	28.94		
Therapist assessment during	62.4	18.65	1.95	n.s.
Survivors--anger awareness now	81.6	23.30		
Therapist assessment now	79.4	14.25	.54	n.s.
Therapist assessment before	30.2	25.51		
Therapist assessment during	62.4	18.65	6.83	p << .001
Therapist assessment during	62.4	25.51		
Therapist assessment now	79.4	14.25	4.86	p << .001

Table 24
Symptom Improvement and Overall Improvement

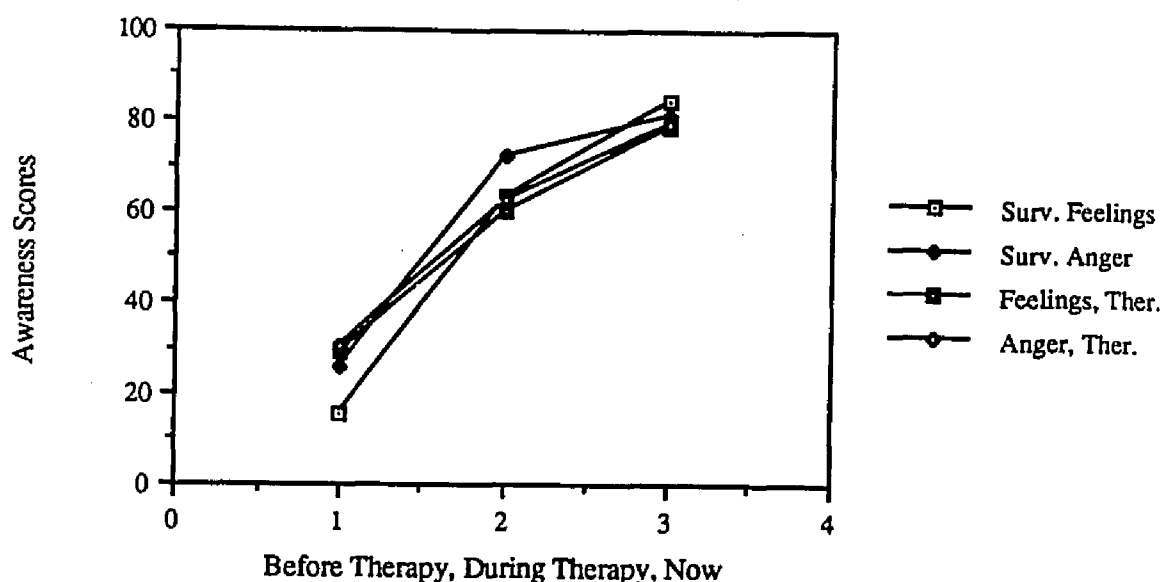
Subject group/instruction set	Mean score	sd	t	Significance
Symptom improvement--survivors	79.2	16.38		
Symptom improvement--therapists	75.3	13.89	1.19	n.s.
Overall improvement--survivors	91.2	10.24		
Overall improvement--therapists	78.4	14.24	4.88	p << .001

The fourth hypothesis that there would be no difference between therapist report and the self-report of incest survivors about the outcome of therapy was false. The enthusiasm of the survivors about their improvement is counter to the general outcome of therapy literature which often reports therapists more optimistic about the outcome of therapy than clients.

There is very little difference between the therapist perceptions and the client perceptions about feeling and anger awareness over time. Both of the therapist assessments are very close together. Clients seem more aware of their anger during therapy than therapists believe they are. That slight difference could be explained by the number of survivors who were impressed by the strength of their feelings and who may be more surprised about those feelings than their therapists were. A visual representation of the awareness changes in feelings in general and anger in particular over time for both survivors and therapists is plotted in Table 25.

Table 25

Feeling and Anger Awareness Changes



Type-Related Anger Results

Answers to the Type-Related Anger Questions by survivors showed that slightly more than half of the survivors (56 percent) claim to process anger the same way on the E/I dimension as their MBTI type would indicate while the other 44 percent claim to process anger in the opposite internal/external world. Therapists were slightly more accurate at guessing the anger processing energy of their Introverted clients (54 percent matching the E/I choice of their clients on the Type-Related Anger Questions) than with their Extraverted clients (47 percent matching their clients' Type-Related Anger Questions responses).

Clients were divided into dominance groups according to their MBTI types and then their selection of dominance on the Type-Related Anger Questions was tabulated with respect to whether that choice represented the MBTI dominant function, the MBTI auxiliary function, the MBTI tertiary function, or the MBTI inferior function for each

individual. (See Myers and McCaulley, 1985, for the explanation of how to determine each function.) There were only three survivors in the Thinking-Dominant category. One of them chose the auxiliary function and two chose the tertiary function as anger processing dominants. Percentages were not calculated for that small group. Frequencies and percentages of dominance choices on the Type-Related Anger Questions are shown for the other three dominance groups in Table 26.

Table 26
Dominance Choices on the Type-Related Anger Questions

MBTI dominance n = 45 Percentages	Type-Related Anger Questions dominance choices			
	Dominant	Auxiliary	Tertiary	Inferior
Sensing n = 18	3 17%	3 17%	5 28%	7 39%
Intuition n = 11	3 27%	4 36%	1 9%	3 27%
Feeling n = 13	3 23%	7 54%	1 8%	2 15%

Therapist guesses about dominance based on their responses to the Type-Related Anger Questions failed to match their client's responses for 37 (82 percent) of the 45 survivors. If it were argued that therapists might be assessing true type of their clients instead of their anger coping type, then the expectation would be that therapist guesses about dominance would more nearly match survivor MBTI dominance categories than those generated by the Type-Related Anger Questions. On inspection, therapists matched MBTI dominance on only five survivors, mis-matching in 40 cases (89 percent).

Interview Data from Survivors

Problems in Families of Origin

These survivors were raised primarily in traditional two parent families (42 survivors, 93 percent), with two survivors being raised by grandparents and one being raised in a family where the two parents were a mother and a grandmother. Four of the survivors were only children, thirteen were oldest, fourteen were middle, and fourteen were youngest children. There were an average of 3.5 children per family in the families having more than one child. There were 22 survivors who lived with an active alcoholic in the family unit and 4 more who had active alcoholics in the extended family (uncles, grandfathers, great-grandfather). Abuse of prescription drugs was done by seven mothers and one father of the survivors, and abuse of street drugs was done by three fathers and one mother. Overall, 59 percent of the survivors lived in families where there was substance abuse.

Physical abuse was reported in addition to the sexual abuse by 33 (73 percent) of the survivors. Violence in the home included witnessing the throwing of knives, having heads banged against carports and walls and poles, receiving whippings with a cat-o'-nine tails, belts, fly swatters, extension cords, the branch the survivor picked off the tree for that purpose, and the spatula the parents carried in the car "in case you didn't behave." In two families violent older brothers terrorized the survivors. In twelve families, the father beat the mother. In 26 families the father beat the children. In 11 families the mother beat the children. In one family the father beat the dog.

Emotional abuse was reported in addition to the sexual abuse by 43 (96 percent) of the survivors. Mothers delivered the emotional abuse in 29 cases. Fathers delivered the emotional abuse in 37 cases. Grandparents and other relatives were emotionally abusive in four cases. Descriptive words used about the emotional abuse from mothers

and fathers by survivors are shown in Table 27.

Table 27
Kinds of Emotional Abuse Experienced by Survivors

From mother	From father
Critical, negative	Sarcastic
Absent	Sadistic
Totally non-available emotionally	Wanted me to be perfect
Unsympathetic	Absent
Harsh	Blackmailer
Controlling	Conditional
Ignored the problem	Favoritism toward my sister
Major denial	Caustic
Put me down	Unpredictable, rules changed
Manipulator	Criticisms
Favoritism toward my brother	Verbal anger
Screamer	Blame
Emotional abandonment	Name calling
Withdrawing affection	Cruelty
Treated me like I was the other woman	Harassment about mistakes
	Mean
	Teaser
	Tickle until it hurt
	Humiliation

In 27 families there were multiple incest victims (61 separate victims), as assessed by the survivors. Some of the abuse was confirmed directly by their siblings;

some was denied by siblings and remembered circumstantially by survivors or confirmed to survivors' satisfaction by the symptoms of their siblings. In six families, the abuser abused others outside the family (neighbors, cousins). In four families, siblings of the survivors were abused by other people besides the incest perpetrators.

In 38 families (84 percent), survivors reported that their parents had had marital conflict. The types of conflict they remembered are as follows: tense silence, constant arguing, quiet, civilized conflict, yelling, chasing each other with butcher knives. They remembered, "She hid her pain;" "She was submissive;" "He was a misogynist;" "He cheated on her;" "They slept in separate beds;" "They fought about money, alcohol, chores, and the behavior of the kids."

Social isolation was a problem for 17 families. Some of the reasons for the isolation of the families were cultural-ethnic prohibitions, living in a rural area, moving too often to make friends. Some of the reasons for the survivors' own feelings of isolation were "he blocked my friends and participation in school activities," "my brother's reputation for violence," "my fears of wetting the bed at someone's house," "only his drinking buddies came over." One survivors remembered her father's rules when they were at somebody's house: "You sit quietly. You don't eat anything. If somebody offers you something, you say, 'No, thank you.' You don't get close to anyone." Social isolation was not a problem for 14 normal-*appearing* families, whom survivors described as "pillars of the community." "I had lots of friends. I went to their houses. There was an upstairs apartment in our house full of aunts, uncles, and cousins. There were people in our house a lot. He took out his anger on us. He molested cousins and another cousin molested a cousin. There was always secrecy. He was clever and instinctive. He knew who to approach and who to stay away from." Extended family provided the primary social outlet for 10 families. Twenty-two of the

survivors had friends themselves; 12 said they usually went to the houses of their friends and did not have their friends come to their houses. Four survivors noted the importance of receiving a model of a healthy family from the families of their friends.

Health problems affected some of the childhood environments of the survivors. Mother's health was a problem in 17 families; father's health was a problem in 6 families; the survivor had health problems in 3 families; and siblings had health problems in 2 families. "Mother had polio when I was nine months old. She was away from home for two years, then she was confined to crutches and a wheelchair. One of her sisters took care of me. When I was four years old, she had a malignancy of a kidney, surgery and radiation. Mother was very independent but actually very dependent. It was clearly the expectation of her side of the family that I was to take care of her." Mental health problems of parents were difficult for five of the survivors. Three parents were diagnosed schizophrenic and were on occasion violent and unpredictable. Two parents were clinically depressed. One mother had a "nervous breakdown" when she learned about her daughter's abuse.

Poverty was a problem in nine families. Survivors remember, "welfare and Mom's three jobs," hand me down clothes, free lunches at school, seasonal work and unemployment. Six of the families were upper middle class. Those survivors remember, "all three of us went to a private prep school," "we lived on a 100 acre ranch," "we had charge accounts as kids." The rest of the families were in the middle or the struggling middle class. Some survivors remembered symbols of their security or their insecurity: "They built and owned their home." "Mom sewed." "He had a new red truck." "He got taken on a lot of schemes, wanting to be a big shot." "Our apartment was very cold. I remember getting dressed under the covers before school. But my mom went to the beauty parlor, and they always went away one week on

vacation. It was crying with a loaf of bread under your arm. We always had controlled portions of food and instructions not to eat what was in the refrigerator."

Other problems that survivors remembered as being important were class disputes within the extended family (one set of grandparents not approving of a parent's choice of spouse, or family pressure for achievement if a father were not making as much money as his brothers), or problems from the previous generations that were handed down into their families (child abuse when parents were children, "Dad's father was a compulsive eater; he was huge," "Both parents came from broken homes, also dysfunctional families"). Personal life events that presented problems were learning about her adoption ("fear that if I wasn't good they'd get rid of me"), teen pregnancy (a problem for 4 of the survivors), having mentally retarded siblings (2 of the survivors), feeling abandoned by siblings ("Grandmother sold the house we lived in; my younger brother left for school. I resented him a lot for leaving me. Then my sister committed suicide. She was the best friend I ever had. She abandoned me. I started on medicine cabinet drugs at age 11 and dropped out of high school my sophomore year, drinking heavily."), and witnessing a suicide attempt by a mother.

Disclosure of the Incest

The 45 survivors experienced a mixture of positive and negative reactions to their disclosures about the incest. When they tried to tell as children, they rarely got the protection they needed. "I did try to tell Mom and she chose to ignore it on several occasions." "When I told Mom, she said I was evil and that I was trying to destroy the family." "I couldn't have told Mother. She cried when I got my period and my sister told me what was going on. My stepmom was the first. She believed me and supported me in getting out of the house. She took me to see a judge. He removed me from the

house. I lived with a family that I knew. They were my legal guardians until age 18. My stepmom left him at the time and then came back to him later. Mother didn't know until right before she died." Another survivor recalled,

I was in high school. Something happened that morning. I got on the school bus crying and upset. A friend told the Home Ec teacher I was upset. The teacher offered to talk to me. She told me one thing I remembered: It happened to a lot of girls my age. She went home with me and to tell my mother. It was a pretty brave thing to do. My mother could not accept it. She felt it was my imagination. I refused to stay there. I went to stay with my grandparents. They didn't ask why, they were of the "it's none of their business" school. Nobody ever asked me my feelings.

When the disclosures first happened in their adult years, the survivors also got both positive and negative reactions. "I always had part of the memory but never told anyone until two years ago. I was getting a body massage. She was working on the tight places when she asked me, 'Were you ever sexually abused?' That's when I started to remember. She was very sympathetic and open. I told my husband next and he was supportive and open." "When I told my husband, his reaction was, 'What did you do to deserve it. Forget it. It's in the past.' The second person I told was my mother. I told her about the teenage boy who raped me, stuck me with pins, burned me with cigarettes, tied me to a bed and let his friends rape me. She said, 'Oh but the poor boy, do you remember what a horrible life he had?' I hung up on her." When they remembered and told in therapy, the response was more dependably positive. "She was supportive. She told me I wasn't crazy and she believed me." "I remember being extremely ashamed. I told my first therapist and got a neutral response, non-judgmental." "I made her not look at me and turn out all the lights. I was sure she would think less of me as a person. The bestiality was even harder to tell her. She was affirming and supportive and admiring. She empowered me to decide who to tell."

Anger Prior to Therapy

The survivors described themselves as generally out of touch with feelings of anger before entering therapy, even though they sometimes had angry outbursts and labeled themselves "bad tempered." "I felt anxious, frustrated, insecure, not angry." "My training in anger was that you had to whisper. We were not allowed to argue unless we whispered." "I was trained to be a door mat, and then I would explode--slam doors, throw glass, yell so bad I'd lose my voice." "I would collect coupons and then blow." "Anger has always been a problem for me. Internalized anger has especially been a problem. Knowing when I'm angry, having access to my feelings, and not injuring myself was a problem. Also anger was a problem because I tried to own my anger by marrying someone who was always angry. That created another set of problems." A summary of the survivors' descriptions of their anger prior to therapy for the incest is listed in Table 28.

Table 28
Survivors' Descriptions of Their Anger Prior to Therapy for the Incest

Description of anger	Number of survivors	Percent
Not in touch with anger	15	33
Angry all the time (rage) and don't know why	13	29
Suppression and then volcano	9	20
Family prohibitions to anger expression	7	16
Displaced on husband and children	7	16
Self-abusing	6	13
Numbing (including drug use)	3	7
Sarcasm	2	4

Connecting Anger to the Incest

"No one ever said I had a right to be angry," one survivor said, remembering her anger in her teen years. "My mother used to say, 'If you don't control your temper, you're going to kill someone.' I had angry tirades of verbage, swearing, screaming. I was self-destructive, hitting myself with a hair brush, hitting my head on walls, punching walls and doors. The only power I felt I had was when I expressed my anger." The challenge of realizing that their anger was justified and that the experiences of rage were neither random nor without purpose was a major part of their learning to express anger in appropriate ways. "As soon as the memory came I could really get focused on what my anger was really about, picturing exactly what happened, putting myself there, feeling what that was like." "It took me a long time to figure out what my feelings meant. They would be erupting in my body and I would not show it to my therapist. There was no conscious thought, 'I've got to hide this from her.' I would figure it out *days* later, 'Oh, I was *angry* at that moment!'" One woman described her learning from a sexual assault subsequent to the incest:

Being raped was real important for me because it was a socially acceptable way to feel. And the rape was not the major wrong thing in my life. A real important turning point in therapy was when I was able to say, "The guy who raped me was honest with me at least. I didn't have to cook breakfast for him the next morning." He was honest. He didn't screw with my head. Everybody had been hurting me all my life and I was supposed to love them and I had to live in the same house with them. This guy just came along and raped me and left--it was the first honest relationship I ever had. That was a red letter day in therapy. And it didn't have to be secret. We had a trial and everything. It didn't have to be a secret like my family had to be a secret.

Sometimes the identification, "This is anger in my body," was triggered by external events in the present, a phone call from Mom, someone yelling at a child in the mall, the story of another group member. In all cases, connecting anger to the abuse involved attributing responsibility for the abuse to the abuser. That connection happened in

therapy, during reading, in dreams, as a slow process, and as a cathartic experience. One woman described having episodes of shaking and an overwhelming feeling of fear:

I would be trembling with fear, my jaw would shake. I would feel the need to control this fear that this feeling would overwhelm and consume me. I sensed there was anger I couldn't get in touch with. Driving to a friend's house one day the trembling started again. My jaw was shaking. She said, "Why don't we walk through this together?" We sat on her bed. I started screaming and hitting the bed, cussing. I couldn't stop. I was screaming at the top of my lungs. I felt like I was giving birth. It was an incredible experience. She held me. Talking to my mother, "Why didn't you protect me?" Since that experience I can recognize anger now in daily life, recognizing, "I'm angry." I still have trouble expressing it, but I'm getting better. I can tell my friends and my husband when I am angry and I am demanding the same of him. It has been painful, but over all our relationship is better now. It's scary sometimes, but I didn't want to go back to the way things were. Getting in touch with my anger freed up all this energy. I didn't feel fatigued as much, I could sleep better. It freed up lots of creative energy to think of new directions, new possibilities. The more I faced things the more energy I got.

Fears About Anger

The 45 survivors described their anger as an enormous force. "It was literally blind rage. I couldn't see anything but a tiny speck of light." They expressed a helplessness in the face of such force, "not knowing how to drain the huge cauldron of anger." After feeling the enormity of the feeling, their next reaction was to feel afraid. "I was afraid of the explosion." "I've wondered if I could be violent. That always scared me because of the way my father was. Was it in my genes?" "I was scared. Scared I would die and I would kill everybody else; scared I would destroy the whole planet. I was comfortable with the anger, scared of the emptiness. Scared if I let go of it then what else would I have. It was hard to admit that fear." Another survivor said, "If I really let myself be as angry as I wanted, I would splinter in a million pieces, and I would never get myself back. Another woman's metaphor was "green slime." "I was scared to let the deep, deep anger out. I used to call it green slime. It was poison. I was scared if I let any of it out and it touched anyone it would destroy them and anything

around." The sense of potential catastrophe seems to be the way the survivors expressed their respect for the strength of the feelings they were having.

Only two of the 45 survivors said they did not feel afraid of their anger, another one said she was not afraid of the anger per se "but of being stuck in it and never getting beyond it," and another one said she felt "the total unfamiliarity of it," not fear. A summary of the fears the survivors expressed is listed in Table 29.

Table 29
Survivors' Fears About Their Anger

Fear	Number of survivors	Percent
Fear I will hurt myself or someone else	25	56
Fear I will be out of control	15	33
Fear I will be overwhelmed, I could lose my mind	11	24
Fear I will be punished, hurt, changed	11	24
Fear that it will last forever	7	16
Fear of rejection by others	7	16
Fear of being like the abusers	4	9

Survivors' Descriptions of Dealing with Anger

A process for dealing with anger for these survivors seems to have emerged from their collective descriptions of how they got in touch with their anger and how they

worked it through during therapy. They described themselves before therapy as unhealthy and depressed. Now they recognize (1) permission to feel angry, a welcome inclusion of anger among the list of useful human emotions; (2) a method of identifying when they feel angry; (3) an analysis of whether the source of their anger lies in the past or the present; and (4) a repertoire of ways to express their anger. They hasten to say that things do not go perfectly and that they are still working on avoiding suppression and smoother ways of expressing themselves, but there is a sense overall of their satisfaction with what they have learned. Thirty-six survivors reported a decrease in the frequency of their anger from prior to therapy for the incest to the present. Eleven survivors reported an increase in frequency, "more now because I'm not numbing the feelings," "more frequent but I'm dealing with it now," "more specific to situations; I'm much more aware of what is present and what is past." Thirty-five survivors reported a decrease in the intensity of their anger from prior to therapy for the incest to the present. Eight survivors reported an increase in intensity, which they saw as a positive thing, a demonstration that they are no longer numbing their feelings. Two survivors reported no change in intensity, "It can be very intense when someone truly pisses you off." They reported a change in the quality of the anger. "Yeah, I get mad. It doesn't feel good, but I feel it. I'd rather be angry than not feel anything. I'd rather nobody piss me off. I would define that as normal." "I don't think it's a problem. I deal with it now in small pieces. I've gotten comfortable with it. I'm not in a rage all the time. I'm less critical of other people. That's been a real blessing in all of this. I've become far less critical."

Twenty-three survivors (51 percent) reported that anger is no longer a problem to them-- "only if someone does something to my children that reminds me of how I was treated," "it's a gift to me now," "wondering if I've really gotten in touch with what's

there," "it's appropriate now; I no longer ignore anger toward manipulation," "only when I use it as a barrier." Fourteen survivors (31 percent) reported that anger did present a problem now: "it's not the anger that's the problem; it's what to do about it," "how to express it, how to control it, not a problem of awareness," "definitely, when I feel I don't have control of a situation or feel overwhelmed," "when I get emotionally hooked into my unworthiness, I still get angry at myself," "stuffing it will always be a problem for me, my first impulse." Five survivors reported their anger to be a problem "sometimes," and three survivors are still working on their anger, "it's a whole new thing for me, learning how to deal appropriately with other people.

There seems to be confirmation in the anecdotes of survivors for the use of the coping resources they reported on the CRI. In response to the question, "What helped you get in touch with your anger?," survivors reported a total of 46 separate anecdotes which matched the top three coping resources they had chosen. In five more anecdotes, their level of enthusiasm for those particular coping resources was higher than their scores on the CRI might indicate. The specific strategies, tasks, and rituals they mentioned for getting in touch with and working through their anger, by coping resource are listed in Table 30 and by MBTI preference in Table 31. The MBTI preference anger strategies are listed under Introversion, for example when a survivor mentioned the helpfulness of journal writing. No attempt to differentiate between which survivor offered which example was made because Introverts often scored themselves as Extraverted on the Type-Related Anger Questions, and the process of healing for these survivors does not relate clearly to type.

Table 30

Anger Strategies, Tasks, and Rituals by Coping Resource

Coping resource	Specific strategy, task, ritual
Cognitive (positive sense of self-worth)	Separating mother, thinking only about her. My body is mine and I like it. Start accepting praise.
Social (social support networks)	Talk to my therapist. Go to group. Go to church, talk to people there. Talk to the people I work with. A couple of girl friends I talk to. Seeking the support and presence of another person gave me courage to feel my feelings.
Emotional (express a range of affect)	Decided it was O.K. to feel my feelings. Allowing my anger a voice. Got more comfortable with it (anger). Made friends with it. When I confronted my father I felt like Arnold Schwarzenegger. Cried a lot in church. Affirmation over and over again: It's O.K. to be angry. It's just a feeling.
Spiritual/Philosophical (stable and consistent values)	Helping other people. Giving talks about child abuse prevention. I took on a spirituality. There was a God. He wasn't going to abandon me. I wasn't going to become a monster. I don't hold on to grudges much. I have a tolerant and forgiving heart. I think that's the way God made me.
Physical (health-promoting behaviors)	Trying to be really aware of what I'm feeling when I feel it. Staying conscious and in my body. Listen to stress management tapes. Eating good food, taking care of myself. Exercise, balanced diet, lost some weight. Working out really helped. I would run to the anger. I could run 4-5 miles. Got an 80 lb. punching bag. Built a gym in my house so I could work out.

Table 31

Anger Strategies, Tasks, and Rituals by MBTI Scale Preference

 MBTI scale preference
 Strategies, tasks, rituals

Extraversion

Talk about it; express it. Learning to say, "I'm angry."
 Therapist's reassurances that I wouldn't hurt anyone.
 Screaming, pounding my pillow.
 Yell. Beat the bed with a pillow. Scream at something draped over the
 exercise bike. I got a scratchy voice from yelling.
 Get in my car and scream.
 Role playing.

Introversion

Journaling, writing about my feelings helped the most.
 Image whatever I needed to do to gain power back into my life (image I
 stopped the abuse, cut off his penis, fried it, gave it to him to eat).
 Confronting my parents in my mind.
 Stay by myself a lot.
 Meditation.
 Sitting down alone and blocking out everything. The feelings pass very
 quickly. Quick functional feeling it and getting through it so I feel
 like I have control over it again. Not feeling like I have to react to it.

Sensing

Body work. I learned that the body contains so much pain.
 Pacing, churning inside while pacing.
 Drawing, writing didn't work.
 Tearing newspapers.
 Throwing darts, throwing pillows, throwing ice cubes at stick faces.
 Taking a plastic baseball bat and beating the hell out of my bed.
 Needing to break a window physically, not just imaging a window
 breaking.
 Pounding nails. Hitting a chair with a bataca bat.
 I have a punching bag.

Intuition

Visualization of myself going back to a time that gripped me the most.
 Seeing myself as tall as a giant and my father as small didn't work. I
 would make myself his size and make him very dumb. I had all the
 answers. He had none. I would replay the scene 6 or 7 times until
 the burning stopped.
 Working with wood on the machines.
 I drew mutilated penis pictures. Dynamite to blow up their balls.

Thinking

Resentment list.
 Talked to the parts who held the anger.
 Channeling it to where it belonged.
 Putting myself back there and changing what went on. The less helpless
 I feel the less angry I feel.
 Rating the anger on a continuum. Rage is over there. That's where I
 am. Good. You have a right to be there.

Feeling

Count to 10. Time out. Pity party in my head.
 Music or a movie to make me cry.
 Poetry helped--emotional.
 Working with clay; made penises out of play dough, chopped them up.
 Playing the piano. The Moonlight Sonata was a barometer for how
 upset I was.
 Wanting to get closer to who I really am and letting that be out there,
 not just the anger.

Judging

Planning a way to express anger. When I leave here, boy, am I going
 to do something special.
 Putting his name on the bottom of my shoe and stepping in dog shit.
 Planning things so I won't get angry because things are all messed up.
 Not wanting just to stay in anger for the rest of my life. Time to get rid
 of the old coping ways.

Perceiving

Kicking or throwing boxes at work in the stock room.
 Breaking pencils when I have to be quiet.
 Throwing phone books on the floor, it's both noisy and safe.
 When I feel really angry and I'm not somewhere I can vent it
 emotionally, I grab a peice of paper and write *hate, hate, hate,*
fuck, fuck, fuck, something like that.
 Trying different things. I'm sleeping with a Teddy Bear now.

Other things that helped individual survivors to work through their anger were considering changing her maiden name, bringing a lawsuit against her father, volunteering at a local rape crisis center, appearing on television to talk about having survived child abuse, breaking ties with the family until her boundaries can be respected,

accumulating an extensive library on child abuse and the healing process. Another survivor said, "I cried a *lot*.. I think it cleans your soul. My mother used to tell me a woman needed to cry once a week or our head would get full." Another survivor said "Getting in touch with the inner child was important, letting her have a voice. A friend and I buy each other toys, Christmas presents for teddy and cow. They took away my blanket and said I was too old. My friend bought me a yellow blanket with nylon binding. If the kid has something to say, I really need to listen. I've always maintained my sense of humor. They couldn't take that away from me. I refused to let them drive me insane. It really helped to laugh along the way." Coming to closure with the abuse was important to some of the survivors. One woman helped bury her father recently, "I got to help pour the ashes in the hole. I had the dust of his body on my hands. I think that helped with forgiveness. He never asked to be forgiven. Maybe forgiveness is not the word. Maybe it was letting it go. I don't feel bitter toward Daddy. I believe he had to face the pain he caused. And that doing that would drive even him to sorrow."

Accepting responsibility for their part of the work, the healing after the abuse seemed as important as assigning responsibility for the abuse itself to the perpetrators. One woman talked about how she realized that she had a deep, long term fear that she would die if she changed and that it would be safer for her to consider dying than changing.

I thought change in therapy was supposed to come about like you start therapy and then when you come out you're changed. But you really have to *do* things to change. You have to make steps. You can't just theorize about it. You have to *do* it. We reached the point (I always get to this point in therapy) where I understand how my abuse affected me and how my family affected me and I understand it all and nothing changes. She looked at me and she said, "Well, where are you stuck?" I felt she was putting it on me. "You are stuck. What are you going to do about it?" That was the point where I finally said, "O.K. I am the one who is stuck. I have to get me unstuck," and I stopped relying on her to do the magic. I think the hard part for me as a survivor and not having anyone that I could ever confide in or that would help me, I gave my therapists too much power. I wanted them to save me and I kept looking to them to have the magical answers. But then she didn't let me get away with that.

Survivors found their therapists to be very helpful in working through their anger, even though they were clear that the responsibility for the work was theirs. "One of the main things she has done for me is to create an environment where it is safe to express my anger, where I'm not imperiled." "She taught me assertiveness and asked me what I was angry about. She wanted to get to the bottom of it instead of covering it up." "Her main suggestion was that I feel my feelings." About her anger work, another survivor said,

We spent a long time on it. I think she helped me understand that anger is a normal feeling and that nothing will happen if you get angry; that I'm an adult now. A real turning point for me was when she said that I was responding like a child would respond to a situation and that I needed to handle it more like an adult would. Instead of being afraid and wanting to run away from it and finding somebody else to blame that I really needed to look at the situation and respond like an adult would. And she had to do a lot of coaching: "You're not a child any more. You don't have the same things to fear. And if you express yourself now, you'll be heard."

From the perspective of having finished a large part of the therapy, one survivor noted that the therapy relationship had changed from the early times when she attributed a life-giving importance to the connection with her therapist.

I don't remember suggestions he made as much as I remember feelings. Feeling that it was safe with him to be angry. Feeling that it was safe with him to be anything. Scared he would die, because if he died, I died, because there was so much rage and this was the only outlet. He would encourage me when I got too scared to talk. The letter he wrote me was crucial. After that I was pretty sure I was not going to die.... It's amazing how the cycles of therapy go. During that time he was like my family then, but a positive family. That's transference, I guess. Now he's just a guy--a good guy. He's my therapist but he's another human being trying to make his way in the world and that's O.K.

Survivors had a way of measuring the results of working on their anger by comparing times they remember exploding with times recently when they felt proud of themselves about the way they handled an anger-producing situation. One woman

developed an agreement with her carpool partner to be allowed to "spew angry words" on the way home about a difficult boss who is not likely to change. Another woman is learning to say, "I feel . . ." instead of "You piss me off!" Another woman was clear that her anger feels different now.

It's like regualr anger now. I deal with it as opposed to not dealing with it. Because my anger now is nothing like the anger I've already been through. I say it. I say it to whoever is involved in it. It's not connected with my self-esteem any more. So we're not talking the same class of anger. I know who I am and I know that I am loved and loving and worthwhile. I know that so if I'm angry over something, I'm only angry over that thing. Every time I get angry now it's not over everything that has ever happened to me in my life. Like if a guy stands me up, I don't go back to the same anger of being a child. I'm just a little pissed that I got stood up, that's all. And if something happens at work, it's only something that happened at work. It's not the anger of the ages. It's easy to deal with now 'cause I feel.

Another woman shared the letter she had recently written and mailed to her father as an example of how she had learned to focus her anger now:

To The Man I Thought Was My Father:

There was a name for what you did to me during my childhood. It is called incest. I want you to know that I hated it when you molested me. I lived in fear of you. You robbed me of my childhood, destroyed my chance for family, stripped me of my self-esteem and personal power. For me, it was a life of chaos and stress. I never knew what was going to happen next. During my waking hours I was constantly scheming ways to protect myself from you, the enemy. The night brought terrifying nightmares.

You were a sick, abusive man. Your abuse was physical, mental, emotional, spiritual, and sexual. I was an innocent, powerless child. I became your scapegoat, your victim. I survived your abuse, but at great personal cost to my soul. I overcame your sarcastic taunts. Hear me when I say that I am not an idiot, imbecile, nincompoop, numskull, or anything else you called me. My name is not Mumbles. I am an intelligent, creative, nurturing, and conficent being.

Through therapy my soul has been healing, but it can not bring back all the lost years. I am holding you accountable for your actions, and the damage you inflicted upon my soul. My soul was raped. No monetary sum could ever equalize the devastation. However, I am enclosing a bill for my therapy. If necessary, I will take further legal action.

Issues More Difficult to Deal With Than Anger

Survivors rated some other parts of their therapy as equally problematic for the as anger or in some cases more of a problem. There was no formal rating system, so the summary of issues should be labeled as part of the most difficult work of therapy from the survivors' points of view. Lack of self esteem was the most difficult issue for 9 of the survivors, the most who shared any common concern. An aversion to sex or problems with their sexuality was the most difficult issue for 7 of the survivors. "Sexuality has been a major problem. I have acted out sexually. I have found low level sexually abusive relationships. I've been attracted to people like my father: distance, criticism, emotional and physical sexual sliminess." Guilt and feeling responsible for what happened was the most difficult problem for another 7 survivors. "Dealing with guilt was difficult, because it happened, because I didn't say no, because my body responded to the sexual contact, because I blew off so many wonderful people all my life. I couldn't let them get close." Fear was the most difficult for 6 survivors. "Fear of total loss of control for ever and ever was difficult. If you express one emotion, you have to let all the rest of them out: pain, grief, love. It's scary. I'm learning how to love. I know I didn't know what it was. I don't think I ever truly was loved. I do not believe I came from a loving home or had loving parents." Facing the incest was the most difficult for 5 survivors; being able to trust people was the most difficult for 4 survivors. Several problems were mentioned as most important by 3 survivors: telling family, the tidal wave of anger, feelings of helplessness and powerlessness, not knowing how to say no (trouble establishing boundaries), being comfortable with attractiveness, the relationship with father and how to handle him, abandonment, having to be constantly in control, not ever being loved, loss and grief. The following problems were mentioned as most important by 2 survivors: finding fault with my mother,

depression and fear of being depressed again, shame, learning to get in touch with my feelings again, hurt. Single individuals named the following issues as most problematic: finding a lawyer to pursue litigation against father, overcoming a dissociative habit, going to the doctor after being molested by a doctor, honest communication with herself, validating her experience, wishing there were a facts record, "learning I don't owe anybody anything and that it's O.K. to love myself." One survivor said,

I guess maybe the biggest issue in retrospect is absolute lack of love for me. that was probably more important than being angry. One of the direct results of my childhood was I did not matter. That was more important, I see now. I had to get that back before my anger even counted. So that was the biggest problem, that I had no love for me and consequently I was unable to love others, I was unable to be in relationship, unable to function as a person, unable to integrate. I did not count. I did not matter. I was here as a result of some terrible mistake. That was the most important problem.

Advice to Other Survivors

Survivors seemed to reach out toward other survivors with warmth and support as they answered the question about what advice they would have for other survivors just beginning to deal with their anger about the incest. Nineteen of them recommended continuing in therapy with a qualified therapist. "Therapy has been the single most uplifting experience of my life." "Get into therapy. Stay in therapy. You are worth it. Love yourself. Be gentle with yourself. Know that it's going to feel rotten for a long time, but it's better than not feeling." "That's what therapy can do for you--the *confidence* in myself to tell people what I need, to tell people how I feel, and not to feel used and abused by the world." Nine survivors said, "Go forward with it; go with the anger." "To allow yourself to be angry and be thankful you can be angry because you have a right to be angry." "The only way out is through. You won't drown in it. It won't overtake you. And you're not alone." Nine survivors endorsed, "Take the risk to

talk to people. Join a recovery group. Be in a support group." Seven survivors passed on the suggestion, "Don't be afraid of your anger. Don't fight it. It won't hurt you." "That monster you're hiding inside is not a monster but a lost child whose voice was never heard." Seven survivors promised, "It can be conquered." "You can heal."

Six survivors said, "Trust your feelings." "If you don't agree with your therapist, do it your way. All they're trying to do is help you. They don't have all the answers. If they're not in line with what you need to hear, tell them." Six survivors also made each of the following suggestions: "Find people to give you the support you need." "Don't give up." "Tell people you trust." "Don't blame yourself. It's not your fault." Several survivors endorsed moving through the healing process (1) your way, and (2) at your pace. "Express your feelings." "Don't limit yourself. If it works, it works--whatever works for you, no matter how unconventional." "Get physical with it: scream if you feel like screaming; hit if you feel like hitting; run until you drop. And if you can't do all of those, do what you can. Take that first step--get angry about someone hitting a child in the mall." "If you can't still work on the anger, then stay with the hurt. The anger comes along." "Don't rush your healing." Some additional suggestions offered by individuals were: "Don't expect people to react the way you want them to." "Do body work." "Use a daily affirmations book." Explore communication, risk-taking, relationship-building, honesty, caring." "Read any book on healing, recovery; get what you can and don't worry about what you don't get." "I've found doing dishes very therapeutic. You can drown the abuser." "Explore spirituality." "Trust your higher power."

Interview Data from Therapists

Assumptions about Treating Adult Survivors of Incest

There is an orthodoxy among the 25 therapists about treating adult survivors of incest. They hold to the principle of "first do no more harm" in that they believe therapists should not further abuse these clients. They also believe in the trauma theory of abuse treatment--that it was the situation that is abnormal, not the person, and that "any kind of dysfunctional behaviors for the most part were helpful in terms of survival and can be looked at as positive and helpful to the client." One therapist told a story about two puppies that he tells his clients. "Two puppies were born into the same litter and they were placed in two households as soon as they were weaned. One puppy went to a house with a big back yard and ate plenty of food and played in the sunshine all day and learned to fetch the ball the children threw. The other puppy went to a house where nobody was home all day and where they often forgot to feed it and where the adults beat it when they got drunk. If you were to compare these puppies two years later when they had grown to be dogs, what would you find?" His point was that the environment in the households of his clients provided them with a learning experience that they did not control, just as the puppies did not control the learning experiences they faced. The therapists also strongly endorsed the notion that recovery is possible, that healing does happen, "that the prognosis for a good life is wonderful." Only one therapist still had questions about the ethics of offering hopeful possibilities to clients as opposed to teaching them to live with their limitations. She was the sole therapist among this group who spoke about burdening clients with "false hopes."

All therapists expressed general agreement with Denise Gelin's assumptions of treating incest survivors that hold the adult responsible for the abuse but recognize the loyalty of the child to the parent despite the limitations of the parent. The therapists were

not willing to let loyalty become self-blame for their clients. These therapists participate in scapegoating the abusers as a way of validating the clients' anger at times, but they do not bond with the anger. Their care was expressed several ways: "Loyalty is part of their developmental self. That's the tricky part. How do you work with opposites? That's why they can't deal with it either." "A therapist has to stay very neutral in the whole area of disclosure and confrontation of an abuser and encourage exploration of the reasons for doing that and the possible consequences." "It depends on the form the loyalty takes. I don't think you always have to open it all up. Some people are so damaged you don't do them a favor. Careful assessment of external current supports and their personality structure is needed to determine how much opening up is appropriate." "You don't take family away from someone. You help *them* resolve their relationship, even if it is never seeing them again." One therapist had a wish that her clients would grow to be more balanced in their view of the abusers.

When the victim gets in touch with her anger against the perpetrator, she tends to monsterize her abusers for a long time. She makes them *all evil*. I would like to see her humanize her abusers a bit. I think it will come in time. I'm not pushing forgiveness. In time it would help to understand where that person comes from. That person may have gotten a lot older and may not be able to hurt them at all. I think it would be beneficial for them to move forward when it is safe for them.

Another therapist noted that childhood sexual abuse survivors seem to reach out for safe touch (a hug at the end of the session that is clearly non-sexual) than other clients. Assumptions the therapists mentioned from their own experience with survivors are listed in Table 32.

Table 32
Therapist Assumptions about Treating Adult Survivors of Incest

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- That they are essentially strong people or they would not have survived.
 - That they have choices and that they can raise children without abusing them.
 - That the family will deny that it happened and will try to get her to recant or tell her she's crazy.
 - That women can get through this and be healthy.
 - That I will be consistent and genuinely concerned for them.
 - That transference is inevitable.
 - That it was the situation, not the person that is abnormal.
 - That it wasn't her fault.
 - That there is a legacy in the family of generations of dysfunction that they have been victimized by. The adult who is the perpetrator is on some level being dishonest and has disowned his/her responsibility and is unconsciously seeking a scapegoat themselves.
 - That the memory and experience of the incest is blocked in the victim's body and is likely to be only minimally known and remembered in the conscious mind.
-

Assumptions About Anger

The therapists also articulated some assumptions about anger as a part of treatment of adult survivors of incest that inform their approach to the survivor as a person and their selection of interventions during the course of therapy. They see anger as a source of power to clients. One therapist phrased it, "Anger is a metaphor for power." Another said, "I see anger as freedom." "It's the cork that's in the bottle that holds empowerment," was another therapist's metaphor. They believe anger is a useful emotion, and they set out to teach recognition, acceptance, and safe expression of anger to their clients. "It's part of the essential human emotion of establishing a boundary or a

limit that all of us need to avoid being swallowed up by another person." "My job is helping them recognize the helpfulness and beauty of their own anger, how it is a healthy, useful part of themselves." They also see anger as rage for these clients. "Anger is rage for survivors. How could someone who's supposed to love and protect you hurt you? It's rage at their loss. They will never have the family they think everybody else has." Other assumptions about anger that they mentioned are listed in Table 33.

Table 33
Assumptions about Anger in the Treatment of Adult Survivors of Incest

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- That anger is invariably present.
 - That anger is an acceptable emotion, that it can be a healthy motivator, that it can be empowering, and that it is a measure of a survivor's progress, when they get to it.
 - That anger must be accessed and expressed for healing to take place.
 - That accessing the anger is a crucial factor in moving from the position of victim to the position of mastery.
 - That some people are more in touch with anger than others.
 - That anger is often masked by guilt.
 - That anger can be a defense against facing hurt and vulnerability, and hurt and vulnerability can be a defense against facing anger.
 - That it is appropriate to feel anger about abuse.
 - That anger needs to be directed against the abuser.
 - That anger is better outer-directed than focused against the self, and that the purpose of therapy is to get it out.
 - That survivors can learn to express anger appropriately.
-

When it comes to identifying a pattern of presentation and working through the anger, the therapists were in agreement that clients either exhibit Anger-In characteristics,

where their anger has been repressed and in extreme cases where they might not feel it at all, or Anger-Out characteristics, where they express excessive amounts of anger at all times. For the Anger-In client, therapists see the task of therapy as helping clients touch their anger and become empowered by it, "use it as a signal that you're being badly treated." For the Anger-Out client, the task of therapy is to direct the anger where it belongs. Another way to phrase the two client presentations with respect to anger is, in one therapist's words, "(1) Absence of--where you spend the whole treatment working on access, acceptance, and identification of anger, or (2) Rage--where you spend the whole treatment working on, 'Be the rest of who you are.'" Not all therapists had worked with clients presenting both ways. More therapists had worked with Anger-In than Anger-Out clients.

Within those two ways of presenting, therapists' experience with their clients showed a high level of individuality regarding what comes next in treatment. One therapist said, "It's highly individual but I find that once the incest is acknowledged, the losses and transgression acknowledged, grief and anger reactions come up at almost the same time. Survivors are commonly afraid of their anger, afraid of expressing it. They don't know how to express it constructively and may have been threatened if they got angry. I think the process is either one of learning or re-learning about anger." Another therapist agreed that survivors are afraid of their anger:

Most often those who deny their anger choose to feel guilty instead of feeling angry. They are more comfortable feeling guilty and it's also more acceptable than feeling angry. Those who are spewing anger everywhere are afraid to feel the hurt and pain so they use anger. How they learn to get it from the inside out and how they learn to express it appropriately is very individual. Part of that individuality is based on their value systems. One survivor may be able to fantasize killing the perpetrator. Another survivor may be able to fantasize beating him in a foot race and turning around and sticking her tongue out at him. Some can write an angry letter and some can't.

Anger During Treatment

Twenty-two of the therapists (88 percent) said that when their clients' anger presents in therapy, they encourage it, validate the feeling, welcome it, identify it, "I don't judge it or project any fear of it," "I don't interrupt them." "I love seeing it because it's been so tucked away that it's scary sometimes for survivors. It's really pretty rewarding when they can come in here and share their anger with me and we can work through that." "I see it as a very healthy function when they can express and feel their anger." The therapists reported that their next move after facilitating the ventilation of the anger was to suggest something empowering to the client. "I ask them to write letters or journal writing. They have a sense of control when they contact their anger that way." Another therapist encourages daily writing by his clients to provide continuity of therapy. He reads and makes written comments in the journals weekly. His observation was that some clients find the courage to say things to him in their journals that they have not yet brought up during the therapy hour.

Two therapists use breath work to help anger emerge and one therapist uses bench work, sustained beating on a bench with a bat while accompanied by a supportive group of people. These experiential, expressive therapies have as their goal a reconstructive experience for the clients in addition to reliving the original trauma. One of the experiential therapists explained,

It is important to re-experience the traumatic situation. By re-experiencing I really mean experiencing it for the first time all the way. When they actually experienced the abuse in space and time they had to shut off their natural response to the abuse in order to self protect. So their rage, going public with affect, all that had to be truncated. So when they experience it now, talk to me about the abuse, they go all the way through it for the first time. In breath work getting the body involved for a complete energetic release of the experience in the presence of others and after the release experiencing gentle touch and support as a corrective experience creates a unique opportunity to provide a whole different imprint for that part of their lives.

Another experiential therapist outlined the multiple events that are taking place while anger work is being done.

Trauma is bound energy in the body, and rage moves the body. There is a clearing of past feelings. A natural grief process can start to happen then after this other work has been done. When I use anger I don't mean to condone free floating hostility leaking out in their lives. When anger is focusing a whole lot is happening. Denial is breaking up. Energy is moving. There's a major shift that's happening in the organism from fear (giving power away to the perpetrator) to a deep knowing that they *can* survive, that they don't die from telling the truth--a shift from being a victim to being an equal power to the perpetrator. That's very important. It's a reclaiming of their souls.

Most of the anger work the therapists report observing and participating in with their clients happens during the middle phase of treatment, "when the client has remembered something and has gotten through their feelings of disbelief, denial and self-blame." "Frequently the steps are (1) work through denial; (2) accept reality; (3) work through the pain; (4) then comes anger. The last two steps can be reversed." Another therapist said, "Some people deal with anger before they can deal with the sadness and grief. Some deal with the sadness and grief before they can deal with the anger. One will cover up the other. It depends on what their coping mechanisms are as to what is on the top of the pile." Several therapists use anger for measuring their clients' stage of development in therapy. When anger comes, they are getting better. Conversely, "If they haven't done anger, they're not done."

The therapists have a list of strategies, tasks and rituals they often suggest to their clients. That list is presented in Table 34. When it comes to the intuitive process of "fit" between client and strategy or technique, the therapists found it difficult to articulate a clear scheme. "It depends on what hits me at that moment when I'm with someone." One therapist has a two-question assessment method, "Are you visual?" and "Will you write?" Another therapist takes into account her clients' primary representational system.

"If they are visually oriented, I paint word pictures. If they are tactile, I ask them to hit, punch, pull. If they are auditory, I talk to them about the rushing wind and crackling fire. I listen to how clients present their images and then use that modality."

Table 34

Strategies, Tasks, and Rituals Therapists Suggest to Clients

-
- The individual really needs to develop his/her own metaphor, tasks, rituals. I facilitate that. Empower them to decide, choose.
 - Create a climate of safety in the therapy frame.
 - Recognize body signs of anger.
 - Imagery. Empty chair. Guided imagery. Images in lieu of action.
 - Breath work, body work, bench work.
 - Running, exercise.
 - Role play.
 - Listen to a tape on anger.
 - Relaxation techniques, self-hypnosis
 - Writing a letter to the abuser. Writing daily in a journal.
 - Rate your anger on a scale from 1 - 10
 - Photographs from childhood
 - Hit a rubber hose on a board. Hit tennis racquet on the bed.
 - Punch a pillow. Punch a punching bag.
 - Break dishes, throw pots, break glass.
 - Throw darts at a picture. Throw water balloons.
 - Tear up paper bags. Punch paper bags. Tear up magazines that remind her of parents.
 - Pound nails on boards. Write names with the nails. Draw faces with the nails.
 - Tape name to bottom of shoe and take a walk. Tape name to tires and take a ride.
 - Draw a feeling. Make an anger collage.
 - Visiting grave site of abuser, yelling, kicking grave stone.
 - Scream in the car with the windows rolled up.
 - Keep a daily diary of feelings.
 - Make a resentment list.
 - Verbalize your anger to other people.
 - Understand the anger.
 - Use humor to amplify a fantasy.
-

An example of use of humor by a therapist was his amplification of a client's image of her stepfather (still alive) being chased by the hounds of hell with one foot in the grave

and one foot on a banana peel. To make the image even more vivid, he suggested that dogfood be painted on his balls to attract the hounds of hell.

Issues More Difficult in Therapy than Anger

Anger was endorsed by some of the therapists as being indeed difficult to deal with. They said that where the anger was directed made a difference. Some of them found suicidal behavior more difficult to deal with than anger. Therapists identified the following issues as more than or at least equally difficult to deal with as anger: shame, self-blame (guilt), grief work ("loss of innocence, sense of self, loving family, the lie that was so much of their life in the past"), lack of trust, "They don't trust themselves. They don't trust their responses . They don't trust their guts, any intuitive response to something," pain (a repetition of the vulnerability), identity issues, sexual issues, ongoing victimization, flashbacks, mutilation, internalized family, abandonment and rejection. Therapists have difficulty with these issues because their effects seem to be more persistent than those of anger. "The issue of betrayal is a big one for many clients. Having been robbed of something. For me the toughest part is the grief that the family that they always wanted is never going to be the way they wanted--the grief that it is never going to be a whole world. Mourning the ideal childhood--that mothers and fathers do love and protect their children. That happens toward the end of treatment." One therapist's paradigm for her clients' struggles to accept the defects of their less-than-ideal families is the "shiny bunny" story she heard from one of her clients, "When you look around the stores at Easter, do you notice that there are shiny chocolate bunnies and dull chocolate bunnies? And do you know the difference? The shiny bunnies are hollow." They went on to explore the "shiny bunnies" in the survivor's life, and the grieving took on a symbol that the therapist has used with subsequent clients.

Countertransference Issues for Therapists

Therapists were open about talking about the effects on themselves of working with incest survivors. They all used the countertransferences to inform themselves about how treatment was going and to point their way to personal learning. A list of the countertransferences experienced by these therapists is shown in Table 35.

Table 35

Countertransferences from the 25 Therapists Toward Adult Incest Survivors

-
- Identification with the victim.
 - A defensive countertransference in wondering if it really happened in the way it was being described. Not wanting to know what really happened because it is so horrible.
 - Being attracted sexually to the client.
 - Helplessness, frustration when things are stuck and they can't tell me what is wrong.
 - Strong desires to protect and defend.
 - Tendency toward over-nurturing.
 - Being seduced into splitting regarding other involved therapists.
 - Women who are the same age as my daughter.
 - Seeing client as fragile and feeling responsible for her.
 - Temptation for male bashing, "Men are all sexually obnoxious acting out animals."
 - Defensive feelings when clients' anger is directed at me.
 - Sense of outrage about abuse.
 - Righteousness, "I'm not abusing you!"
 - Feeling inadequate. Being deskilled.
 - Separating friendship issues. Keeping distance.
 - Any questions I have about my own worth and self-esteem.
 - My own unmet needs regarding my parents. My own grief.
 - My disappointment at crummy mothers. I want women to do better than that.
-

More therapists said that anger was an occupational hazard for them than not, that working with incest survivors increased the amount of anger they had to deal with in their personal lives. One female therapist said, "It's taught me to be a lot clearer in expressing my anger, learning to practice what I preach. Battered women taught me about righteous anger. Working with incest survivors, I came to see anger as empowerment. Being in touch with your feelings, all of your feelings, both positive and

negative, is a way of building your own reality base. I see anger as an ally." Another therapist explained that the repression was the factor that was potentially contaminating to the therapist, not the anger. "It's the repression that is taken on. It's the repression that is contagious. With the hands on body work I do, the level of affect in the air, I'm sure I'm taking some of it on. I have to take care of my own body. I can feel tightness in my own body. It's the repression that I absorb."

Directions for Future Research and Training from Therapists

Therapists expressed some skepticism about the usefulness of much of the research that has been done for clinical applications. Some of them expressed a wish that research would focus more on the "real world." They liked the ideal that clinicians were being consulted about their experiences in the clinic for this study. "I'm not sure about research. This is the first research I've been contacted on. *Treatment..* What works best? How can therapists be most helpful? What about single session hypnotherapy claims of helping survivors? Is *The Courage to Heal* method better--you stay out of their way and you help them the best you can. What about coordinating multiple services for someone (e.g.: substance abuse)? What works and what is beneficial? What is the most helpful way to educate therapists?" Other research topics therapists suggested are as follows: confronting and forgiving, breath work, body work, male survivor issues, gender of therapist with male survivors, length of treatment, non-abusing parent, perpetrators, female abusers, developmentally-based effects of abuse (e.g.: under 3, 5-8, pre-adolescence), treatment of sexual dysfunctions, what factors affect the resilience of the personality, treatment of different cases along the dissociation continuum, the ritual abuse controversy, when medication helps, how to involve spouses and partners in treatment. One therapist also wondered, "Are there any

better ways to teach coping with flashbacks than I know? Two therapists also wondered about the impact of intelligence on treatment. One said she had difficulty working with low-normal intelligence clients. One said his hunch was that even though high intelligence clients had more potential for doing well in therapy, they had difficulty getting better in treatment because they could "beat themselves up cognitively with more skill."

Additional training needs of the therapists were identified by the therapists as the last question on the interview, and they are listed here in order of frequency of request: (1) peer supervision, consultation; (2) multiple personality disorder; (3) hypnosis; (4) anything on treatment; (5) body work, breath work, bio-energetics; (6) male survivors; (7) anger; (8) assessment; (9) borderline symptoms; (10) substance abuse. Single suggestions came for each of the following topics: sand tray, play therapy, group, spiritual connections, chronic trauma, trust, memory recall, grief, sadness, the neurochemistry of trauma, ritual abuse treatment, and one therapist who wanted an annotated bibliography of books that would be good for clients in their self-work. She had neither time nor budget to read all the books available on incest for survivors and wanted the bibliography to help her make reading suggestions to her clients.

CHAPTER 5

CONCLUSIONS

Discussion of Results

This study of 45 adult female survivors of childhood incest was undertaken to expand the research knowledge about mental health treatment for this population particularly about the experience and expression of anger as an element of their therapy. The dimension of anger was addressed in objective assessment and interview format over the time lapse of before they were treated for the incest until the present time. The self-reports of clients were compared to the assessments of the therapists. In addition to the experience and expression of anger, survivors also were given a measure of their coping resources, which was compared to the therapist's rank ordering of coping resources for each survivor, and a measure of psychological type, to determine if their scores would show a relationship between type and coping resources similar to that found in previous research on other populations. Interview data was also gathered from therapists to determine, qualitatively, whether they, as community-identified experts in treatment of adult survivors of incest, had assumptions or philosophies of treatment in common that, if reported, could be a benefit to therapists less familiar with treating this population.

Demographically, the survivor group had spent an average of 32 months in therapy with their current therapists. Twenty-four survivors had completed therapy. Twenty-one survivors were in the ending phases of therapy and were thought by their

therapists to be able to talk about their experience with anger before, during, and after treatment. The survivors' average age was 38 years old. Thirty-four of them (76 percent) were educated past high school. Their occupational satisfaction was 2.5 on a three point scale. 69 percent of them are parents. About half are married and half single.

For 60 percent of the survivors the incest began at or prior to age 5. All had been abused at or prior to age 12. The abuse lasted through the teen years for 60 percent of the survivors. The duration of the abuse was four or more years for 82 percent of the group. Over half the group experienced forced vaginal, anal, or oral sexual penetration. Sexual contact happened weekly or more frequently for about half of the group. The survivors experienced abuse from 150 separate abusers, an average of 3.3 abusers per survivor.

Demographics of the survivors include factors that would make the outcome of therapy appear favorable. Demographics of the abuse include factors that would predict the most severe long term effects. Outcome data from survivors' anecdotes indicate that survivors were proud of their progress and that they were crediting the therapy process for guiding them through their improvements. Their anecdotal reports were confirmed by the outcome measure, where they rated their mean overall improvement 91.2 on a 100 point scale and their mean symptom improvement 79.2 on a 100 point scale. Therapist assessment on the same outcome measure showed no significant difference from client report on the mean symptom improvement score. Therapist assessment of 78.4 on a 100 point scale was significantly lower than the client score at much less than the .001 level, a finding that was not expected based on the outcome research in which therapists often report more optimistically about the outcome of therapy than clients report (Garfield and Bergin, 1986). Therapists' modesty about the overall outcome might be interpreted instead as clients' somewhat extravagant enthusiasm about overall outcome. In any

case, therapists and clients agree that outcome was positive, both anecdotally and by objective measure.

Another measure of outcome was the comparison of ending stage and post-therapy survivors with "normal" women approximately the same age on the STAXI and the CRI. If indeed the long term effects of childhood sexual abuse are persistent, and living with their limitations could be the best possible scenerio for these survivors, then the expectation would be that the survivors would be angrier than the STAXI norm group and have fewer coping resources available to them compared to the CRI norm group. That expectation was unfounded. The survivors at present were not significantly different from the STAXI norm group on the State-Anger scale (a measure of how angry they felt at the moment), on the Trait-Anger scale (a measure of how angry they were in general), and on the Anger-In scale (a measure of repressed anger). The survivors were more expressive of anger to other people as measured by the Anger-Out scale than the norm group, which may be an indication that they are more skilled at anger expression than the norm group, having worked so hard in therapy to be conscious about their anger. There were no indications in the anecdotal reports that these survivors were suffering from symptoms of hypertension or other negative somatic consequences of expressing their anger. Therapists predictions about survivors on both the Anger-In and the Anger-Out scales did not differ significantly from the survivor reports.

On the Coping Resources Inventory, the survivor mean total coping resources scores did not differ significantly from the mean total coping resources scores of the norm group. So the survivors, in so far as these measures can be taken to indicate healthy adjustment, have emerged from treatment for severe childhood sexual abuse with a positive outcome. There is consistency between the anecdotal reports of how they coped with the abuse, how they dealt with their anger about the abuse, and the top

ranked coping resources for each survivor. There is consistency between the anecdotal reports of the strategies they used to cope with the abuse and the expected strategies by MBTI preference. The sample is too small to indicate anything about frequency of type or over or under-representation in this population compared to the CAPT data bank or the Myers high school sample.

A final measure of outcome was the awareness measure that asked for therapist assessment and survivor self-report in three separate time frames, prior to therapy for the incest, during therapy, and at the present time. Both therapists and survivors showed an increased awareness of feelings in general and of specific feelings of anger over the time lapsed. Therapists reported survivors more aware of their feelings in general before therapy than survivors reported their own awareness. That score is the only one that differs significantly between therapist report and survivor report. It may be possible that survivors' enthusiasm about their improvement may have influenced their perception of their starting point. It may also be possible that survivors' subjective appraisal of their distress prior to therapy is more accurate than their therapists' projections would indicate, and it is also possible that the survivor self-reports reflect additional improvement over time since therapy has ended, since over half of the sample have finished their treatment as much as three years ago.

The Type-Related Anger Questions results were inconclusive. Therapist guesses were less related to dominance categories than survivor report. That instrument was validated prior to this study only by review of three expert Myers-Briggs Type Indicator users. Clearly, more research needs to be done on that assessment tool before it could be determined whether psychological type has any direct relationship with how a person copes with anger. Jung's question about how a person overcomes an obstacle remains unanswered here. These results do not clearly match Dopson's (1986) type

path through trauma. There is a need for more detailed case material like Courtois' (1990) to focus on type patterns in therapy to determine the application of Dopson's theory to incest survivors.

Only eight of the therapists use the MBTI in their clinical practice; seventeen do not. Because the anger strategy lists for both survivors and therapists fit into the type framework, some intriguing questions are raised about the intuitive process therapists use with their clients. Sensitivity to the cues given by the clients may contribute to the success of these therapists and to their recognition in the communities as experts. Finding a "fit" between wound and healing, finding the teachable moment for their clients may involve tuning into their clients' psychological type characteristics whether or not therapists actually use or are even familiar with the MBTI.

Implications

Taken together, the anecdotes of the survivors, the outcome measures, and the conceptualizations of treatment by the therapists, these results constitute a testimonial for qualified therapists. The survivors went through 164 separate therapists, or an average of 3.6 therapists per survivor, before finding their current therapist. The 195 therapists on VAASA sexual assault crisis center referral lists represent only 4 percent of the licensed mental health professionals in Virginia. The question from one of the therapists for future study, "What's the most helpful way to educate therapists?," is well spoken. One of the policy questions at present concerning the future of mental health treatment for survivors is will we be content to find a few self-selected experts who have trained themselves both by continuing education and experience to treat the increasing volume of survivors seeking services? Or is there a way that the number of qualified professionals with specialized training in recovery from childhood sexual abuse can be increased rather

quickly to take care of the volume of requests?

The implication of this study with respect to the anger literature is that another category of anger may need attention in the research. This justified, validated, encouraged, welcomed, celebrated anger from childhood abuse, as described by these survivors and these therapists is a different-sounding phenomenon from the "maladaptive" anger that is described in the anger literature. This study seems to indicate that the etiology of anger does matter and that the treatment of choice that these survivors and these therapists have found to be successful, the program of permission to feel it, locating it in the body, articulating its presence, expressing it, and working it through should not be discouraged on behalf of some other program of anger control, anger management, or anger reduction.

It seems fitting that the survivors should have the last word in this study. Their stories have been a tribute to the resilience of the human spirit. They have suffered and they have healed their wounds. Their outreach to each other in their answers to the question about what suggestions they might have for another survivor seems to be another implication of this study. With healing, a transformation occurs where something bad, the abusiveness of the incest, becomes something of benefit to others. A final part of their empowerment, reclaiming the power that was taken from them in the abusive past, seems to be the determination of these survivors to do something to benefit others. That was the motivation many of them had for participating in this study, and that is the motivation that has led them to become social workers, therapists, nurses, volunteers in their local rape crisis centers, educators for child abuse prevention, support group members, non-abusive parents. And how will the healing happen? One survivor's suggestion was, "Be patient. Be true to yourself. Ask yourself are you ready to deal with it? Be willing. Know that you'll get out of therapy what you give to it."

APPENDIX A

Table 1. Type Table for Four Samples

	ISTJ		ISFJ		INFJ		INTJ	
	N	%	N	%	N	%	N	%
Counselors	4	7	1	2	5	8	1	2
Associates	12	11	4	4	15	13	18	16
MBAs	3	11	1	4	3	11	1	4
Stress	2	10	0	0	3	14	3	14
	ISTP		ISFP		INFP		INTP	
	N	%	N	%	N	%	N	%
Counselors	0	0	2	3	8	13	4	7
Associates	3	3	2	2	4	4	11	10
MBAs	0	0	0	0	1	4	3	11
Stress	0	0	0	0	3	14	1	5
	ESTP		ESFP		ENFP		ENTP	
	N	%	N	%	N	%	N	%
Counselors	0	0	1	2	11	18	2	3
Associates	0	0	2	2	11	10	6	5
MBAs	1	4	0	0	1	4	5	19
Stress	1	5	2	10	0	0	2	10
	ESTJ		ESFJ		ENFJ		ENTJ	
	N	%	N	%	N	%	N	%
Counselors	3	5	10	16	7	11	2	3
Associates	4	4	5	4	2	2	13	12
MBAs	2	7	1	4	1	4	4	15
Stress	0	0	1	5	1	5	2	10

Table 2. Relationship between Coping Resources and MBTI
Continuous Scores in Four Samples

Sample	Cog	Soc	Emo	S/P	Phy	Tot
Counselors (N=51)						
EI	-.38**	-.55***	-.45**	-.16	-.04	-.44**
SN	.06	-.07	.10	-.29	-.10	-.02
TF	.16	.18	.21	-.17	-.02	.19
JP	.01	.00	.10	-.33	-.04	-.06
Danforth Associates (N=100)						
EI	-.25	-.65***	-.45***	-.02	-.25	-.47**
SN	.19	.06	.14	.13	.16	.19
TF	.17	.49***	.26**	.23	.02	.33**
JP	.00	.20	.19	-.21	.18	.11
Stress workshop participants (N=20)						
EI	-.34	-.28	-.36	.36	-.30	-.29
SN	.22	.06	.32	.34	-.05	.25
TF	-.17	.09	-.11	-.16	.20	-.03
JP	-.01	.35	.43	-.26	.20	.26
MBA students (N=26)						
EI	.26	.09	.00	.15	.14	.18
SN	.04	.00	.09	.05	.03	.06
TF	.33	.06	.55**	.06	.10	.30
JP	-.23	-.07	.09	.09	-.18	-.04

Note: ** $p < .01$; *** $p < .001$

Table 3. Rankings by Dominant Functions on CRI Scales

	Tot	Cog	Soc	Emo	S/P	Phy
ENFP	1	1	1	1	2	1
ENTP	4	3	5	3	5	6
ESFP	3	2	2	5	4	5
ESTP						
ENTJ	3	3	5	4	3	2
ESTJ	5	1	4	2	8	6
INTJ	10	3	10	7	3	8
INFJ	2	2	6	5	1	4
ENFJ	8	4	3	9	4	7
ESFJ	7	7	6	6	2	9
ISFP	8	6	7	6	1	10
INFP	9	3	8	8	2	8
ISFJ	3	2	5	5	2	3
ISTJ	11	4	9	8	6	7
INTP	12	6	10	10	7	5
ISTP	6	5	10	5	4	5

Note: There were no ESTP's in this sample

Table 4. Rankings by the 16 types on CRI Scales

	N	Tot	Cog	Soc	Emo	S/P	Phy
ENFP	11	1	1	1	1	2	1
INFJ	15	2	2	6	5	1	4
ENTJ	13	3	3	5	4	3	2
ESFP	2	3	2	2	5	4	5
ISFJ	4	3	2	5	5	2	3
ENTP	6	4	3	5	3	5	6
ESTJ	4	5	1	4	2	8	6
ISTP	3	6	5	10	5	4	5
ESFJ	5	7	7	6	6	2	9
ENFJ	2	8	4	3	9	4	7
ISFP	2	8	6	7	6	1	10
INFP	4	9	3	8	8	2	8
INTJ	18	10	3	10	7	3	8
ISTJ	12	11	4	9	8	6	7
INTP	11	12	6	10	10	7	5

Note: There were no ESTP's in this sample

Table 5. Top Resources for Each Type

ISTJ Cognitive (4)	ISFJ Cognitive (2) Spir/Phil (2)	INFJ Spir/Phil (1) Cognitive (2)	INTJ Cognitive (3) Spir/Phil (3)
ISTP Spir/Phil (4)	ISFP Spir/Phil (1)	INFP Spir/Phil (2) Cognitive (3)	INTP Physical (5)
ESTP	ESFP Cognitive (2) Social (2)	ENFP Cognitive (1) Social (1) Emotional (1) Physical (1)	ENTP Cognitive (3) Emotional (3)
ESTJ Cognitive (1) Emotional (2)	ESFJ Spir/Phil (2)	ENFJ Social (3) Cognitive (4) Spir/Phil (4)	ENTJ Physical (2) Spir/Phil (3) Cognitive (3)

Note: Numbers in parentheses where each type ranked on the resource compared to other types; types with similar scores were given equal ranks

APPENDIX B

Client Interview Questions

Today's date: _____

1. Age
- Gender
- Ethnicity
2. Marital and parenthood status
3. Level and source of income
4. Age at which incest began
5. Age at which incest ended
6. Type of sexual contact
7. Frequency of sexual abuse
8. Identity of abuser (s)
9. Family of origin problems:
 - Alcohol
 - Drugs
 - Physical abuse
 - Emotional abuse
 - Multiple incest victims
 - Marital conflict
 - Social isolation
 - Health problems
 - Poverty
 - Other (specify)
10. Experience with first disclosure of incest
11. Therapy history

12. What symptoms brought you to therapy with this therapist?
13. How did you choose this therapist?
14. Was anger a problem to you prior to therapy?
15. Describe connecting your experience with anger to the incest?
16. What did you do that helped you get in touch with your anger?
17. What were some obstacles to you in dealing with anger?
18. Did you feel afraid of your anger? What were your fears?
19. What did you do that helped you manage your anger?
20. What suggestions did your therapist make to help you deal with your anger?
21. Which of the therapist's suggestions did you follow?
22. What else did you do that helped?
23. Was there something about your therapist or the therapy process that presented an obstacle to you at some point during your dealing with your anger?

24. What are your favorite strategies, tasks, rituals for dealing with anger?

25. Is anger still a problem for you?

26. Say something about (1) frequency and (2) intensity of anger prior to therapy and now.

27. Were there other issues in therapy about the incest that were more of a problem to you than dealing with anger? What are they?

28. What advice could you give to another incest survivor just beginning to deal with his or her anger?

____Permission to be contacted to participate in further research.

Type-Related Anger Questions:

Please mark an (X) in the space next to the response that most nearly represents your preference on each of the following questions:

1. Would you be more likely to process the anger you experience

_____ externally (talking about it)

_____ internally (thinking about it)

2. Would you be more likely to process the anger you experience

_____ as a discrete piece, related only to the event of the moment

_____ as a whole feeling, associated also with anger from a past event(s)

3. Would you be more likely to express the anger you experience

_____ using concrete objects

_____ using mental imagery

4. Immediately upon feeling angry, would you be more likely to

_____ turn inside to look for your part in the situation

_____ externalize the blame onto others

5. Would you characterize your way of dealing with the initial experience of anger as

_____ linear (step by step)

_____ non-linear (unorderly free associations)

6. Would you be more likely to process the anger you experience

_____ with objectivity of logic

_____ with intensity of feeling

7. Would you be more likely to express the anger you experience

_____ with control

_____ with freedom of expression

8. Would you be more likely to express the anger you experience

_____ with planning

_____ spontaneously

9. Would you be more likely to process the anger you experience

_____ once and for all

_____ as a continuing process

10. Would you be more likely to express the anger you experience

_____ in the presence of others

_____ alone

11. Before choosing a way to express your anger, would you be more likely to

_____ focus on a justification for your anger

_____ focus on the feelings of the person who will receive your anger

12. What would prevent you from taking action on your anger or what would encourage you to take action on your anger?

_____ need more information

_____ need to feel finished with the exchange

Therapist Interview Questions

1. Age
 Gender
 Ethnicity
2. Prior familiarity with MBTI
3. Type of clinical training
 Degree
 Theoretical orientation of your program/mentor
4. Own theoretical orientation
5. Number of years in practice
6. Number of years treating incest survivors
7. Approximate number of incest survivors you have treated individually
 % of your case load AMAC
8. Modality of choice for treating incest survivors:
 individual, group, both
9. Optimum combination in your experience

10. If you also treat incest survivors in a group format, approximately how many people have you treated in those groups?

11. Are your groups open ended? time limited?

How many sessions weekly or other? (specify)

12. Denise Gelinas has stated the following underlying assumptions in treating incest survivors:

- (1) Whenever there is sexual contact between an adult and a child, it is always the adult's responsibility.
- (2) A child is intensely loyal to his or her parents, and that loyalty must be explicitly supported in treatment.
- (3) The adult is held accountable for the incest, but the therapist must never scapegoat, nor allow scapegoating.

Do you agree/disagree?

Add some?

What underlying assumptions do you have regarding anger as an issue of treatment for incest survivors?

13. Is there a natural history of anger in treatment, i.e. any recognizable usual pattern of presentation and working through for your clients, or would you say instead that each person's anger journey is individual instead of common?

14. What do you do when your client's anger presents?

What are your favorite strategies, tasks, suggestions for clients regarding anger?

What techniques work for which clients?

15. Is there a particular stage of treatment at which anger becomes an issue?

16. How do you conceptualize anger as a treatment issue for incest survivors?

17. Are there other issues that are more difficult to deal with in treatment than anger? If so, what are they?

18. Anger as an occupational hazard: Does treating incest survivors add to the amount of anger you deal with?

19. What countertransference issues with incest survivors have you encountered?

20. What questions for you are still unanswered regarding treatment of incest survivors?

What direction would you like to see research on incest survivors take in the future?

What additional training for either personal or professional development would you like to have?

_____Permission to be contacted to participate in further research.

Client-Specific Questions for Therapists:

Therapist ID# _____

Client ID # _____

Presenting problem for this client _____

Date therapy began _____ Date therapy ended _____

Frequency of sessions _____ Initial DX for this client _____

Number of sessions _____ Any change in DX? _____

(please specify)

In terms of how your client copes with the trauma of the incest, please rank order the following from her/his

MOST USED COPING RESOURCE = 1

to

LEAST USED COPING RESOURCE = 5

- _____ Cognitive
- _____ Social
- _____ Emotional
- _____ Spiritual/Philosophical
- _____ Physical

Definitions of the scales:

- COGNITIVE:** The extent to which individuals maintain a positive sense of self-worth, a positive outlook toward others, and optimism about life in general.
- SOCIAL:** The degree to which individuals are imbedded in social networks that are able to provide support in times of stress.
- EMOTIONAL:** The degree to which individuals are able to accept and express a range of affect, based on the premise that a range of emotional response aids in ameliorating long-term negative consequences of stress.
- SPIRITUAL/
PHILOSOPHICAL:** The degree to which actions of individuals are guided by stable and consistent values derived from religious, familial, or cultural tradition or from personal philosophy. Such values might serve to define the meaning of potentially stressful events and to prescribe strategies for responding effectively. The content domain for this scale is broader than traditional western religious definitions of spirituality.
- PHYSICAL:** The degree to which individuals enact health-promoting behaviors believed to contribute to increased physical well-being. Physical well-being is thought to decrease the level of negative response to stress and to enable faster recovery. It may also help to attenuate potentially chronic stress-illness cycles resulting from negative physical responses to stressors that themselves become major stressors.

Completed By (check one)

Outcome Measure:

 X Therapist ID# _____

_____ Client ID# _____

Please place a mark (X) on the line at the point which most nearly represents your evaluation of each of the following:

1. Please rate your client's awareness of his or her feelings before therapy:

Unaware _____ Extremely Aware

2. Please rate your client's awareness of his or her feelings during therapy:

Unaware _____ Extremely Aware

3. Please rate your client's awareness of his or her feelings at present:

Unaware _____ Extremely Aware

4. Please rate your client's awareness of feeling angry before therapy:

Unaware _____ Extremely Aware

5. Please rate your client's awareness of feeling angry during therapy:

Unaware _____ Extremely Aware

6. Please rate your client's awareness of feeling angry at present:

Unaware _____ Extremely Aware

7. Please rate your client's overall improvement during therapy

Not Improved _____ Much Improved

8. Please rate symptom improvement over the course of therapy:

Symptoms _____ Symptoms
Unchanged _____ Gone

9. Please list which symptoms you thought about when you answered question #8:

10. Please list any symptoms that did not improve during the course of therapy:

Type-Related Anger Questions (Therapist Form):

Therapist ID# _____

Client ID# _____

Date _____

Please mark an (X) in the space next to the response that most nearly represents your client's preference on each of the following questions:

1. Would your client be more likely to process the anger he or she experiences

_____ externally (talking about it)

_____ internally (thinking about it)

2. Would your client be more likely to process the anger he or she experiences

_____ as a discrete piece, related only to the event of the moment

_____ as a whole feeling, associated also with anger from a past event(s)

3. Would your client be more likely to express the anger he or she experiences

_____ using concrete objects

_____ using mental imagery

4. Immediately upon feeling angry, would your client be more likely to

_____ turn inside to look for his/her part in the situation

_____ externalize the blame onto others

5. Would you characterize your client's way of dealing with the initial experience of anger as

_____ linear (step by step)

_____ non-linear (unorderly free associations)

6. Would your client be more likely to process the anger he or she experiences

_____ with objectivity of logic

_____ with intensity of feeling

7. Would your client be more likely to express the anger he or she experiences
_____ with control
_____ with freedom of expression
8. Would your client be more likely to express the anger he or she experiences
_____ with planning
_____ spontaneously
9. Would your client be more likely to process the anger he or she experiences
_____ once and for all
_____ as a continuing process
10. Would your client be more likely to express the anger he or she experiences
_____ in the presence of others
_____ alone
11. Before choosing a way to express anger, would your client be more likely to
_____ focus on a justification for his or her anger
_____ focus on the feelings of the person who will receive the anger
12. What would prevent your client from taking action on his or her anger or what would encourage your client to take action on his or her anger?
_____ need more information
_____ need to feel finished with the exchange

APPENDIX C

Dear Therapist:

You have been identified as an expert in your community in the treatment of adult survivors of incest by the VAASA Sexual Assault Crisis Center in your area. I am conducting research on anger as an issue for incest survivors as part of a Doctoral program in Counseling at The College of William and Mary. The title of the project is "Anger and Type-Related Coping Resources in the Experience of Adult Survivors of Incest." I would like to include you and some of your clients in the study.

I am looking for male and female post-treatment survivors, persons who have successfully terminated therapy with you or who are in the last phases of treatment and could reasonably be expected to terminate within the next few months. By "successful termination" I mean

- (1) that the termination was mutually agreed upon by you and your client,
- (2) that the termination was not premature because of moving away or changes in insurance benefits, and
- (3) that you and your client further agreed that the remaining work of healing from the incest could be done by the client with his or her own resources.

I am including in the sample both male and female incest survivors who may have participated in group therapy or a support group for incest survivors as well as having had individual therapy with you.

I am enclosing a letter explaining the clients' role in the research and their freedom to drop out of the study at any time. Their participation will, of course, be confidential, and their contribution to the results of the study will be reported anonymously. The time commitment that will be required from each individual will be about an hour and a half filling out paper and pencil inventories and about an hour and a half in a semi-structured interview with me.

In addition to the interview with your clients, I will also need to interview you, the therapist, to ask you to be a second "measure" of the client's experience with anger. The interview will involve filling out some paper and pencil inventories about each of your clients as well as collecting demographic information about you and listening to you explain how you conceptualize anger in the treatment process of your incest survivor clients. I anticipate that the time commitment required from you would be approximately one hour. Funds are available in support of this research to pay you for an hour of your time at your usual rate. An alternative to accepting the fee, if you so choose, is that a \$50 donation will be made to VAASA on your behalf in thanks for your cooperation with this study.

The purpose of the study is to provide the treatment community with some specific descriptive data about anger as an element of incest treatment. The need for the study exists because of the growing number of reports of childhood incest experiences that are reaching VAASA's Sexual Assault Crisis Centers. The survivors are requesting services in record numbers, and there is a growing need for sharing the expertise that only a few therapists, such as yourselves, have accumulated.

I appreciate your help with this project, and I will follow this letter with a phone call to determine your willingness to participate. I will provide you with client packets including an explanation letter, consent form and release form for all the clients you nominate as possible participants in the study. As a way to protect your clients' confidentiality, I am suggesting that you send the client packet with your own cover letter to your clients, so that they can make a decision about participation in the study independently. The mail back consent form and release form will give me permission to contact them and to contact you about them.

The study design has been approved by the School of Education Human Subjects Research Committee at The College of William and Mary and is intended to protect the rights of your clients and at the same time to collect some important information about their experience with anger. Should their participation in the study stir up some unfinished therapeutic work for them, I am assuming that you would be available as a resource to help them work it through. My dissertation chair, Charles O. Matthews, and I are both Licensed Professional Counselors and will be available to you and your clients for consultation should an emergency arise.

Enclosed are an example therapist cover letter and a client packet for your information. If you have further questions about the study, please feel free to contact the chair of my dissertation committee,

Charles O. Matthews, Ph. D., L. P. C.
Graduate School of Education
The College of William and Mary
Williamsburg, VA 23185
Phone: (804) 221-2340

I look forward to the prospect of working with you on this project. I will be glad to provide you with a copy of the results of the study, if you wish.

Sincerely,

Kathleen M. Giles, Ed. S.
Licensed Professional Counselor
Phone: (804) 244-0594 or 898-0828

Sample Therapist Cover Letter:

Dear Client:

I am writing to inform you of an opportunity to participate in a research project designed to help other survivors of incest receive the help they need to heal. The researcher, Kathleen Giles, is a therapist who directs a Virginians Aligned Against Sexual Assault (VAASA) Sexual Assault Crisis Center in her area. She wants to meet you and ask you some questions about your experience in coping with anger, and she wants me to comment as well about what I remember of your experience with anger during therapy. She is hoping that your experiences combined with the experiences of the others who participate in the study, will provide some information to therapists about meeting the needs of incest survivors who seek counseling.

I have talked to Kathleen, and I believe her study to be worthwhile. If you want more information about what the study involves, please call me. If you do decide to participate, mail her the consent form and the release form and she will call you to arrange an appointment for the interview.

Sincerely,

Your Therapist

Client Packet:

- (a) Letter explaining the research**
- (b) Consent form**
- (c) Release form**

(a) Dear Client:

Your therapist has recommended you as someone who is in the process of or who has successfully completed therapy for the sexual abuse you experienced as a child. I am interested in interviewing you about your experience in therapy coping with anger. It is my hope that other survivors of incest can benefit in their therapy from what this study will discover.

Specifically, I want to make an appointment to talk to you and to ask you to fill out some paper and pencil questionnaires. The time required will be about one and one half hours for the paper work and one and one half hours for an interview with me. I also want your permission to interview your therapist about his or her memory of your experience with anger. Everything you write down and say to me and all information from the interview with your therapist will be confidential. I will report summaries of all the interviews I do with survivors and therapists, so anything you write or say or anything your therapist writes or says about you will be reported as part of a group or as an anonymous quotation. I will be glad to provide you with a copy of the results of the study if you wish.

If you decide you want to participate in the study, please read the consent form and the release form, sign one copy of each and return it to me, keeping the other copy for your information. I look forward to the possibility of meeting you and working with you on this study.

Sincerely,

Kathleen M. Giles, Ed. S.

Licensed Professional Counselor

Phone: (804) 244-0594 or 898-0828

(b) Consent Form

This consent form is to request your voluntary participation in a study to be conducted in 1991 by Kathleen M. Giles in partial fulfillment of the requirements for the doctoral degree in Counseling at The College of William and Mary. Please read the following information carefully and sign the section marked "Informed and Voluntary Consent to Participate" if you are willing to participate in the study.

Purpose of the Study

The purpose of this study is to investigate the experience of adult survivors of incest with anger from the retrospective post-therapy point of view. The participants will be asked to comment on what they remember about their anger experience before, during, and after therapy. Because very little research has been done on anger as it relates to sexual victimization, this study will describe the survivors' experiences using objective measures to which they self-report and using a semi-structured interview. A second measure of their experience will be provided by their therapists, themselves experienced in treating incest survivors. The goal of the study is to provide information previously unavailable to mental health care providers about what has been helpful to survivors in coping with anger.

Amount of Time Involved for Participants

Participants will be asked to fill out three standardized measurements (The Myers-Briggs Type Indicator, The State and Trait Anger Expression Inventory, and The Coping Resources Inventory), a researcher constructed therapy outcome measure, and a researcher constructed scale relating type and anger. It is expected that the test battery will take about an hour and a half. Participants will also be interviewed about their experiences with anger during therapy. It is expected that the interview will take about an hour and a half. Participants will receive by mail their MBTI report form and a copy of *Introduction to Type* by Isabel Myers for interpretation of their results. A summary of combined results of the study will be sent to participants who wish to receive copies.

Therapists will be asked to fill out one standardized measures, an outcome measure, and a the type-related anger scale for each client and to comment in a semi-structured interview about their memories of each client's experience with anger during the therapy process as well as their own conceptualizations about treatment and suggestions of techniques for dealing with anger in treatment. Therapists will receive a summary of combined results of the study if they so wish.

Assurance of Confidentiality

All data collected in this study will be kept confidential. Participant data will be assigned a number and only the investigator will have access to that number. For purposes of reporting results, only group data or anonymous quotations will be used. No data will be used for any purpose except that expressly specified in this study.

Assurance of Voluntary Participation

Participation in this study is strictly voluntary. You have the right to withdraw participation at any time.

Availability of Results

Please check here if you wish to receive a written summary of the results of this study_____

Informed and Voluntary Consent to Participate

I have been fully informed and consent to participate in the study outlined above. My right to decline to participate or to withdraw at any time has been guaranteed.

Volunteer's Signature

Date

Address

Phone Number

Please mail completed form to: Kathleen M. Giles
P. O. Box 1273
Grafton, VA 23692

(c) Release Form

Kathleen Giles has my permission to interview my therapist _____
about my experience with anger as part of my therapy. My therapist has my permission
to release information about me to Kathleen for the purposes of her research project on
anger.

I understand that the conversations between Kathleen Giles and my therapist
will be held in confidence and that any reports of the conversations will be made as part
of a group of results or anonymously, with no identifying details about me.

Signature

Date

Please mail completed form to: Kathleen M. Giles
P. O. Box 1273
Grafton, VA 23692

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