Incest: Clinical Treatment Perspectives

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Beverly Chitty Bennett

Approved, November 1984

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The concept of family therapy as it pertains to father-daughter incest, has been the source of speculation in research on incest. This study examines the existing literature of the most commonly used treatment strategies -- family, individual and group therapy -- in an attempt to show the most effective treatment method. The position taken in this paper, formulated from the author’s clinical experience, interest and research in this area, is that family therapy most effectively deals with this issue. The criteria used in assessing the success or failure of the three methods is based upon the following:

1. The treatment methodology’s usefulness in restructuring the incestuous family. The term restructuring refers to the changing of relationships among family members so that dysfunction within the family is remedied and patterns maintaining the problems are alleviated;

2. The treatment methodology’s ability to reunite the incestuous family and to keep the family unit intact;

3. The success of the treatment methodology in establishing appropriate patterns of responsibility, with the major goals being the father assuming responsibility for his actions, the mother realizing her part in the family triangle, and both parents viewing the daughter as a victim, rather than an instigator;
4. The success of the treatment methodology in alleviating the incestuous relationship.

Additionally, the family system factors often found in father-daughter incest families will be examined to determine how they affect members of the family unit. It will be suggested the childhood social and psychological factors of parents actively or passively participating in the dysfunctional system are causative or contributory factors to the development of the incestuous family. The formulation of strategies will be limited to the incestuous family in which the victim is a female child.
INCEST: CLINICAL TREATMENT PERSPECTIVES
INTRODUCTION

The central question addressed in this thesis is whether an effective therapeutic intervention can be developed for the incestuous family by viewing incest as a confused, distorted or dysfunctional means of coping within the family unit. In incestuous families, role identities become confused and boundaries become enmeshed (Minuchin, 1974). This research explores the belief that incestuous families can be returned to acceptable levels of functioning through a mental health milieu utilizing family therapy. This treatment approach is unique in that the family system is treated as a whole rather than exposed to the fragmentation inherent to alternative methods. Family group therapy was first undertaken in the early 1960's by such notables as John Bell and Nathan Ackerman. This type of treatment is an outgrowth of a shifting emphasis from the view of the child as a victim of his/her family. Rather, the family is viewed as a social unit whose operations can be understood only in terms of the reciprocal expectations of the family members. According to Ackerman (1966), the family molds the kinds of persons it needs to carry out its functions. The members in turn influence the family toward satisfaction of their personal strivings. The identity of the individual requires support from family identity.
To understand the dysfunction of the family, histories of both parents must be explored in addition to the dynamics of the incestuous father/daughter/mother triad. The view adopted in this research is that of Gutheil and Avery (1977) in which incest is an expression of the collective psychopathology of all members of the family. This view holds that all family members share the burden of the dysfunctional unit.

To clarify this thesis, both legal and clinical definitions of incest must be formulated, since these definitions differ from one another. Legally, incest is defined as sexual intercourse between individuals who are too close by degree of consanguinity to marry (Courtois & Watts, 1982). The specific legal definition of incest varies by state, but all consider certain basic characteristics: victim’s age (which, in part determines the degree of prosecution of the offender), the type of sexual act, and the blood relationship involved. The Statutes of the State of Florida, for example, defines incest as:

Whoever knowingly marries or has sexual intercourse with a person to whom he is related by lineal consanguinity, or a brother, sister, uncle, aunt, nephew, or niece, commits incest, which constitutes a felony of the third degree. Sexual intercourse is the penetration of the female sex organ by the male organ, however slight; emission of semen is not required (Florida Statute, Number 826.04, 1976, p. 408).

Clinical definitions of incest are more encompassing since clinicians have found that sexual activity which produces incestuous implications is not limited to sexual
intercourse. Clinically, the sexual acts may range from fondling to intercourse. Also, sexual acts with relatives, or surrogate and quasi-relatives can represent incestuous overtones resulting in adverse psychological effects for the victim. From this perspective, incest encompasses several categories of partners including father, stepfather, grandfather, uncles, siblings, cousins, in-laws, and close family friends (such as the live-in boyfriend of a victim's mother who serves as a parental figure) (Ibid, Courtios, 1976).

This research emanates from a combination of four years of clinical practice on incest which included the treatment of over 50 families utilizing the three methods, a strong interest in the topic, and a concern for the lack of specific treatment formulations throughout professional literature. Further, incest is most often reported to child protection agencies; and, it is therefore, most often presented for treatment to clinicians. It is currently estimated that 4.5% (or 3,802 victims) of the child abuse and neglect reports received in the state of Florida for the 1982-83 calendar year involved sexual abuse of a child in which the majority involved female victims (1).
Chapter 1

PARTICIPANTS IN FATHER/DAUGHTER INCEST

Characteristics of Father. The social and psychological characteristics of the incestuous family are important factors that should be explored by the clinician whether the treatment administered is family, individual or group therapy. The purpose of this section is to present a pattern or description of the members of the incestuous family. Renshaw and Renshaw (1980) noted that typically the incestuous father most often reported for treatment is in his late 30's or early 40's. It is at this stage that marital problems most likely develop. Also, death of a spouse, separation, and divorce are more likely to appear at this time. When the father is confronted with an increasingly frustrating marriage and an increasingly attractive adolescent daughter, overt incest may occur (Ibid, Renshaw & Renshaw, 1980) if the father is not able to satisfy his sexual and emotional needs outside of the home.

Intellectual capacities among incestuous fathers have been reported on the average as falling within the normal (Cavallin, 1966, & Lukianowicz, 1972) and bright normal (Weiner, 1962) ranges of intelligence. Gebhard et.al. (1965), found that fathers engaging in sexual relations with their daughters twelve years and under were more intelligent.
than a noncriminal matched group.

Using the Minnesota Multiphasic Personality Inventory (MMPI), Panton (1979) described incestuous fathers as self-liaened, despondent, impulsive, rigid, and inhibited individuals, with feelings of insecurity and a fear of not being able to function adequately in heterosexual relationships. These findings are consistent with specific personality patterns described throughout the professional literature.

The professional literature does not present the incestuous father as a mentally ill individual. Rather, he possesses disorders within his personality structure. In his studies, Rosenfeld described the father’s behavior as defending internally against gross immaturity, fears of homosexuality, strong unmet dependency needs, and an inability to deal with grown women. These men tended to view their wives as rejecting and/or threatening, but unable to pursue women outside of the family due to their fear of adult women. Fear of divorce was a major concern for these men due to their unmet dependency needs and apprehension regarding separation (Rosenfeld, 1979). Henderson (1980), Rosenfeld (Ibid, 1979), and Weinberg (1955) refer to the term endogamic in describing the incestuous father whereby the father’s introverted personality leads to an extreme ingrown relationship with a disproportionate investment in the nuclear family. Here, the father confines his sexual
objects to members of his own family (Geiser, 1979). Rosenfeld (Ibid, 1979) termed endogamic incest as a "victim-victim" interaction.

Weinberg (Ibid, 1955) identified two additional groups of incestuous fathers. He noted that incest may be a part of a pattern of indiscriminate promiscuity. The second group consisted of fathers described as pedophiles, whereby the abuser has an intense craving for young children. These individuals may be sexually involved with children both inside and outside their homes. The primary focus of this paper will not include these two groups of incestuous fathers, and the endogamic (or overinvolved) personality will be the focus. Clinically, treatment of the pedophilic personality is almost never successful and they are best managed solely by legal punishment.

Summit & Kryso termed this predominant fear and hatred of women as misogynous incest. The perpetrator usually has a history of conflict with his own mother and a tendency toward violence and punishment of women. The daughter is seen as a possession, and possessing her sexually is an assertion of his ability to control women as well as a form of punishment and defiance toward his wife (Summit & Kryso, 1978).

Studies by Anderson & Shafter (1979), as well as a number of other authors, found the incestuous father as having major difficulty with impulse control. However,
Anderson and Shafter elaborated upon the effects of the lack of impulse control causing the following behavior:

1. Chemical abuse, which included a low frustration tolerance and demand for immediate gratification;
2. Poor judgement;
3. Conflicts with authority;
4. Predominantly physical, rather than verbal, expression of needs;
5. Manipulativeness used as a major tool of need satisfaction;
6. Irresponsibility in some form;
7. Little or no expression of guilt about social behavior;
8. Callousness, narcissism, self-indulgence, relating to people as objects;
9. Low anxiety, with depressive symptoms, purely situationally based;
10. Major conflicts with dependency;
11. Inability to tolerate intimacy, covered by a "sociable" facade (p. 438).

In addition, Gutheil & Avery found the incestuous father to have suffered rejections by his parents and had maintained strongly dependent but fearful ties to their mothers. They had strong feelings of inadequacy and anxiety, but almost always were able to mask these feelings. Gutheil & Avery also pointed out that when the marital
relationship reaches an impasse, the incestuous father turns to the daughter to relieve the fear of abandonment. Further, it was noted the father unconsciously senses his wife’s collusion in the incestuous alternative to the conjugal bond (Ibid, 1977).

To document the characteristics of the incestuous offender, Kroth (1979) collected data through the use of a computerized intake system from the Child Sexual Abuse Treatment Program, located in Santa Clara County, California. This program was funded in 1976 by the state of California for the prevention of sexual abuse children and the development of programs to be used by city, county, and state personnel. To date, this program, headed by Dr. Harry Giarretto, and its components have been adopted or emulated by numerous treatment facilities across the United States. In assessing this program, Kroth reviewed data on 92 adult offenders (20 perpetrators were not in therapy and of the remaining 72, 63 were offenders of intrafamilial sexual abuse). The study by Kroth is unique in that previous studies by authors were only able to collect data from county, police, and welfare records, giving credence to the theory that sexual abuse occurred in isolation among the lower intelligent, poor, inner city or rural family. Kroth’s study discounted this theory; his findings show incest and sexual abuse occurring across various socioeconomic classes. As shown by Kroth (Ibid, 1979), Giarretto’s profile of the
incestuous father was that of an individual functioning in a professional, semi-professional, or blue collar position, earning an annual salary of $13,415, and having completed 12.5 years of schooling.

Kroth discovered the link of high unemployment (18.5%) with the occurrence of molestation (Ibid, 1979). (Unemployment in Santa Clara County was between 8 and 9% at the time of data collection.) The annual family income of the remaining perpetrators resembled the modal family income of the area. The offenders were not particularly drawn from the lower socioeconomic strata; also they were not representative of the hard core unemployed, nor were they considered to be poor. In clinical experience, I have found an equal balance of lower and middle income fathers presented for treatment related to an incestuous relationship. One possible explanation for this is that they are most subjected to stresses outside the family (financially and socially); therefore, they turn inward to the family, specifically to a daughter as a source of nuturance and as a means of coping, maintaining control for themselves, and assuring themselves of power within their family.

In describing the incestuous father, Cavallin (1966) noted the widespread occurrence of paranoid traits and unconscious hostility fused with uncontrolled genital impulses toward the daughter. Weiner (1962), in his
research, gave supportive evidence to this theory. He found that many incestuous fathers had a disturbed relationship with a harsh authoritarian father whom they ambivalently hated but admired. Further, Weiner found these fathers to possess ensuing, passive homosexual longings for their father which promoted a process whereby they obtained a fantasized affection from their own fathers through an incestuous liaison with a daughter. Cavallin (Ibid, 1966) additionally noted that the incestuous father, during childhood, was usually denied access to a loving, warm mother.

Still another perspective of the incestuous father’s behavior is that presented by Kaufman, Peck, & Tagiuri (1980). They asserted that desertion and reactions to this desertion were the common source of anxiety motivating the incestuous situation. In their study of eleven incestuous families, they found all incestuous fathers and stepfathers deserted their children at some time via divorce, living away from home or just away due to alcoholism. (Eight fathers in their study were alcoholics.) Also, desertion was a factor in that the maternal grandfathers had deserted their families at some time during the father’s childhood. In addition to these factors, Cavallin (1966) noted that the incestuous father generally came from large (5.4 children) families.

Therefore, the incestuous father can be identified as
having experienced: emotional deprivation in childhood by one or more parents; some form of sexual abuse (in varying degrees) with a family member as a child; physical abuse during childhood; and paranoid feelings (conscious or unconscious) about his sexual identity. The incestuous father may have experienced one or all of these factors.

CHARACTERISTICS OF MOTHER. In incestuous families, the mother is often perceived as the family member who aligns the father and daughter for the incestuous relationship, primarily by withdrawing from her sexual role in the marriage and ignoring the development of the father/daughter relationship. Research has found few cases of mother's direct participation, but she is almost always thought to be partially responsible through her failure to take any action to prevent or terminate the relationship.

In situations where the mother is unopposed to the occurrence of incest, she usually possesses certain characteristics that would render her ineffective in restraining or preventing the incestuous relationship. Stern & Meyer (1980), through their studies of the incestuous family at the Center for Rape Concern in Philadelphia, discerned the incestuous mother as: domineering, complemented by a passive spouse; or passive, with the incestuous father acting as a patriarchal figure; or emotionally weak, complemented by an emotionally weak spouse.
In families where the mother assumes the passive role, she often does so out of fear of her husband and her unwillingness to confront him since he is usually her sole financial or emotional support system (Meiselman, 1979). According to Meiselman, the woman can be viewed as immature, since the incestuous husband is often emotionally cold and abusive, making her dependency needs exceed those normally existing in a marriage.

The mother in the incestuous family, as in the case of her spouse, often experienced an atypical family life. The mother’s relationship with her own mother is characterized by rejection and hostility (Ibid, Meiselman, 1979). This theory is given support by the study of eleven incestuous families conducted by Kaufman, Peck, & Tagiuri (Ibid, 1980) in which they found a similarity of personality structures among the maternal grandmothers, which helped to contribute to the emotional position the mother would assume within her future family. The maternal grandmothers were found to be stern, demanding, controlling, cold, and extremely hostile women, who rejected their daughters and pampered their sons. They were often abandoned by their husbands, forcing them to assume most of the responsibility for support of their family. They usually displaced their hostility onto their daughter.

The assertion by Kaufman, Peck, & Tagiuri (Ibid, 1980) was that the dysfunction of the mother/maternal grandmother
relationship added to the incestuous family pathology. They felt the mother’s opinion of her self-worth was continually low due to her own mother’s negative attitude toward her. They found that this mother remained tied to her mother literally and psychologically, and was unable to emotionally move away. These mothers held constant hope that they would receive the love and encouragement they never received as children themselves. These authors found that at least one-half of the incestuous mothers were either indirectly self-destructive, (neglecting their health, hoping someone would care enough to stop them) or promiscuous in their behavior.

Kaufman, Peck, & Tagiuri (1980) in their study described incestuous mothers as careless in dress, infantile in behavior, dependent, and intellectually dull. They were often poor housekeepers, panicky in the face of responsibility and seemed on the surface to be satisfied to live in disorder and poverty. An important finding in their study was the clarification that, upon closer observation, the incestuous mother emerged as being brighter than average, with a potential of achievement far beyond their actual performance. If the mother entered into a second marriage, the second husband was more irresponsible and unsuccessful than the first. This appeared to be a repetitive pattern established by the maternal grandmother. The mother was acting out what she felt was expected of her by the maternal grandmother, i.e., in the sense of rendering
herself worthless, according to these researchers.

A widespread view found in the literature was the view presented by Pittman (et.al.1976) which stated that because the mother tends to be infantile and dependent, she reverses the mother-daughter role and assumes with her daughter the relationship she wishes she had with her own rejecting mother. Also, since she feels worthless as a mother and woman, her general denial of sexuality makes it easy for her to deny the sexually charged intimacy she has encouraged, consciously or not, between her husband and daughter. Concerning the incestuous mother’s childhood sexual experiences, little attention has been given to this area in the professional literature. However, Spencer (1978) noted the mother’s own incestuous involvement in childhood likely occurs in more cases than previously identified. Clinically, I have found that at least 90% of the 50 documented treatment cases in my practice, incestuous mothers recounted an incestuous/extra-familial sexual experience in childhood that was negative or detrimental to her emotional development. Therefore, I hold strongly to this viewpoint, but to date the professional research is inconclusive and more studies are needed in this area.

Characteristics of the victim. As a rule, it is the eldest daughter whom the father selects for his incestuous liaison (Raphling et.al. 1967). Cavallin (Ibid, 1966), in his study of twelve incestuous families, found the average age
of the victims to be thirteen, with a range of three to eighteen years. Relationships lasted from a few months to a maximum of three years before detection, in all but one case. Giarretto (Ibid, 1976) found the average age of the victim to be ten. Herman & Hirschman (1977) suggest that the oldest daughter is chosen for the victim's role in that she is often obligated to maintain all housekeeping duties that include supervision of the younger children. As the eldest daughter becomes less and less cooperative with the father's sexual advances, family disequilibrium is temporarily averted if a younger child within the system can replace her older sister as the incestuous object (Brown, 1979).

Meiseleman (Ibid, 1978) noted that physical attractiveness of a daughter as the incestuous object is not a predisposing factor to the onset of incest. Maisch (1972) points to a strong, positive correlation between the development of secondary sex characteristics, and the age of the victim at the onset of incest. Physical maturity of the daughter at the time of onset is stressed by much of the professional literature (Cormier et.al.1962; Gebhard et.al.1965). However, this finding was discounted by other authors (Herman & Hirschman, 1977; Giarretto, 1976), who reported the average age of initial incestuous perpetration to be several years prior to the onset of puberty. Therefore, findings in this area are not conclusive. The literature is more conclusive regarding the intellectual
level of the victim, indicating the majority of daughters incestuously involved to be functioning within the normal range of intelligence (Gligor, 1966; Maish, Ibid, 1972; Meiselman, Ibid, 1978).

Kaufman, Peck, & Taguirí's (Ibid, 1980) study of eleven girls, ranging in age from six to fourteen, where sexual relations were prolonged for at least one year and up to six years, found depression and guilt were universal. When given Rorschach tests, the main trends of behavior projected were: depression, anxiety, confusion over sexual identity, fear of sex, oral deprivation, and oral sadism. The primary defense mechanisms found were denial, repression, and sometimes projection. Additional psychological testing (Thematic Apperception Testing) projected the mother figure as cruel, unjust, and depriving. The Draw-A-Man test demonstrated further confused feelings about their sexual identity.

Research by Geiser (1979) also confirmed that daughters in incestuous relationships showed negative feelings toward their mothers, but further pointed out they are usually ambivalent or positive toward their fathers. Since they felt deprived of affection from their mothers, they turned to the more available parent for warmth and nuturing. When nuturing is found through sexuality, she may feel betrayed, but she is unable to ask her mother for support or protection due to their distant relationship.
Effects Upon the Victim. The violation of trust is a key psychological issue for the victim. She usually enters the sexual relationship willingly due to trust of the abuser as a parent and symbol of affection and closeness. When she discovers her father perceives the relationship differently, she feels manipulated and betrayed. The victim is prone to grow up distrusting, possibly hating, adults and men in particular. A consensus found throughout the literature is that the female victim, in her adult life, tends to develop an inability to get close to, or trust, men. Divorce, frigidity and failure to have orgasm are found to be factors associated with incest (Ibid, Geiser, 1979). Cormier (1962) concluded that when incest occurs prior to adolescence and is terminated prior to this developmental stage, anxiety and guilt is not pervasive until adulthood. The trauma associated with this experience is often repressed until later life, reappearing in the form of neurotic conflicts.

Support for Geiser’s theory dealing with the victim’s difficulty in forming close female relationships in adulthood (Geiser, 1979) can be gained by viewing the victim’s adolescent behavior at the time of incestuous involvement. The victim’s close relationships with female friends are almost always limited because her sexual experience exceeds that of her peers due to her early introduction into a sexual relationship (Muenchow & Slater,
In clinical experience, many female victims have reported the feeling of being uncomfortable among their peers due to frequent conversations arising about sex. Some victims further described their efforts as pretending not to be knowledgeable about sexual issues. In general, they all seemed to feel a sense of not belonging—either to the adolescent or adult world. Pittman (Ibid, 1976) referred to the victim as being socially awkward.

The victims, in preadolescence and adolescence, may act out their fears and concerns through sexually aggressive behavior, dressing seductively, delinquency, hostility toward others, sexual promiscuity, prostitution, truancy, running away, substance abuse, and increased fearfulness. There may be expressions of self hatred, a sense of worthlessness, and feelings of being damaged or dirty (Giarretto, 1976). Suppression of feeling, according to Geiser (Ibid, 1979), leads directly or indirectly to the victim's acting out behavior. Often the victim reacts to incest via somatic complaints. Abdominal pain is most common, possibly related to pregnancy fantasies. Other somatic symptoms are eating or sleeping disturbances, learning difficulties, anxiety, hyperactivity, withdrawn behavior or fatigue, with generalized aches and pains. Landis (1956) reported the nature of the incestuous offense influenced the effects upon the victim. He further noted that when genital contact was involved, the prognosis for
treatment was poorer. Additionally, Geiser (Ibid, 1979) found that the effects of the incestuous act depended upon the victim's level of ego development, the nature of the event and whether the involvement was an isolated event or part of a continuing experience.

Recent studies have indicated frequent school behavior problems among children experiencing sexual relationships with a father or stepfather (Browning & Boatman, 1977). This supports the claim by DeFrances (1969) that approximately two-thirds of his sample of 263 child victims of sexual assault were emotionally disturbed by the offense. Kaufman et. al. (1954) suggest:

The purpose of the sexual promiscuity seemed to be to relieve the experience with the father, and hence, through the mechanism of the repetition compulsion, to work through their anxiety and at the same time achieve a restitution of the lost parent (p. 275).

Spencer (Ibid, 1978) concludes that promiscuity results from the daughter's inability to form heterosexual relationships resulting directly from intense conflictual feelings concerning the incestuous affair. Unfortunately, long-term, documented clinical studies are lacking in this area to provide additional support to this finding.
Chapter 2

DYNAMICS OF THE FAMILY UNIT

Boundaries, Opportunity and Marital Conflict.

Boundaries are not clearly defined within the incestuous family, adding to the chaos and confusion of roles among family members. The intimacy of family life may include crowded quarters, common beds, and, as within most families, a relaxation of dress code. However, in the incestuous family, privacy among individuals is seldom taught or allowed (Ibid, Renshaw & Renshaw, 1977). The children are often allowed to call their parents on a first name basis. Weich (1958) exemplified the importance of the terms "mother" and "father" as a defense against incest, in that parents are the only ones within the family allowed free sexual expression with each other.

As a family survival pattern, Lustig (et.al.1966) proposed that incest becomes a transaction which serves to protect and to keep the family intact. He proposed that incest is an attempt to reduce family tension by preventing confrontation with underlying sources of anxiety. Lustig (et.al.1966) further noted that this defense may be satisfactory as long as each member is able to maintain a facade of role competency. Herman & Hirschman (1977), in following this hypothesis, suggested that when the daughter
assumes the mother’s traditional role as the responsible party for nurturing and taking care of the family, the father senses no obligation to nurture and care for the family himself. However, he does feel entitled to continue to receive the services from the daughter that had once been provided by her mother. Initially the relationship between the mother and daughter is positive (Kaufman, 1954). Often the mother may become dependent upon the daughter, confiding in her and describing her personal difficulties (Herman & Hirschman, 1977). However, once the mother relinquishes her role to the daughter, the daughter then becomes the object of maternal displacement of hostility and aggression. This stems from the (victim’s) mother’s emotionally deprived relationship with her mother.

Lustig (et al. 1966) posits five conditions usually present, which contribute to the dysfunction of the family: the emergence of the daughter as the central female figure of the household, in place of the mother; sexual incompatibility between parents, with unrelieved sexual tension in the father; the abuser’s unwillingness/inability to seek outside sexual partners; shared fears of disintegration and abandonment; and the unconscious sanction by the nonparticipant mother, who condones or fosters the assumption by the daughter of a sexual and affectional role vis-a-vis the father (p. 31, 1966). father (p.31, 1966). According to Geiser (Ibid, 1979), everyone in the incestuous
family is searching for the mother they did not have. The basic anxiety of family members revolves around abandonment by the mothering or nurturing adult.

Eist & Mandel's (1968) case study of ongoing incest within a family exemplifies the dynamics often found operating in the system, and also illustrates my own clinical observations of the incestuous family. This illustration is useful in that it encompasses the effects upon each family member, and thus demonstrating that effects of father–daughter incest cannot be isolated from the consequences it has on other members of the family unit. Although this is a study of a single family it is consistent with findings that are well documented throughout the professional literature (i.e. Lustig, et.al.1966; Raphling, et.al.1967; Kaufman, et.al.1954). Critical factors within the family unit studied by Eist and Mandel were:

1. A lack of respect for the physical and intellectual integrity of others (i.e., speaking for others) as well as little or no regard for personal territorial rights (i.e., touching the other against their wishes). Statements of others were not respected and trust was distorted.

2. Feelings of inadequacy by the adults in their parental role, often making powerful demands on the children to assist in functions they had never fully accepted (i.e. childcare, domestic responsibility).
3. Needs, primarily emotional, of the children were often not considered and they were often placed in the adult role (i.e. for the parents to ventilate). Role reversal frequently occurs, with parents assuming the role of the child.

4. At some point the children may begin to implement the adaptational coping methods modeled by the parents, upsetting the family balance. When overt conflict arises in the family (i.e. mother-daughter conflict) the children may resort to acting out behavior (i.e. truancy) which often places them in direct conflict with the outer segment of society. This places them back into the family system where the parents rescue the child and reinforce in the child the belief that the society external to the family system is not to be trusted (Eist & Mandel, 1968).

In the incestuous family, there is a strong emotional bond, but it is a conflictive and pathological one. In many ways the child victim sees incest as a way of saving the family. She takes the guilt upon herself and endures the behavior in an effort to keep her parents together. When the relationship is discovered, her guilt may center more around her failure to keep the family intact rather than on the violation of the incest taboo (Ibid, Geiser, 1979).

The development of incest usually progresses over a period of time. As a very young child, the daughter may have never been allowed privacy by her parents. This may be
symptomatic of her father's paranoia of losing control of his daughter, and his possessiveness or distrust of her. In addition to her lack of personal space, she may also be exposed to her parent's sexual relations, resulting in overstimulation which may be frightening and confusing. Although some professional research points to crowded living conditions as a variable in incestuous family systems, Weinberg (1955) concluded that the interpersonal relationships and individual psychopathologies inherent in the family system were more causative in nature than the physical setting of the home.

While crowded living conditions may not be present in an incestuous family, physical territorial boundaries are lacking. Doors are seldom closed and the incestuous father may join his daughter in intimate tasks such as trips to the bathroom, the taking of showers or dressing. Since this type of interaction usually begins at an early age for the child, she may react with surprise upon hearing that this behavior is perceived as unusual. Psychologically, the effect upon the victim of this lack of physical space is essentially the same as the lack of emotional space, i.e., it assures the debarment of individual separation (Ibid, Eist & Mandel, 1968) from the family unit.

Incestuous families are similar in one perspective. For the incestuous relationship to occur, there must be opportunity for physical contact between father and
daughter. Sexual activity is almost invariably introduced by the father, even where the daughter is described by the father as acting seductive (Ibid, Maisch, 1972). Incestuous relationships are frequently initiated by the father joining his child in bed at night while she is sleeping or feigning sleep (Ibid, Meiselman, 1978). Many studies suggest that sexual activity including genital petting and fondling of the breasts often precedes coitus attempts.

Although the professional research concerning unemployment as a contributor to the occurrence of father-daughter incest is inconclusive, the opportunity to engage in incestuous activities appears to have more relevancy. Finkelhor (1979) asserted that having radically different working hours than their spouses or the lack of availability to the spouse (i.e., outside interests) in combination with the unemployment variable lends opportunity for the development of the incestuous relationship. Additionally, in my clinical experience, I have noted another factor that appears to lend opportunity for the development of incestuous families. That is, families that tend to be highly transient and unstable in their living environment appear to be at a higher risk for the development of family sexual abuse. A contributing factor seems to be their increased emotional dependence upon each other.

In his sample of thirty-two incestuous offenders, Westermeyer reported the males initiating sexual activity
with the victims had almost universally lost access to adult sexual partners for reasons of cohabitation, refusal, divorce, illness or death (1978). Lustig (1966) suggests that many wives in the incestuous family system were sexually rejecting to their husbands while at the same time demonstrating a sexually provocative demeanor, almost in a sadistic fashion. Maisch (Ibid, 1972) commented that 33% of the mothers in his survey had experienced physical illness before or during the incest period, supporting the claim of the mother's incapacitation or absence from the home as a factor contributing to incest.

Throughout the professional literature, a poor marital relationship is cited as the basis for the development of the incestuous relationship. Incest rarely occurs when a couple has a nurturing, sharing, communicative, or rewarding relationship. According to Satir (1967), the marital relationship of the parents is a key factor in determining system development and balance. If the marital partners possess low self-concepts, they will manifest these images in angry, disillusioned, destructive behaviors that disrupt the marital relationship and stifle the growth of individual family members. Reconstitution of the family must involve delineation of cross generational boundaries, while same sex coalitions are generated, with an emphasis toward strengthening the marital relationship.

Power, Coercion, and Disclosure. Findings in the
literature support the belief that incest does not occur in conjunction with paternal violence. Herman & Hirschman (Ibid, 1977) reported no incidence of physical force demonstrated by fathers when attempting to enter into a sexual relationship with their daughter. Maisch (Ibid, 1972) reported the absence of violence at the onset of incest in 94% of his cases. The literature further supports Maisch’s view that the father uses verbal coercion to maintain secrecy about the affair. Verbal threats and intimidation may be used by providing false information to the victim on a consistent basis. However, Gebhard (1965) points out that threats or duress are seldom necessary at the onset of the sexual encounter, unless the father is initiating oral-genital relations with his daughter or genital intercourse with a very young child. Rather, verbal seduction is usually all that is necessary since the victim, in most cases, views this adult in a trusting, authoritarian and affectionate manner. Reimer (1940) & Weinburg (1955) conclude that these feelings of intimidation and fear result in the daughter’s passive participation in the incestuous act. Weinberg further noted, concerning younger children, paternal sexual advances are perceived as a further extension of physical affection expressed by the father. These feelings are greatly enhanced when the daughter assumes the "daddy’s little girl" role, enjoying many privileges denied to the other children in the family during
the course of the incestuous relationship (Ibid, 1955).

Nonverbal coercion is frequently used by the incestuous father. He does so by attending regularly to his daughter, buying gifts and protecting her physically from the approaches of other males. Extreme jealousy is exhibited by the incestuous father when his daughter attempts to engage in normal courtship experiences outside the family system (Cormier et al. 1962). To maintain the secretive nature of the relationship, often the father will attempt to rationalize the incestuous behavior to their daughter, i.e., it is for sex education purposes. However, over long periods of time these rationalizations become unconvincing as contradictory messages are given by peers or other family members, combined with an increasing interest in other romantic relationships (Meiselman, Ibid, 1978). At this point the daughter begins to use learned power and manipulation techniques, often bribing her father for material possessions to maintain secrecy about the affair.

When the daughter can no longer tolerate the domination, informing an individual inside or outside the family unit becomes a consideration. However, she also experiences an intense, debilitating fear as a result of threats related by the father not to expose the incestuous details (Ibid, Maisch, 1972; Riemer, 1940; Weinberg, 1955). Herman & Hirschman (Ibid, 1977) reported 86% of the father-daughter relationships remained a secret within the
family system. The termination of the incestuous affair is often a deliberate process that tends to progressively develop as the victim gets older rather than disclosure by the daughter to outsiders during the active stages of the affair (Ibid, Maisch, 1972).
Chapter 3
THE TREATMENT PROCESSES

Family Therapy. The type family therapy supported in this thesis is that of structural and strategic family therapy, since these are the concepts implemented by, and most familiar to, this clinician in her treatment of incestuous families. Additionally, these are the methods most often supported by the professional literature in treating the incestuous family. The intent of this paper is to provide support for the family systems approach in effecting change within the incestuous family. Support is not limited to one family systems modality as each are similar in concept but vary in structural approach. The goal is to suggest a feasible family therapy approach to treat the incestuous family.

In implementing the family therapy modality to reshape the incestuous family, two factors of equal importance must be considered: the needs and therapeutic expectations of the specific incestuous family in treatment and their ability to absorb the administered treatment concept; and the clinician's ability and comfortableness in implementing the family therapy modality.

To provide depth in understanding the family therapy approach to treatment, Resnikoff (1981) noted ten areas that
are critical in utilizing the family therapy modality:

Observation of the outward family appearance: (i.e.: Who sits next to whom, who stays closest to the therapist). This can indicate the psychological closeness or distance. In the incestuous family, I have most often found that the daughter places physical distance between herself and mother. Also, she frequently aligns herself with the clinician, suggesting the search for a "protector."

The cognitive functioning of the family: Dysfunctional families often use masked and indirect communications instead of clear and direct communication. In communicating with another within the family system, often two messages are sent instead of one. This is often observed in verbal and nonverbal communication, each contradicting the other, creating a form of "double bind". Also, it is important to note who gives and receives communication. Often in the incestuous family, the daughter is observed as the spokesperson for the mother, and the father's patriarchal dominance over his family is further noted.

Repetitive and non-productive sequences: i.e., an incestuous mother scolding a child for misbehavior and the maternal grandmother scolding the mother, in the presence of the child, for being an ineffective parent; each cancels the other by rendering the mother powerless and encouraging manipulation of the system by the victim.

The basic feeling state in the family and the person
Although one member may exhibit a certain mood (depression, anger) all members are likely to be feeling this affect to some degree, often referred to as the "family music" (Ibid, Resnikoff, 1981). The mother's depression or the daughter's hostility toward her mother may control the family feeling state in the incestuous family.

**Family defenses, resistances, and individual reinforcement:** If a family member is limited to only one characteristic response or interaction (i.e. "no" as a constant response given to the child by a parent), that individual will be unable to utilize other alternatives to solving the family's problem. Projection of blame is often viewed within the incestuous family as a form of defense and resistance, especially by the incestuous mother.

**Operative subsystems within the family:** In the incestuous family the victim becomes a "symmetrical" partner engaged in a power struggle and competition with her mother. It is a triangular situation, where the daughter relieves the stress from the marital interrelationship.

**Power within the family:** This is the rule maker, and family spokesman. This powerful member usually has much invested in this position and has little wish to change. Change is most likely to occur within the family if this person can give up some of their power to other family members. He or she must develop anxiety within his powerful position and be able to tolerate change. This powerful role
is usually maintained by both the abuser and the victim in father-daughter incestuous families. The victim's power is usually in the form of material objects and special treatment by the incestuous father (Ibid, Resiknoff, 1981).

Ackerman (Ibid, 1966), in his assessment of the family system, regarded it as a kind of barter unit. This is the process whereby the values exchanged are love, food, protection, material goods and information. Within the group, the parents are, in the beginning, the prime givers. The children are, at first, mainly receivers, but across time, they also make significant returns in kind. In the incest family, the father utilizes his bartering power to sexually manipulate his daughter.

The differentiation of family members and the subgroup boundaries: This allows the clinician to observe to what extent each family member has a separate psychological identity or to what extent other family members intrude by either feeling, thinking, or judging for members (Ibid, Resnikoff, 1981). Within incestuous families, enmeshment of individual family members is commonly seen.

In therapy, the family structure (Minuchin, 1974) must be changed. Within the incestuous family, the mother is usually isolated from the daughter and the father has become the overinvolved parent. This indicates that the father must take a more distant position. Where the father has previously been the primary caretaker of the victim, the
mother must be encouraged to take a more active position in this role. The purpose is to provide direction to help strengthen the marriage and increase the boundary between parent/child.

The family's life cycle stage and their methods of problem solving: This area focuses upon the family's willingness to deal with their problems and their abilities to work together (Ibid, Resiknoff, 1981). For example, in the incestuous family, to what extent is the marital couple able to admit or focus upon their marital problems.

The clinician's reactions to the family: Here the clinician must develop pathways to understand the important family issues. This is based upon individual style, professional training, and is often accomplished through gut feelings, word associations, or visual imagery (Ibid, Resiknoff, 1981).

In implementing structural family therapy within the treatment process, the desired change must take place within the actual session (enactment), with the family sitting in the room (Hoffman, 1980). One important process in restructuring the incestuous family, is for the father to admit responsibility for the incestuous relationship to the daughter, within the therapeutic setting, to remove feelings of guilt and blame. This sets the stage for each member to begin assuming their appropriate familial role. The admission of responsibility for the incestuous affair serves
two purposes. First, the father is assuming his adult role. His admission serves as concrete evidence to his wife that the daughter was not to blame for the incestuous relationship. She is more likely to accept this fact if she has the support of her spouse. Second, this aids the daughter in returning to her child/daughter role, as well as removing guilt and blame for what has occurred between her and her father. This process of returning to the daughter role is sometimes difficult due to the familial power she has accrued within her pseudo adult role. The structural family therapy method asserts (Ibid, Hoffman, 1980) that if families can make change within sessions, they may continue to make changes outside of the therapeutic environment.

Strategic family therapy implements change through the "interactional processes set off when a therapist intervenes actively and directly in particular ways in a family system" (Haley, 1971). The goal (Ibid, Resnikoff, 1981) is to substitute new behavior patterns for old ones. A way of achieving this would be the process of assigning tasks, or through paradoxical interventions.

Resnikoff (Ibid, 1981) supports the initial use of structural family therapy in dealing with families, whereby the focus is upon joining, accommodating, testing boundaries and restructuring. If this method initially proves ineffective or inappropriate, he suggests switching to a
predominantly strategic approach. Resnikoff (Ibid, 1981) clarified that strategic techniques were developed from treating excessively homeostatic families (e.g. those of schizophrenics) and are more effective for dealing with extreme "resistance". I have found this method effective in dealing with incestuous families where an alcoholic father is involved.

Following success with strategic methods, the therapeutic approach should at this point return to a structural approach. It forms the final phase of the family restructuring phase. The goal is to have the identified patient (which many times is the victim in incestuous families) become less and less central and family members start to behave as separate people rather than as systems which have a massive impact upon the other members' reactions. At this point, boundaries and restructuring the family can be enacted (Andolfi, 1979).

During the therapeutic process of over fifty families, I have identified three major problem areas consistently encountered by the father-daughter incestuous family, where the family has chosen to remain an intact unit after disclosure of the incest. In addition to strengthening the mother-daughter / mother-father relationship, the following areas must be treated:

1. Desexualizing of affection between father and daughter. This area usually remains strained and difficult
even after the need for therapy no longer exists. Questions frequently arise as to what are appropriate and inappropriate methods of affection. Fathers must relearn how to show affection to their daughters in a nonsexual manner.

2. Separation anxiety in which the family becomes preoccupied with fears of loss of family members must be decreased. The process of individuation is strengthened when parents can accept their child's eventual adulthood and their leaving home.

3. Appropriate parenting must be learned. A concomitant of the incestuous family constellation is the inability of the parents to work together in setting rules and providing discipline for the children. An equal balance for this responsibility must be developed.

Individual Psychotherapy. This section examines and defines the use of individual psychotherapy with various members of the incestuous family. How individual therapy affects these members will be the focus rather than setting forth a particular strategy of individual counseling. For clarification purposes, a basic definition of the model will be given.

Individual psychotherapy establishes a one-to-one relationship between client and therapist. In the incestuous family, it is usually the chosen treatment for the very young child whereby play therapy can be utilized since play is considered a natural means of communication.
For some incest victims, ones who are pseudomature in their social development (due to their sexual experience and role assumption within the family unit), this form of treatment allows them to become less restricted and to assume the appropriate role as a child. They learn to act as a child instead of little mothers or seductive teens (Boatman & Borkan, 1981).

The method of psychotherapy for the incestuous father depends greatly on the therapist's specialization or area of concentration in the field of psychotherapy. Although there are various forms of psychotherapy, all forms (in application) employ the patient-therapist relationship to influence the patient to unlearn old/maladaptive response patterns and to learn more affective or appropriate ones (Hinsie & Campbell, 1970). The therapeutic process involves observing the patient's verbal and nonverbal behavior, after which the therapist comments on what he observes. The patient, witnessing the same behavior, and viewing it in the light of the therapist's comments as well as his own reactions, then is placed in a position to re-evaluate his past behavior, making behavioral changes possible. The therapist, as a participant observer, fosters learning by decoding and interpreting the patient's unconscious messages. As in all sustained and important relationships, some learning or change occurs as the result of imitation, identification, and various subtle influences (Hollender,
Strupp (1978) defined psychotherapy as a collaborative endeavor or a partnership, in which the patient, almost from the beginning, is expected to play an active part. Gradually patients are to become more autonomous, more self-directing and more responsible for their feelings, beliefs, and actions. Strupp noted that in order to feel better about themselves, their relationships with others and their behavior, they must learn to make changes within themselves and in their environment that permit them to feel and act differently. The process of psychotherapy is designed to help patients change themselves rather than relying upon the therapist to decide which behaviors should be changed (Ibid, 1978).

Strupp (et.al.1978) referred to psychotherapy as a "learning process", whereby the role of the therapist is similar to that of a teacher or mentor. Psychotherapy is based on the assumption that feelings, cognitions, attitudes, and behavior are the product of a person's life experience (Strupp et.al.1978). Psychotherapy asserts that if something has been learned, modification (Strupp et.al.1978) of the previous learning can occur. Therefore, psychotherapy is ineffective in persons where learning (Strupp et.al.1978) is impossible (i.e. conditions created by genetic/biochemical factors). Similarly, (Strupp et.al.1978) the psychotherapeutic model encounters
difficulty if a person has no desire to change (i.e. whereby court ordered counseling for the incestuous offender becomes a questionable endeavor). Also, if the problem precipitating counseling (incest) is solely due to factors in the person's social milieu (poverty, oppression or imprisonment), the effects of counseling via individual psychotherapy appear limited, if not ineffective. Therefore, successful psychotherapy must include: (1) Motivation for change by the client; (2) The environment in which the person lives must tolerate change; and (3) The inner obstacles to learning (defenses and rigidities of character) cannot be insurmountable (Strupp et al. 1978, p.4).

Wolberg (1954) distinguishes three types of individual psychotherapy: supportive, re-educative, and reconstructive. When counseling the incestuous offender and victim individually, I have most often implemented the supportive and re-educative models. Their definitions, as noted by Wolberg (Ibid, 1954) are:

(1) **Supportive therapy**: This model consists of encouraging or promoting the development of maximal, optimal use of the patient's assets. Its objectives are to strengthen existing defenses, elaborate better mechanisms to maintain control and restore to an adaptive equilibrium. Included in supportive therapy are guidance, environmental manipulation, externalization of interests, reassurance (in the context of reducing or removing anxiety), pressure and
coercion, persuasion, catharsis, desensitization, and inspirational group therapy (Hinzie & Campbell et al. 1970).

(2) Re-educative therapy: (This term, throughout the literature, is used interchangeably with insight oriented therapy.) This method aims at providing to the patient insight into the more conscious conflicts, with deliberate efforts at goal modification and maximal utilization of existing potentialities.

(3) Re-constructive therapy: The goal is to give the patient insight into his unconscious conflicts and to facilitate extensive alteration of character structure. Reconstructive therapy consists of such therapies as psychoanalysis (Freudian), Adlerian and Jungian therapy (Ibid, 1970).

Each of these methods have common factors, as identified by Strupp (Ibid, 1978):

(1) The identified patient is seen as one who suffers from demoralization and a sense of hopelessness. Factors such as understanding, respect, interest, encouragement, and acceptance are utilized to boost morale.

(2) Each of the psychotherapies tend to operate in terms of a conceptual scheme. Contents of the schemes may vary among the therapies, but they have common morale building functions. They combat the patient’s demoralization by providing an explanation (acceptable to both patient and therapist) for the patient’s behavior. This
process serves to remove the mystery from the patient’s suffering and eventually to provide hope for change (Strupp et al. 1978).

Several uses of this model have been noted in the beginning of this section, i.e., play therapy for the young female victim, individual treatment for the offender, as well as individual treatment for the non-participant (in the offense) mother. For the victim, individual counseling provides an opportunity to help her understand what has happened and that she is not to blame. However, if individual counseling is the sole method of treatment utilized, the victim is never totally reassured of her lack of blame in the matter. Further, it appears the matter is never finalized within the mind of the victimized daughter until the offender reassures the victim within a structural context (therapeutic setting). This has been a common theme throughout this counselor’s involvement in treating the sexually abused daughter. Therefore, individual therapy should serve as an adjunct to family or group therapy to provide the victim with important validation of her feelings (Ibid, Browning & Borkan, 1981). Individual counseling offers the child an opportunity to experience an intimate relationship with an adult (patient/therapist) which is neither overwhelming nor self-serving; one which may assist the child in developing an appropriate and trusting relationship with another adult, something the child has not
previously experienced. However, Knittle and Tuana (1980), in their work with 48 sexually abusive families, noted the long period of time needed to build a trusting relationship as a problem with the model.

If the incest experience is shared only with the therapist in individual therapy, it may recreate the conditions of secrecy associated with the incest (Ibid, Boatman, Borkan, & Schetky, 1981; Ibid, Knittle & Tuana, 1980). Further, authors Knittle and Tuana stated that individual treatment for the adolescent victim places the therapist in a double bind. If the abuse is not openly discussed, shame and maintenance of the family secret is reinforced. But if the molestation is discussed whereby the therapist's attempts to be supportive through kind words or touching, the child may become fearful since both are generally associated with sexual assault. These authors further noted that if the molestation incidents are addressed at an intellectual level, the child's defense of suppressing feelings is further strengthened. Knittle and Tuana (Ibid, 1980) pointed to the child's pseudo-maturity as a trap for the therapist due to children's ability to present a view of pseudo-togetherness, leading the therapist to believe problems no longer exist. A further criticism of the individual model in treating the adolescent victim, is that often the child feels pressured to "do something" (Ibid, 1980) which evokes further stress within the child.
Additionally, individual counseling as a sole counseling method cannot change the feeling of isolation or of relating to peers, a factor generally associated with incest victims (Ibid, Boatman, Borkan & Schetky, 1981; Ibid, Knittle & Tuana, 1980).

A final limitation of the model concerning individual treatment for the victim is the therapist’s lack of control over the child’s environment. If a child is in foster care, she may suddenly be returned home. If the child remains with her parents, she may be prematurely withdrawn from counseling based on their own fears or refusal to accept what has occurred. This is often the case whereby the victim’s mother finds it difficult to tolerate the intimacy between therapist and child (Ibid, 1981) due to her own unmet needs or dysfunctional relationship with the daughter. Therefore, if individual counseling is the chosen method of treatment, individual counseling is also indicated for the victim’s mother.

For the incestuous father, individual counseling offers the opportunity to work on longstanding problems as well as accepting his responsibility concerning the sexual relationship with his daughter. The obvious limitation is his emotional commitment in achieving these goals. It has been my experience, and supported by the professional literature, that few incestuous fathers voluntarily enter counseling and a court order is often the motivating factor.
Therefore, his desire to change may be only temporary to avoid further litigation.

**Group Counseling.** This section explores the usefulness of group counseling in treating the incestuous victim. Further, the basic differences in group and family therapy will be examined, followed by a discussion of the types of groups reported in the professional literature and in the clinical setting. In assessing the basic differences in group and family therapy, Handlon & Parloff (1962) provided the most concise explanation throughout the professional literature. The following is a summary of their findings:

1. In group therapy, consisting of victims or perpetrators, motivation for change and acceptance of the client by the group is found through a development of a permissive atmosphere. In a family therapy group, members do not see themselves as equally in need of treatment, nor do they enter treatment with equal power status in relation to each other. Therefore, in the family therapy group, there exists a lack of protection to speak frankly about one's feelings or thoughts for fear of punitive measures from the powerful members of the family unit. Tropp (1966) also supported this view of the family’s hierarchical structure as a major difference between family and group counseling. In addition, McBroom (1976) pointed out a similar and important difference. She noted that the
leader with power and instrumental responsibility in group therapy is less likely to purposely frustrate the goals of a member. In family therapy, this is often the case, especially in interaction between parent and child, when each are seeking gratification of his/her own needs.

(2) Group therapy provides an opportunity for the stimulation of typical interaction patterns which avail themselves for examination and analysis by the group. Since families share unique and complex mythologies, their intrafamilial communication patterns are not readily understood or intercepted by the therapist in family therapy. As noted by Hartford (1972), the family is different from the group (counseling) in that it has previously established goals and the affectional alliances in families are quite strong.

(3) Group therapy provides an opportunity for reality testing in a relatively unthreatening atmosphere. In comparison, distortions are shared and supported by the family in and out of therapy.

(4) Group counseling provides an opportunity for its members to display transference distortions that can be therapeutically useful. However, when transference surfaces in family therapy, it often has negative effects upon its members since these distortions are supported by the family mythology. The therapist has little control over the problem of transference since there exists the potential for
multilevel transference, depending upon the number of generations involved. (Handlon & Parloff, 1962, p. 90).

Further, Bell (1972) commented on the difference between group and family therapy. They noted that the group is constructed for therapy, but there is no concern for its fate since it is expected to dissolve when therapy concludes. On the other hand, the family group is not constructed solely for purposes of therapy and is together all the time. Group goals also differ from family goals. A major goal of family therapy is to improve the family’s functioning as a whole, so that it can better maintain itself. Members of group therapy consist of those seeking to improve their own individual functioning (Lieberman, Yalom, & Miles, 1973) and share minimal concern for the fate of the members outside of the group sessions.

Group Types. The professional literature and clinical professionals render major support for group counseling for the adolescent and preadolescent female. As reported by Knittle & Tuana (1980) group counseling most effectively deals with the victim’s therapeutic needs. They assessed group counseling’s effectiveness in the following areas:

Isolation and alienation from peers: Most incest victims do not believe their conflicts regarding their sexual molestation could be understood by others or that they have experienced similar feelings. The presence of others in the
group who have survived sexual abuse, who may attend the same school or live in the community, is reassuring and decreases the feelings of isolation.

Distrust of adults and authority figures: Utilizing individual counseling, long periods of time are needed to build a trusting relationship since victims associate a fear of being hurt or exploited with adults or authority figures. Relating to other group members with similar experiences facilitates the building of trust and self-disclosure. This leads the victim to an exploration and expression of feelings.

Guilt and shame: These feelings are almost always paramount within the victim of sexual abuse in that they feel responsible for the sexual contact and the subsequent family problems. A survival technique learned and used by these abused children is to assess how others want them to respond. They have learned to relate to people by taking care of others' feelings at the expense of their own. This can be utilized in the group setting to assist the victim. For example, when one victim speaks to the group about her feelings of responsibility for the abuse, other victims generally become enraged as they can express feelings for others that they cannot express for their situation. These feelings can then be mobilized (by the therapist) to help the victim relate this to her own situation.

The group is powerful and confrontation of self
destructive assumptions is effective. Individual counseling is seldom able to lessen these strong defense techniques or intervene at deep emotional levels.

_Fear of intimacy (with therapist/other adults):_ The group offers the victim a setting whereby she is not constantly the focus of attention or feeling pressured to perform. The environment is non-threatening while allowing the group members to role play appropriate limit setting relating to personal preference for intimate contact.

_Working through anger:_ Each victim feels a degree of anger and betrayal by someone they loved and looked to for guidance. The victim tends to turn these angry feelings inward toward themselves. It is important to assist the victim in understanding that one can love a person but hate specific behaviors and to assist them in expressing these feelings outwardly.

_Unmet dependency needs:_ Group counseling assists in meeting dependency needs, in part, by strong peer approval. In learning to care for one another, the group members gradually learn to care for themselves.

_Helpless victim model:_ In incestuous families, victims usually were rendered helpless because of a need to or fear of not pleasing their parents. Group counseling teaches assertativeness and a sense of mastery over situations in which they were once helpless.

_Development of social skills:_ The sexual abuse victim
often feels socially awkward due to previous family restrictions, self-imposed isolation from peers, and low self-esteem. The group setting offers a safe place to learn and practice these skills. The group offers a setting to learn about human sexuality and birth planning. Although these children have been exposed to a sexual relationship, they generally have little knowledge or are misinformed about sexual issues.

In addition to assisting with social skills, the group setting also provides support in getting through many developmental stages that the adolescent victim must master: separate and individuate from parents; develop satisfying peer attachments; develop a sense of identity in familial, social, sexual, and work areas; develop a flexible set of life goals. The group process assists the adolescent in coping with maturational conflicts through the friendship and caring of the group members (Knittle & Tuana, Ibid, 1980).

Carozza & Heirsteiner (1982) provide additional support for the group treatment for the female incest victim. They developed and implemented an art therapy model which consisted of 22 sessions coupled with regular family sessions. Ages of group members ranged from 9-17 and group size varied from 6-10 girls. Meetings were held weekly after school. They described the treatment process as consisting of five stages:
**Gathering:** This is the initial phase in which rules and norms are established. Trust among members is established and the group identification process is begun. Art therapy also begins in this process and the projects are structured and non-threatening (i.e. Draw-A-Person and Kinetic Family Drawings).

**Self-Disclosure:** To assist in this phase, the authors utilized a film portraying previous incest victims ("INCEST: THE VICTIM NOBODY BELIEVES") and their experiences. Group cohesion is further developed by the creation of individual art projects as well as group art projects which allow the girls to define their inside and outside selves.

**Regression:** This phase implements the use of paint (i.e., finger painting with instant pudding, food coloring, etc.) as it encourages more free-flowing unconscious work. The authors stressed the importance of this phase as it permits the externalization of intense inner conflict as well as permitting a "free child" experience often denied victims because of adult responsibility associated with incest.

**Reconstruction:** Here group projects (i.e., group scribbles) are supplemented by encouragement to explore their individual pasts and future anticipations.

**Ending:** Here activities are geared toward dealing with separation issues, which are often painful for incest victims. Each girl is encouraged to explore her inner

These authors reported a high weekly attendance (80 to 100%) as well as a low recidivism rate. Of the 22 group members, only two reported the reoccurrence of repeated molestation. The effectiveness of their group model, in their evaluation, was also demonstrated by: movement toward confrontation and communication in the families; behavioral changes observed in the group; and changes reported outside the group (Ibid, Carozza & Heirsteiner, 1982).

The authors provide strong support for the group treatment model through the development of their own treatment models (Ibid, Boatman, Borkan, & Schetky, 1981; Ibid, Knittle & Tuana, 1980). With the exception of the Parent’s United Program, few professionals have devoted time to explore group treatment as an alternative for the sexual offender or his spouse. This conclusion is based on this author’s research of the professional literature as well as the available clinical programs.
CHAPTER IV

CONCLUSIONS

From the research gathered, it appears that the family therapeutic model cannot be immediately implemented when a family is presented for treatment. Individual family members or dyads within the family may need to be seen. When the incestuous relationship is revealed to authorities, a family crisis is presented, with each member reacting. Emotional levels of each family member are heightened and hostilities among members that were previously covert now become overt. These members are not prepared to deal with family matters until his or her reactive emotions concerning the incestuous relationship have been dispelled. These emotions include confusion of the victim, denial or humiliation of the incestuous act by the father, and anger or denial by the mother.

Depression by the mother may be a causative factor in her role incompetency, although this area has received little focus within the professional literature. However, the literature does consistently place much responsibility upon her for the development of the father-daughter relationship (i.e: Ibid, Lustig, 1966; Ibid, Weiner, 1962). A few authors have pointed to, but failed to elaborate upon, the therapeutic need to strengthen the position of the
mother within the incestuous family via treatment of the mother's depression (Herman & Hirschman, 1981). Geiser (Ibid, 1981) touches upon this concept, indicating that this depression may be related to her marital state or by a physical incapacity, but he did not elaborate upon a treatment methodology. Guthiel & Avery's (Ibid, 1977) case study of an incestuous family in treatment described the mother as "depressed and angry," (p. 186) but presented no treatment alternative for her to relieve these symptoms. Browning & Boatman (Ibid, 1977) did report a notable degree of success in therapy with the mothers in incestuous families by asserting the passivity of these women was often due to a chronic depression that could respond to appropriate treatment interventions (specifically, individualized treatment). Giarretto (1978) is also supportive of individual treatment for the mother of the father-daughter incestuous family primarily for this mother to "take inventory of the good and bad aspects of her marriage and to wonder if it is truly salvageable" (p. 236). While this is an important function, specific concern must first be given to her depression before she can begin to consider what to do about her marriage.

Although the mother's depression must be treated, counseling must first begin with the victim (Ibid, Giarretto, 1978). She must be allowed to discuss her feelings about the sexual experience with her father, to
express her anger, hostility, hatred, or other feelings she presently feels. Great care (Ibid, Giarretto, 1978) must be taken to prevent girls from coping with the enormity of what has happened to them by "turning off sexually" (p. 236). She must receive the message that sexual feelings are good and normal (Ibid, Giarretto, 1978). The listening ear of the therapist while the victim recounts her sexual experience with her father is very important. It indicates to the victim that she is accepted by another, regardless of what has happened to her.

Following individualized treatment of the mother and daughter, Giarretto (Ibid, 1978) supports joint mother and daughter counseling to strengthen their bond. He suggests sessions also with the mother and remaining children in the family, including the victim. This allows the children to express their feelings about what has occurred. Counseling must help to maintain the framework of change of family behavior rather than blame of one member. This is a critical family stage as siblings often begin to direct blame toward the victim if the father has been ordered out of the home by authorities or for the potential loss of his job or for bringing them into counseling. During this process, the father should also receive individual sessions to provide hope that the family will be helped, rather than destroyed. These sessions also serve to assist the father in accepting full responsibility for his sexual behavior.
toward his child. He must admit and believe that the behavior was wrong and not to be repeated, as well as to understand that incest is destructive for the entire family (Ibid, Giarretto, 1978).

For the parents, marital counseling must be initiated after the above process is completed. Marital counseling must not include the children as intimate sexual and marital issues must be addressed. This process also aids the couple in developing privacy within their marriage which must be maintained.

The family therapeutic process should be begun at this point in which the family members are prepared to discuss the critical issues involved. In addition to the therapeutic process, self help groups, such as Parents United, and Daughters United assist parents and daughters in understanding they are not alone in what they have experienced (Ibid, Giarretto, 1978).

Successful intervention of the father-daughter incestuous family depends upon careful coordination of all professional activity (Ibid, Anderson & Shafter, 1979). These authors noted that effective coordination of clinical, court, and social services is crucial but particularly difficult and confusing when multiple agencies with differing professional orientations, roles, goals and expectations are presented.

What occurs after the reporting of the incestuous
The victim may become as distraught by multiple interviews with various professionals, court appearances, and foster placement as they are by the incestuous relationship which previously occurred (Gibbons & Prince, 1963). The authoritative intervention of the judicial system is important to assure protection of the victim and treatment of the individuals involved (Ibid, Anderson & Shafter, 1979). As noted by Giarretto (Ibid, 1978) involvement of the judicial system has a definitive purpose when incorporated with the clinical treatment process. Giarretto noted two reasons for the utilization of the judicial system when treating the incestuous family. That is, people who have committed incest feel that they have sinned and that expiation for their actions is appropriate. Secondly, the criminal justice system involvement provides a powerful authoritative incentive for changing intrafamily behavior and stopping the sexual abuse (p.231).

Giarretto (Ibid, 1978) pointed out that when the incestuous relationship is "found out" the victim is often indirectly punished in the form of widespread adverse publicity, the father’s loss of his job, and other resulting hardships affecting the entire family. Additionally, Giarretto further noted that the incestuous family may be rejected or stigmatized by the community at large. Therefore, support, direction, and empathy from the
treatment agencies involved become vital for the family unit and its individual members.

Giarretto (Ibid, 1978), in his treatment of incestuous families, strongly advocates a humanistic approach that is backed up by the authority of the criminal justice system, but enables intervention in a nonpunitive fashion. Giarretto proposed that the incestuous father’s behavior results from a cyclical pattern in which he implements behavior taught by his parents. Giarretto’s (Ibid, 1978) humanistic model operates upon the assumption that if people knew how to meet their needs more effectively, they would do so. A basic premise of the humanistic model is that when parents do not feel good about themselves, they develop a self-hatred that can only be discharged by acts of abuse toward themselves and others (Ibid, Geiser, 1979). The objective of the treatment model is not to extinguish or modify dysfunctional behavior by external devices, but to help the individual develop self-awareness, leading to better self management (Ibid, Giarretto, 1976).

Direct punishment in the form of incarceration of the incestuous father generally is unsuccessful in bringing about reformed behavior (Ibid, Giarretto, 1978). Additionally, the incarceration badly fragments the family, and intensifies guilt feelings for the victim. The humanistic approach, as proposed by Giarretto, (Ibid, 1978) is one in which the criminal justice system strongly
encourages (and if necessary orders) the perpetrator and family members to receive therapy. The goal is to maintain family integrity and to teach people to assume personal responsibility for their behavior, to eliminate the incestuous relationship and, if possible, to reunite the family (Ibid, Giarretto, 1978).

The thrust of this paper has been dedicated to the belief that the problem of intrafamily sexual abuse requires a family treatment approach. Fundamentally, this approach should: create dissonance within both the enmeshed and distant family relationships; restore the parental status structure, placing both parents in charge of the children; and replace chaos within the family system with structure and a reintegration of role relationships, free of abuse. However, in researching this topic, what became apparent was the need for each family member to progress through various stages of counseling, utilizing the three treatment approaches: family, individual, and group counseling. The findings were inconclusive in supporting one approach as offering an advantage in treating the incestuous family. Rather, support was found for an incorporated model of the three therapies, offering a sense of completion or wholeness in assisting family members both separately and individually in dealing with their problems (Ibid, Giarretto, 1978; Ibid, Boatman, 1981; Ibid, Browning, 1977; et. al.). The most effective approach appears to be one in which treatment
occurs in the following stages: individual (or crisis) counseling for the victim; conjoint counseling for family dyads (mother/daughter); marital counseling and in the last phase, family counseling, supplemented by group counseling. Group counseling appears to supplement and to serve as an enhancement to the above process.

However, when utilizing this treatment approach, the therapist must be aware of each model's limitations. For example, when utilizing family therapy, for effective intervention, the therapist must remain clearly defined as not belonging to the family system. Further, in family therapy, often the therapist and family in treatment are in direct conflict in their goals in the beginning phase of treatment. The therapist wants to understand how the symptoms fit into the family's homeostatic structure, but the family usually wants to immediately get rid of the symptoms. In individual therapy, it is the opinion of this author that the therapist may be entering a coalition with the individual in treatment or it may appear so to other family members. Finally, an apparent danger in implementing the group counseling method is that the therapist has less control over the responses each client receives. The therapist must be alert to destructive interactions between group members and to deal with them appropriately.

In addition to the incorporation of the three treatment approaches, support of the the criminal justice system as an
equal partner in the treatment process appears fundamental. While incarceration of the offender is of little benefit to the offender, victim, or family, the criminal justice involvement is most often needed as an incentive in keeping the abuser and family members in treatment. Incestuous families seldom possess the strength or motivation to remain in treatment due to their tremendous anxiety level within the family unit. This anxiety often brings about denial of the abuse by the victim, the abuser and other family members. Therapy often increases this anxiety level in an attempt to bring about changes within the family. The therapeutic intervention must center around changing the belief system of the entire family. Often, the victim, abuser, and other family members have completely rationalized the abuse incidents and do not recognize the need for change. Because this process is so painful and provides few immediate rewards to the family members, the legal system serves as a vital link to the incestuous family(2).

The research literature strongly supports a concept of equal balance between "prosecuting an illness" and "treating a crime" (Ibid, MacFarlane & Bulkley, 1982) in working with the incestuous family. While professionals in the fields of counseling and criminal justice may differ in their view of incest as a mental illness or crime, each serves as a necessary partner to the other.
Currently, the diversity among treatment programs and the investment of individuals in their own program models serve as the greatest barrier in the clinical development of acceptable universal models to replicate. Comparative research must be done to move beyond the beginning phase of an acceptable treatment approach for the incestuous family. With the dwindling of federal and state monies to conduct research, clinicians must look to their treatment programs within their private practices and conduct this necessary research and evaluation.

The family therapeutic model has only recently (within the past ten years) been recognized as an effective means of treating the father-daughter incestuous family. Further support and understanding of this model will be left to the documentation of the researcher and the development of longitudinal studies reflecting the long term effects of the model upon the family members. Through these studies, it can be more accurately determined whether or not the family treatment model is successful in interrupting the father-daughter incestuous relationship.
NOTES

(1) Information received from Mr. Jim Jolly, Program Specialist, of The Florida Child Abuse Registry, Tallahassee, Florida, through telephone interview in January, 1984.

(2) Conference-Workshop, Advanced Treatment Concepts Of The Incestuous Family, conducted by Miriam Ingebritson of The Minnesota Program For Victims Of Sexual Assault conducted on 10-19-84 in Miami, Florida.
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