Incest and Sexuality

Getting Professional Help

Wendy Maltz
Beverly Holman

Getting Professional Help

Wendy Maltz
Beverly Holman

e-Book 2017 International Psychotherapy Institute

From *Incest and Sexuality* by Wendy Maltz and Beverly Holman

Created in the United States of America

Table of Contents

Getting Professional Help

Many survivors and partners of survivors feel anxious about seeking professional help. Picking up the telephone to call a therapist can sometimes be the most difficult step in the entire process. This is understandable, since incest and sexuality are both very personal areas that have long been culturally shrouded in secrecy. Most people are raised with an unspoken rule: Avoid discussing sexual experiences with anybody. Feelings of shame, embarrassment, and fear of what others will think may surface and inhibit people from getting help.

Anxious feelings about therapy can be overcome and replaced with feelings of confidence. By learning what therapy is about as well as how to find a good therapist, survivors and their partners can know what to expect and can help make their experience in therapy a positive one. Because of the betrayal of trust that occurred as a result of the incest, trust is likely to be an issue in therapy. Survivors have learned that they cannot afford to trust blindly; in the past the cost has been too high. They may have difficulty trusting lots of important people in their lives. They can begin by acknowledging that trusting people does not come easily for them. It makes good sense for survivors to maintain an active, informed

involvement in all stages of their therapy. Survivors can protect themselves from unproductive or even negative experiences by having guidelines for determining good-quality therapy.

The intent of this chapter is to empower survivors and partners of survivors by offering practical information on different aspects of therapy for incest and sexuality concerns. Counselors and therapists treating incest survivors may also find this chapter helpful for further developing their approaches and skills. The topics covered are (1) understanding therapy, (2) finding a therapist, (3) beginning therapy, (4) incest resolution therapy, and (5) sex therapy.

Understanding Therapy

Therapy is a process whereby a client is able to focus consistent time and energy on resolving problems while utilizing the support and guidance of a trained professional. Most clients attend therapy for a one-hour session once a week, but therapy can take place as often as several times a week or as infrequently as once every several weeks. A session once a week works well for most people as it allows clients to sort out feelings and changes that have occurred during the previous week while still maintaining the momentum necessary to keep working toward their goals. For therapy to work well, clients must be motivated to address their concerns and must be willing to expend energy outside the sessions on activities that complement the therapy sessions themselves; doing

individualized exercises, reading books, becoming acquainted with community resources, and reflecting on what came up in therapy the previous week are some examples of such activities.

Counseling sessions usually take place in an informal, relaxed office setting, commonly furnished with living room and office furniture, with a quiet and private atmosphere. Many clients have likened a therapy session to having an undisturbed talk with a concerned friend. While a therapist is certainly concerned with the client's well-being, he or she is not a personal friend in the usual sense. It is the lack of direct involvement in the client's daily life that allows a therapist the objectivity to counsel effectively.

There are several ways to do therapy. They include the following: (1) individual (one client meets alone with one therapist), (2) couple (a couple meets with one therapist), and (3) group or family (approximately three to ten clients meet with one or more therapists). Another method used primarily with couples and families is two therapists working as a team during sessions. This is often a male-female team.

Therapy styles vary from one therapist to another, reflecting both the unique training and personality of the therapist involved. A style used by most is conversational, with the therapist listening to and reflecting back what the client is saying. Some words used to describe the range of differences in style are warm,

friendly, supportive, educational, confrontive, or distanced. The same therapist may vary her or his style to complement the personality of a particular client. For instance, a therapist may assertively point out inconsistencies in logic with a highly involved, psychologically strong client; yet with a timid, insecure client, the therapist may maintain a calmer, slower, more nurturing approach. Good therapists have the ability to shift their style in accordance with how their clients are doing on any given day.

Good therapy is neither a comfortable social experience nor an uncomfortable confrontive ordeal. In most cases, therapists will balance a safe, open atmosphere with gentle questioning to maintain progress and will do so at a pace the client can handle. Clients in therapy have a right to question and comment on the process as well as the actual content of the therapy. It is true that some discomfort may occur. Yet for most survivors this discomfort is far less than the discomfort of not going to therapy and continuing to allow the incest to dominate one's life and sexuality.

Survivors and their partners can increase the likelihood of making positive changes in incest-related concerns when they get professional help. Therapists help clients to identify important issues, and they validate the client's feelings. Ongoing therapy provides a consistent time period in which clients can focus their energy completely on resolving identified concerns. Clients learn how to get through periods in the change process that may be uncomfortable or difficult. By

offering encouragement, information, and a plan, therapists can counter the tendency, stronger in some than in others, for survivors to give up on themselves. Therapists teach new ways of looking at old problems as well as the necessary skills for changing behaviors, attitudes, and feelings. As one survivor remarked:

> The function of therapy sessions is to keep the stuff coming and to give it direction. Once the client gets some experience with the process, I think the therapist becomes more a facilitator than a director.

Because the repercussions of incest are complex and deep, many survivors and their partners find therapy critical to their healing process. All the women in our study were in individual or group therapy for general incest concerns. Over and over again they emphasized how important they believed therapy had been in helping them to recover. A man who came with his partner to couples therapy regarding sexuality issues shared the following:

> I think a couple in which one person is an incest survivor needs to find a good therapist. A mediator for us has done wonders. We were both too frustrated and pulled apart from each other; we needed a third party to help us see and understand the problem from an experienced point of view.

A twenty-six-year-old survivor who had been married for six years entered therapy when she was pregnant with her fourth child. Her goal was to understand and work out the problems in her sexual life; she was very pessimistic about her chances of success. In her first session, she stated:

> I feel disgusted and disgraced whenever my husband touches me. It feels

yicky to me. I resent sex —that it has to be there or else we can't be happy. I wish it didn't exist. Intellectually I know that's not healthy, but that's how I feel…. I have good thoughts about him when he's gone.

The progress she and her husband made is evident in the following story, which she wrote three months after therapy began.

As an adult my memories of when or where the incest started are not real clear. As far as I know I was about three years old. My parents were going through a divorce. My father was the offender. I held him in great esteem. I idolized him and had him on a pedestal. My memories of the incest are of my nipples and genital area being touched. This made me feel very frightened. It was scary not to know why I had to be touched in places that made me feel so different. I didn't like it, so I would cry and cry, but still he never stopped. I would block out what was going on after a certain point. That is what kept my sanity through all the abuse.

The abuse happened various times. Sometimes ten times a year; other times five times a year. It depended on how often I was with my father at his residence. As I grew into a young teenager, I began to view sexuality as something men had to have from women because of their sexual fantasies or desires, which I felt were strong for every boy or man. As I began to use my body sexually, I realized I was enjoying it too. If I became involved with someone who cared for me more than sexually, my body didn't seem to enjoy the sexuality or intimacy. I would run scared and be frightened by any touch from that person.

When I finally did marry, it was to a caring, wonderful husband. He knew about the incest but he didn't really understand it, as I myself didn't at the time. We had a very sexually active life together for about four or five months. At that time he was still enjoying it and I was faking it—afraid of the consequences. I didn't know what they were but I didn't want to disappoint my husband. The honeymoon really seemed to be over. This left me scared. I didn't understand what was wrong with my body. I was five months pregnant at the time, so I thought maybe that was it. Wrong! I still felt that way between pregnancies. Then I was grasping at straws,

never for one minute thinking the incest was the cause. I blamed the fact of childbearing, nursing, and the stress of all this. But after five years of marriage that had more downs than ups, I felt there must be something physically wrong with my body. A medical doctor advised me that stress and childbearing were the reason. He said that hormones get out of whack and I just needed to give them time to recuperate.

About six months later, I consulted a therapist who told me that incest has a very damaging effect on the mental and physical state of the victims. She explained to me that enjoying sex as a teenager happened because I felt I had something my male counterparts wanted. This was my way of getting attention. In giving my body this way, I could get people to like me. This was a big goal in my life. Once I was married and I began to feel as if I didn't have to do anything to make my husband love me, the sexual desires went away. I realized this guy would love me no matter what. I reverted back to having the feelings I had as a child. I didn't want to touch or be touched.

By this time my husband was very frustrated and ill-tempered a lot. He was understanding things a little, but he didn't change. I was in group therapy for three and a half months. We worked on many issues that helped me feel stronger as a person. I started liking myself and changing in many ways, but my sexuality stayed the same. The group therapy helped me to put the blame for the incest on my father and not myself. I learned simple things about myself, like why it was hard for me to say I'm sorry. I realized I had put my husband into a position of the father image. He in turn would react from the position I had put him in.

When I had gained my new self-image and finished my therapy, my sexual desires came back. They were only temporary, however. Then I was referred to another therapist who specialized in incest and sexual concerns. It seemed as though my sexual life was still deteriorating. My husband and I attended these sessions together. We had more work to do. This time it was our marriage in general and the effects of the last five years that needed work. We learned how to be on each other's side and work together, not against each other. We began to learn about sensate focus and how to touch each other without having to be afraid. By doing

this it made me feel very loving and caring about my husband. It gave me a real sense of closeness. He didn't have to feel as though my body was off limits anymore, and I didn't have to worry that his touching me was a sexual thing. We got in touch with how beautiful it is to share our bodies sensually instead of sexually. It brought us back to a beautiful marriage, with lots of ups and fewer downs. By touching each other gently on every point of the body excluding the genitals, we learned how to make and give time to each other. Then we began to touch genitals and realized that was very natural because those were parts of the body too. It drew us closer and closer, and we feel more like two bodies united as one, rather than two bodies afraid of what the other body might do.

I might just say to other survivors to never give up. To finally reach that potential to give love and be loved is a worthwhile commitment that could never be won without proper therapy and the natural human instinct of love. Let the honeymoon begin again!

Finding a Therapist

Professionals who provide therapy for incest survivors fall into several groups, which differ in training specialties, degrees, and fees. Social workers and counselors usually have a master's degree. Psychologists have a doctorate (Ph.D.). Psychiatrists are medical doctors who are able to prescribe medication for mental and emotional problems. It is difficult to generalize about who may be more skilled in dealing with incest and sexuality issues; qualified professionals exist in all categories. The degree is less important than the specialized training a counselor has had. Good backgrounds would include training and experience in incest treatment, sex therapy, couples counseling, family therapy, and depression treatment. A therapist with a background in incest and sex therapy is able to talk

comfortably about sexual concerns while sensitively responding to underlying incest concerns. If someone who does both is not available, you may want to ask yourself whether it is more likely that your incest concerns are affecting your sexuality or that your sexual concerns need to be the primary focus of your treatment. This will help you to choose a therapist. One option is to choose a general incest therapist and later pursue more sexually focused treatment with a specialist in sex therapy who has some understanding of incest.

Another consideration in finding a therapist is the sex of the therapist. Many female incest survivors, because of their general apprehension toward males and their fear of possible sexual overtones during the sessions, feel most comfortable with a female therapist. Some male therapists, however, are very effective in working with survivors and provide an opportunity for them to establish a trusting, nonsexual relationship with a nurturing male figure.

Degrees, training, experience, and sex of the therapist are all important issues. Another important issue is the way the survivor and her partner feel about the therapist. Therapists are human beings with their own style, strengths, and weaknesses. While it is not necessary to like the therapist personally in order to have an effective outcome, it is important to trust the therapist. Feeling the respect, caring, and support of a therapist can be a powerful aid to a client in making changes. The personalities of the client and therapist alike will enter into this complex issue. The basic rule is to trust yourself. Pay attention to how

comfortable you feel. Comfort is not the only issue to weigh, for therapy is not always comfortable, but strong negative feelings about one particular therapist are enough to eliminate that person from consideration. Other factors, such as the therapist's commitment to the equality of women and men, are not reflected in degrees or titles but can be evaluated through direct questioning or careful listening.

Finding a good therapist can require time and effort. A sensible way to start is to ask for referrals from trusted people and agencies. A family doctor, a gynecologist, a mental health referral service, an incest treatment program, a women's center and resource agency, a rape crisis center, a psychologists' association, a sex therapists' association, and friends can all be asked to supply the names of people they know to have good reputations. Identify the ones who are recommended by more than one source. Call them and ask questions.

When financial constraints exist, look for options. Many mental health clinics and private practitioners have sliding scales to accommodate lower-income clients. Look into insurance coverage on existing medical policies. Some therapists will defer part of the payment until after the therapy has ended in order to spread out payments. If a therapist is appealing but not available, ask her or him to recommend someone else.

While interviewing therapists either on the telephone or in person, you may

want to ask the following questions: What is their fee? Is the fee negotiable? Are they willing to have a short initial meeting free of charge? What experience and training do they have in incest and sexuality? What professional memberships do they have—are they licensed, registered, certified? How would they describe their style? What methods do they use? Will they give you the names of physicians or people familiar with their work whom you may call? Take the time to review their answers and think them over. Trust your intuition. Pick the therapist you like best and schedule an appointment.

Sometimes there is a strong client-therapist connection and sometimes there isn't. That is to be expected. However, occasionally a client will begin therapy, then realize she is not working well with the therapist. In such an instance, she may need to stop therapy and change to another therapist with whom she feels more comfortable. However, such a change is most effective when it is clear that the client is making an assertive decision to seek better therapy rather than running away from tough issues. Ideally, this issue would be discussed with the therapist.

A few situations should serve as red flags to leave a therapist. They involve unethical conduct and misinformation. Any therapist who says or implies that the survivor bears any responsibility for the incest is misinformed, and therapy with that person should not be continued. A therapist who suggests or attempts sexual behavior with a client is clearly out of line. This behavior violates every legal and

ethical code of professional conduct. Clients should be suspicious of any therapist who even implies that sex with a client could ever be therapeutic. When a client experiences sexual interest from a therapist, the dynamics of incest are recreated. A trusted person in a position of authority again has made sexual advances toward the client when she feels less powerful and psychologically dependent. If this happens, refuse to participate and report it to the professional organization that regulates the therapist. Then find another therapist.

To protect the client and the therapeutic relationship, we recommend that no other type of relationship with the therapist should occur outside of therapy. This includes personal friendship, work exchanges, socializing, and even going out for coffee. When more than one kind of relationship exists, the waters of therapy can too easily be muddied. Even when therapy ends, it is best to keep to this rule. The client may want to return to therapy later, and the therapeutic relationship is altered—compromised—if other relationships have been entered into. Maintaining clear boundaries in the client-therapist relationship provides for the most effective therapy.

Beginning Therapy

The first therapy session can provide an opportunity for both the client and the therapist to get acquainted with one another. The therapist may ascertain from the client the nature of the problem, what previous therapy has been tried,

and what the client defines as the goal of treatment. It is also a time to obtain background information on the client and begin assessing the problem in order to formulate a treatment plan. The client can utilize the initial session to find out more about the therapist's background and experiences in treating people with similar concerns and how the therapist might work with her concerns. While the first session is devoted more to establishing rapport and assessing the problem than beginning therapy, a client should leave feeling she or he was heard, having confidence in the therapist's abilities, feeling able to work with the therapist, and feeling hopeful.

Most people enter therapy when they realize they have a problem they have not successfully dealt with alone. The problem may currently be causing them psychological pain or may have a strong potential for causing them future psychological pain. Some people feel excited about entering therapy; others may dread it but feel they can't ignore their problems any longer. A few people enter therapy because they are nearly strong-armed to do so by doctors, partners, or family members who have witnessed the pain they are in on account of unresolved psychological issues.

Incest survivors come to therapy via numerous routes. Most commonly they seek a general therapist rather than a therapist who specializes in treating sexual problems. Many have been experiencing concerns such as eating disorders, problems with sleeping, drug and alcohol dependencies, or problems in

interpersonal relationships. Incest is not commonly seen as the root of these concerns. Typically, incest survivors initially exhibit what psychologist Denise Gelinas describes as a disguised presentation.[13] Specifically, the disguised presentation may include symptoms of depression, self-abusive behavior, confusion, impulsive acts, very low self-esteem, and a history of assuming adult responsibilities as a child. Incest survivors tend not to have identified their underlying problem of unresolved incest more directly because (a) as many as 50 percent do not remember the incest, and (b) many who do remember it may consider it irrelevant to their current situation and not even mention it. They may never have defined what happened to them as a form of abuse. Some people were never actually molested but had a parent who behaved seductively toward them. These people can exhibit many of the same concerns as survivors and may be treated by therapists in the same way.

It may take considerable digging on the part of the therapist to discover incest as the source of the symptoms being experienced by the client. A therapist may need to keep pursuing the question over time, as one survivor indicated in the following story:

> I had been in individual counseling for one and a half years. Incest never came up during that time. I was having problems with my social life and relating with other people—and we could never figure out why that was. My therapist had asked me early in therapy if I had been molested. Her question wasn't something I paid any attention to at all—it didn't ring any bells. She asked me again after a year and half of therapy, and my initial reaction again was no, I hadn't been molested. She said she was concerned

> because a lot of the problems I was having reminded her of the constellation of problems experienced by adults who've been sexually abused as children. The question still troubled me, and that next week I started remembering some stuff with my dad that I had remembered but then thought about in a different way. I said to myself, Maybe that stuff he did wasn't quite right, and began dealing with it in therapy from then on. I had no category for sex as a kid so I never filed it as sexual abuse in my mind.

Many therapists have only recently begun to ask routinely about incest in the early stages of therapy. A therapist will get more information by asking, "Was there any unwanted or confusing touch that happened between family members?" than by asking, "Are you an incest victim?" It is imperative that the incest be identified. Therapy for depression is unlikely to be successful if unresolved incest lies at its root. For this reason, therapists should not be afraid to ask about sexual encounters as a child. When survivors cannot remember their childhood or have very fuzzy memories, incest must always be considered a possibility. People who relate to others with strong feelings of hopelessness, defeat, anger, and overt hostility may also be incest victims.

Some incest survivors first see a therapist who specializes in treating sexual problems. The incest may or may not have been identified. In these cases the main motivation for therapy may be to address a specific sexual dysfunction, such as lowered arousal, lowered desire, difficulty in achieving orgasm, erection problems or painful intercourse. Other incest survivors enter therapy because they suffer from sexual addiction problems, in which their behavior has become self-abusive

or potentially harmful to others. They may be concerned with activities such as compulsive masturbation, compulsive promiscuity, prostitution, sado-masochistic sexual acts, voyeurism, exhibitionism, cross- dressing, and so on. They may have histories of being sexually victimized and of sexually victimizing others. Fear of contracting sexually transmitted diseases that correspond with high frequency indiscriminate sexual activity such as acquired immunodeficiency syndrome (AIDS) may trigger the decision to seek help.

One woman had been in a generally satisfying relationship for over two years and wanted to overcome a chronic feeling of disinterest in sex and an aversion to touching herself and her male partner. She had been sexually molested by her cousins as a child and then made to feel responsible by them for what had happened. Upon entering sex therapy she said, “Sexual issues exist and must be coped with. Ignoring sexuality does not make it go away.” As this client demonstrates, motivation for dealing with sexual concerns often stems from a desire to improve the sexual relationship with a partner the survivor cares about.

Sometimes couples enter therapy together to resolve incest issues that affect their current sexual relationship. This can be a very positive approach that affords them an opportunity to address their feelings and concerns and to learn how to communicate about the incest and their sexual relationship without blame or guilt. Couples usually complete therapy with a strengthened bond that comes from jointly tackling a problem that may have once appeared unsolvable.

Therapists who treat sexual problems must be well skilled in assessment. As with general therapists, it is important that they be aware of the possibility that the current sexual problems may relate to previously unidentified, early sexual abuse. When the incest is revealed during the assessment or later in therapy, the therapist must determine the extent to which the sexual problem is a repercussion of the incest. If it is determined that it is indicative of underlying unresolved feelings from the incest, then a treatment plan should be designed to address the incest concerns before or concurrent with the sexual concerns.

On the other hand, the therapist must also be able to assess when the sexual problem is not primarily related to the incest. Some incest survivors believe that all the sexual problems they experience are a result of being "scarred for life" by the incest. But thorough clinical assessment might indicate that the sexual problem reflects a lack of sexual education, a medical problem, or a need for information about sexual techniques. All of these can be easily addressed, and sexual improvement can be achieved relatively soon. For example, a survivor may have never experienced an orgasm during intercourse. Assessment may reveal that lack of adequate stimulation to the clitoris is the main problem.

In the early sessions of sex therapy, most people feel relieved to have found a specialist who is comfortable with the subject of sexuality and who can discuss it in a frank, open, and educational manner. Survivors who have already spent time addressing general incest concerns in individual or group therapy often feel it is a

natural progression to then shift to a sexual focus in treatment and address the longstanding sexual problems they have experienced.

Incest Resolution Therapy

Most survivors are ready to address sexuality concerns only after having spent much time working on incest in general. When survivors begin to like themselves and have resolved their feelings about the incest, they may become motivated to reclaim their sexuality for themselves. Thus the initial phases of treatment, here referred to as incest resolution therapy, constitute a time for understanding incest and its impact and for focusing on issues of trust, assertiveness, self-esteem, anger, self-destructiveness, and body image.

The following summary of eight treatment goals developed in 1984 by Faria and Belohlavek illustrates how therapy can create a logical progression toward dealing with sexual content:

1. Establishing involved commitment to the therapeutic process.

2. Identifying old patterns by which the client flees from relationships.

3. Developing a mutual working relationship based on trust and active self-management.

4. Building the client's self-esteem about survival.

5. Developing the constructive expression of anger.

6. Identifying and gaining control over self-destructive and self- defeating behaviors.

7. Networking with other support systems and developing meaningful relationships.

8. Increasing self-esteem through improving body image and understanding human sexual response.[14]

Incest resolution work can take place in either individual or group therapy. Survivors often choose to be in an incest survivors' group after first establishing themselves with an individual therapist. The combination of both individual and group therapy can have a powerful therapeutic effect. Individual therapy establishes a one-on-one relationship with the therapist in which survivors can explore personal issues and concerns in depth.

In group therapy, the therapist spends a limited amount of time focused on each client. However, survivors benefit from watching and hearing other survivors work through their concerns. Group therapy usually has a wonderful way of automatically overcoming the survivor's fear that she is different from others, and the feeling that no other woman or man has the same types of problems. When survivors learn that others have felt and experienced similar things they usually feel enormous relief and hope for themselves.

Because there are other people present, survivors in groups have the choice of taking either an active or passive role in therapy. They can choose to talk about their own issues or to listen to other people. An example of how beneficial a group experience can be was provided by one survivor:

> After doing private counseling, I got to the point where I believed what my body was telling me and could use the words "incest survivor" about myself. I joined an incest survivors' support group that has been an incredible help to me in going through this process— being among a group of women who know, who will listen to your fears, your doubts, your self-hate, and your growing strength. And being there for them, which to me is the same as being able to be there for your own fears, doubts, hate, and strength, is incomparable. *We are not alone.*

Women survivors who are bisexual or lesbian may find it helpful to get into a survivors' group that has other women-oriented survivors. One lesbian survivor commented:

> I know it was very important for me to get into a group with other lesbian incest survivors. The reason I changed groups was because I was in a group without any other lesbians. I never felt any discrimination, but I just didn't feel I could connect on that with anybody else in the group. I felt on the outside, and you tend to feel on the outside anyway. That's another thing, that as an incest victim, when you're going through it, you always feel very separate and different from other people, and that's reinforced, being a lesbian.

Having other lesbians in the group enables lesbian survivors to identify and validate common concerns. For instance, some lesbians may have intense feelings toward the nonoffending mother that may differ from the feelings of heterosexual

women. The same lesbian survivor went on to explain:

> There are three lesbians in the group of five women survivors. When any of us talks about our mother, the three of us who are lesbian are a lot more condemning of the nonoffending mother than the two women who are heterosexual. For lesbians, what might make the difference is that the expectations are high for women to be nurturing and loving to women.

Incest resolution therapy encompasses a variety of counseling techniques and approaches for helping survivors to process their feelings. To be useful, a technique needs to feel both comfortable to the therapist and appropriate for the survivor. A partial list of techniques and approaches follows (the order in which they are listed is incidental):

1. *Telling the story.* Telling the therapist (or survivors' group) the details of the incest can provide relief. This can be extremely difficult for some survivors to do. Therapists can encourage each woman to share at a pace that is comfortable for her and to respect her own limits by letting the story come out in parts over the duration of many sessions. Some women do not remember their childhood, and others may visualize scenes from their childhood as in a movie—there are images of events but no feeling memory attached to them. A therapist can help by accepting and encouraging all of these stories.

2. *Reframing.* Events and feelings can be viewed in more than one way, just as a photographer can take a number of different shots of the same subject from different angles. A therapist can help a survivor look at events and behaviors and feelings from a

different angle. For example, a survivor may feel that her tendency to "space out" under stress is a negative characteristic that demonstrates her lack of self-worth. She can come to see instead that this was a very positive way in which she coped with the overwhelming stress of incest. It is evidence of her strength and creativity in coping with a traumatic event. She may find that she wants to feel more conscious control in choosing this coping strategy, or she may decide that spacing out is no longer helpful to her as an adult and that she is ready to learn new coping skills. She can then begin to find more appropriate ways to cope.

3. *Power and responsibility.* Many survivors can benefit from a close look at their power and their responsibility. First, a survivor must understand that she absolutely was not at fault and was not responsible for the incest. Believing this can eliminate tremendous guilt. Next, a woman can learn to see how she may have taken on the passive role of a victim and carried that into her adult life. She can learn to appreciate her own power now and begin to take responsibility for changing the parts of her life she does not like. A therapist must be careful to help her learn how to balance this process and how to view the ability to change in a realistic time frame. For another survivor who reacted to her victimization by becoming aggressive and domineering, the therapeutic challenge may involve helping her learn to recognize and respect the rights of others.

4. *Communication skills.* Survivors found as children that their needs and wants were not respected, and often they did not learn effective communication skills. Assertiveness training, owning one's feelings and desires, active listening, and so on, can be very

helpful in reclaiming personal power.

5. *Review of personal and sexual history.* Patterns of behavior can be gleaned from a review of the survivor's life. Awareness of these patterns and how they develop can help the survivor make choices about which patterns she wants to change.

6. *Finding the child.* All adults have a child within. For the survivor, discovering and nurturing the lost child within her can be a major part of therapy. Hearing what the child wants and feels is the first step toward meeting her needs. Survivors are frequently great at giving to everyone but themselves. Learning to balance the adult and the child, to integrate both within herself, is a big task. It can be helpful to look at particular situations that indicate whether a survivor is initiating and responding from her child part or from her adult part. She can then choose which is most comfortable for her in a given situation. For example, the child part of a woman is not the best part to have uppermost when balancing a checkbook but is definitely the best to call forth for playful, relaxed sexual activity. The principles of transactional analysis (TA) may be useful here.

7. *Gestalt.* Gestalt techniques, particularly chair work, can be very powerful. Chair work involves the survivor imagining that someone she has things to say to is sitting in an empty chair in the room. She can talk to the person, taking time to stop and get her thoughts clear and explore her feelings in a way she could not easily do if the person were actually in the room. In this way, a survivor can express sadness and anger to the offender, parent, and others who played a role in her past. This can be particularly

effective when someone has died, is geographically distant, or is inappropriate to confront, or in preparation for an actual discussion or confrontation.

8. *Visualizations and affirmations.* A survivor can learn to visualize, that is, see pictures in her mind of herself acting and being the specific way she would like to be. She can also use an affirmation or statement, such as "I am a beautiful, strong woman right now," and repeat it out loud and/or write it over and over to help herself begin to believe it.

9. *Rational emotive therapy.* A survivor can discover how her thoughts affect her feelings and influence her actions. She can learn to change unproductive thoughts. Challenging irrational, limiting beliefs about how things should be can produce new thought patterns and new behavior.

10. *Relaxation and hypnosis.* Relaxation techniques to help a woman ground herself and release tension are very useful tools. Hypnosis can help a woman reconnect with times and experiences in which she felt strong and competent. Hypnosis can be used to gain access to old memories, previously out of conscious reach. Therapists must take care not to go too far too fast and to avoid overwhelming the survivor with too many memories or with memories of an intense nature. Therapists should have a clear purpose in mind for bringing back the memories.

11. *Journals.* Keeping a written record of feelings, thoughts, experiences, and insights between sessions can be a very useful experience for

a survivor. In addition to the benefits of acknowledging feelings and thoughts, a journal is a useful transition tool which a survivor can continue to use after therapy is over. It is not necessary for the therapist to read the journal. It can be useful to the survivor to feel she has sole control over the content and that she can share parts of it with the therapist if she chooses to do so.

12. *Dreams.* Dreams provide messages from the unconscious and can help a survivor understand herself and her feelings better. Helping the survivor learn to interpret her own dreams enhances her power and self-confidence.

13. *Psychodrama.* Acting out a situation from the past or one she anticipates in the future can provide a survivor with an immediate experience of her feelings and an opportunity to experiment with new responses. Psychodrama can also help the survivor see situations from other people's perspectives. Psychodrama can be an intense experience for the survivor and thus requires the therapist be well-trained in doing it.

14. *Body work.* Bioenergetics, Hakomi, and other physical therapies offer helpful techniques. They can provide opportunities for emotional understanding and release. Grounding and breathing exercises increase a survivor's sense of control and personal power. However, therapists must be careful not to touch a survivor more than she is comfortable with and not to overwhelm her with physical exercises that might result in her feeling out of control.

15. *Letter writing.* Letters to others, living or dead, can help a survivor direct hurt and angry feelings outward instead of holding them

inside. Often letters are never sent; the benefit is in writing them. For some survivors, actually sending the letter or confronting someone directly with a letter may be appropriate. A therapist can help weigh potential benefits and problems.

16. *Family therapy.* Family members can join the survivor in sessions with the therapist. They can be members of the original family (where the incest occurred) or members of the survivor's subsequent family, that is, spouse and children. Therapists who choose to work with the original family should be specifically trained in family systems theory and especially proficient in treating dysfunctional family systems. Survivors may want to utilize a safe, supportive therapeutic setting for disclosing the incest and its effects to the original family. Family therapy offers a possibility for survivors to directly break from a victim role in the family, to obtain a broader perspective on what other family members experienced, and perhaps to reconnect with old family members in new, healthier ways. However, there is a risk involved—family therapy may bring about negative confrontations and thus may not result in family closeness. A therapist can help the survivor weigh the possible outcomes of this approach.

To be effective with any technique, the therapist must first build strong rapport with the survivor. The survivor needs to feel that the therapist is present, listening fully to her, and trustworthy. Confidentiality is extremely important.

Another important issue in incest resolution is loyalty. The therapist must walk a fine line in order to keep full responsibility for the incest on the offender

without attacking him. Bonds between parents and children are strong, and many survivors feel loving and loyal feelings toward the offender. A therapist must paint the picture of the offender as a person with positive qualities who lacked impulse control and made destructive choices; otherwise, the survivor may easily feel compelled to defend him to the therapist. If the survivor feels that the therapist will not see the offender as a monster, she will feel safer to explore all her feelings toward him.

The cornerstone of all techniques and approaches in incest resolution is an emphasis on the survivor learning how to find and use her own power. While maintaining a supportive, nurturing relationship to the survivor, the therapist must be able to encourage the survivor's own expression of assertive strength and action. Healthy therapist- survivor relationships are indicated when (1) survivors feel free to take the lead in suggesting problem areas that they want to address, (2) survivors feel comfortable to express feelings such as confusion, anger, and appreciation to the therapist, and (3) survivors feel that their own opinions, judgments, and ideas are as worthy of expression and discussion as those of the therapist.

Therapists can help survivors to recognize the importance of the survival skills that were developed in response to the sexual abuse. Often survivors are very talented and capable in many areas of their lives, socially and professionally, despite the abuse. Self-esteem can be enhanced when survivors are able to give

themselves credit for the positive personality traits that they developed in response to the confusing sexual experiences of childhood. They can learn to feel proud of their ability to survive and still grow as individuals despite having been raised in a chaotic lifestyle.

Because of the special type of abuse experienced by survivors in their formative years, therapists must relate to survivors with sensitivity, care, and respect. Physical contact in terms of hugs or pats may be inappropriate until such time as the survivor feels comfortable and gives permission for the touch. Touch may trigger feelings of helplessness and confusion, with the survivor again perceiving herself to be less powerful. When touching occurs, it should be clearly nonsexual and should always respect the survivor's best interests—not the therapist's need for reassurance or contact.

Incest resolution therapy is usually long-term, often lasting from one to several years. The amount of time required for therapy depends on the individual and her needs. Some survivors choose to take breaks from therapy and then come back to it over the course of many years. Others may choose shorter-term therapy and then work on the issues away from therapy. Resolving the issues of trust, self-esteem, assertiveness, anger, and so on, can have profound effects on a survivor's life and can open her to the option of reclaiming her sexuality.

Sex Therapy

As survivors begin to experience a sense of resolution regarding general incest issues, and as they develop skills in liking, respecting, and taking care of their own bodies, they may naturally progress toward wanting to address sexuality concerns. Faria and Belohlavek explain:

> Because the body has been used and abused, time must be spent on integrating it as a part of the total person. Aiding the client in knowing her body through exercise, diet, and self-pleasure is the beginning of the process in which she assumes responsibility for and gains control of her body. Education in sexuality and physiological response can assist her in relieving the guilt she may have because of past responses to sexual stimulation from the violator. As the woman accepts control over her body, issues such as sexual dysfunction, sexual preference, intimacy and love can then become a therapeutic focus.[15]

Feeling good about oneself sexually is in itself therapeutic. Benefits include a more pleasant sexual relationship, increased self-confidence, self-awareness, and comfort. Every person is sexual. The positive recognition of her sexuality can help a survivor feel more relaxed in all aspects of her life.

To be motivated to focus on sexuality concerns, survivors need to (a) recognize the unfairness of their situation, (b) believe they are entitled to something more, and (c) make a decision to *reclaim* the sexual part of themselves. Incest resolution therapy can succeed in helping survivors get to this point and can establish a basis for any sex therapy to come. As one survivor suggested to therapists:

> Encourage survivors to tell what happened, help them see how their

problems today stem from the incest, help them understand who was responsible, let them express their emotions about it, encourage them that there is nothing wrong with them —the sexual problems are a symptom of the abuse.

Teen survivors receiving group therapy for the incest may be very eager to gain some resolution concerning sexual issues. Embarrassment, fear, and previous lack of permission to discuss sexuality may hold them back. To compensate for this, adult group leaders, teen group members, and parents may want to jointly plan a series of group meetings specifically focusing on sex. Guest speakers, films, and written materials could be used. Ideas for topics include the following:

1. *Sex education.* Gaining accurate information regarding sexual functioning, drives, behaviors, feelings, and so on.

2. *Self-defense.* Developing skills in verbal and physical self-protection; distinguishing between exploitive and caring touch; learning how to determine a person's potential for sexual abuse.

3. *Relationships.* Learning about sex roles, normal dating sequences, how to choose a partner, positive partner traits, assertiveness, and how sex fits into a relationship.

Early intervention regarding sexual concerns can spare teen survivors years of unhappiness and insecurity. Adult survivors' groups may wish to integrate similar topics into their formats. It can be helpful for adult survivors to share among themselves how they feel incest may have affected their sexuality and what they have done to help themselves overcome their sexual concerns.

Sex therapy is a special type of therapy used to treat specific identifiable sexual concerns such as difficulty in achieving orgasm, pain with intercourse, erectile or ejaculatory problems, inhibited sexual desire, and discrepancies of sexual interest in couples. It tends to follow a brief therapy format in which therapy lasts for only two to six months and in which behavior change is the goal.

Only a small percentage of therapists specialize in sex therapy. Many receive training in sex therapy as part of professional licensure requirements or because of an individual interest in the specialty. The national organization that certifies sex therapists is the American Association of Sex Educators, Counselors, and Therapists (AASECT). Sex therapists must be able to assess sexual problems with regard to medical, relationship, and psychological influences. In many cases, they work closely with medical doctors such as gynecologists, urologists, and family practitioners in assessing and treating the sexual problem.

Survivors find that sex therapy sessions are very similar to general counseling sessions. The only noticeable difference is that sexuality is discussed quite openly and in more detail. Progressive exercises, which are to be done by the client (alone or with a partner) at home between the sessions, are usually given as homework. Sex-focused therapy thus demands a commitment of time and energy to learning outside the therapy sessions through regularly practiced, structured exercises. This structured learning is an essential part of treatment and is effective in undoing the old behaviors and patterns of sexual responding that had

developed as a result of the incest. When clients are motivated and persistent in their at-home exercises, the treatment techniques have very high success rates.

Sex therapy techniques that are used routinely with adult survivors include the following:

1. *Sex education (in session).* The client learns about female and male sex drives, human sexual response cycles, and anatomical functioning. Myths and misconceptions about sex are dispelled, and new information is provided.

2. *Self-awareness (at-home exercise).* After verbal instruction in the therapy session, the client spends time at home acquainting herself with the look and feel of her own body. Over the course of several weeks, she may view herself in a mirror (identifying body image concerns), massage herself (identifying self-pleasuring concerns), and become familiar with the look and feel of sexual areas (naming parts, learning techniques to enhance arousal and orgasm). Male clients learn and practice self-awareness exercises to improve pleasuring, stimulation, and control techniques.

3. *Desensitization (in session, at home).* The client learns relaxation skills and/or hypnosis. She later practices these skills to feel comfortable visualizing images of progressively more overt sexual material. Problems such as painful intercourse and vaginal tightness are often treated with a desensitization technique done at home using graduated sizes of vaginal dilators. Vaginal dilators are medical devices shaped like test tubes. They are made of a hygienic plastic and vary in size from four inches long and the

diameter of a thin pencil to six inches long and about an inch and a quarter in diameter. They come in about six graduated sizes. The client learns mental and physical techniques to facilitate insertion of dilators for prolonged periods of time (up to twenty minutes a day), starting with the smallest size. Desensitization techniques work well to overcome fears. The client remains relaxed and in control while moving forward therapeutically.

4. *Aversive conditioning (in session, and as needed at home).* This technique is occasionally used to help the client overcome strong undesired associations, such as sexual attraction to violence. The client imagines the sexual stimuli (that is, fantasies of violent sexual activities) and then introduces aversive stimuli such as ammonia held under the nose, moderate electric shock, or mental pictures of repulsive behavior like vomiting. Repeating this sequence creates a new association (for example, sexual violence and ammonia) and therefore breaks the old association. As arousal from and sexual response to the negative images are reduced, the client is freed to develop new patterns for sexual stimulation.

5. *Communication (in session).* Partners learn techniques for discussing sexual likes, dislikes, and concerns in a productive, nonthreatening manner. An important goal of therapy is the comfortable communication of specific sexual techniques so that changes can be made.

6.*Sensate focus (a series of progressive, at-home exercises done with a partner).* The purpose of sensate focus is to learn to relate in a physically intimate way without feeling pressure for sexual interaction, and to integrate communication skills previously

> learned. The partners take turns exchanging touch in a safe setting (there is a temporary ban on overt sexual activity). Changes are made slowly, and the tone is nondemanding. Eventually, over the course of weeks, the touching progresses into more overt and direct sexual activity. Sensate exercises are defined in three phases. Sensate phase one maintains the focus on the giver of the touch as she or he learns how it feels to explore and touch the receiver's body for her or his own pleasure. Breasts and genitals and intercourse are initially off limits. The receiver is quiet unless the touch is unpleasant. Sensate phase two involves the receiver giving verbal and gentle physical demonstrations to the giver on how she or he likes to be touched. Sensate phase three concentrates on teaching and learning stimulation techniques for the sexually sensitive parts of the body.

Sensate focus is probably the most important sex therapy technique available to a survivor and her partner, and the results of treatment are impressive. McGuire and Wagner found in 1978 that survivors responded well to an extended period of sensate focus exercises. They identified three important treatment issues that are addressed in detail.

> The first issue involves the *identification and expression of the patient's repressed anger*. As the sensate focus progresses, the patient may experience tremendous rage but may not easily become aware that she had associated the molesting adult of her childhood with her current partner. The angry feelings at the sense of violation as a child were rarely if ever expressed directly at the parent or parent- surrogate, but rather they were later acted out in relationships with other men through teasing, nonresponsiveness, or outright avoidance of sexual contact. She must be

> helped to differentiate these male figures by encouraging verbalizations of direct anger about her early experiences and explaining the mechanism of displacement.
>
> The second treatment focus is that of *control of the initiation and pacing of the sensate focus exercises.* It is important that the patient be given control to initiate sexual or sensual contact and to limit or extend the type of contact. This is a technical deviation from the typical sensate focus in which both partners alternate initiation of the sessions. This helps to counteract the sense of helplessness in the face of sexual approach engendered in the childhood and internalizes the locus of control. Many women need to maintain control in the initiation and in the extent of contact after treatment.
>
> As the sensate focus progresses, the therapist must be sensitive to expressions of *guilt associated with the experience of sexual pleasure.* Childhood stimulation is pleasurable in varying degrees, yet clearly forbidden. The child learns to associate feelings of sexual attention and pleasure with guilt and, later, to repress feelings of pleasure. The permission giving and support from the therapist are exceedingly important in the resolution of feelings of guilt.[16]

Typically, sex therapy for survivors moves more slowly than with nonsurvivor clients, since survivors may be easily overwhelmed by sexual activity and may require plenty of time to assimilate what they are experiencing. The importance of this slow progress is demonstrated by an incident that occurred during couples therapy. Due to a broken light bulb in a projector, the therapist was unable to show a short film that depicted a couple doing the sensate focus exercise. Instead she verbally described the techniques and gave a written handout to the clients. The couple proceeded to do the exercises at home several times a week for three weeks. They were excited about their progress. After the

third week, it was time to begin allowing touch of genitals and breasts. The couple came in and reported on how things went. The survivor stated it was difficult to feel her partner's penis because his zipper was in the way. The therapist was shocked to find out that the couple had been doing the exercises with their clothes on all that time. It was a profound, indirect communication from the survivor of her need to pace exercises and to begin with nonthreatening contact. The next week the couple progressed with ease to doing the exercises with no clothes. The survivor said she was glad she had experienced the clothes-on sessions to start. Since then, when appropriate, the therapist has incorporated clothes-on instructions in working with survivors.

The following treatment progression is a sample of what can happen in couples' sex therapy on a week-by-week basis. This sample describes a treatment plan for a survivor and her partner who wanted to resolve problems of inhibited sexual desire, anxiety about touch, and fear of sex. Other couples might move more slowly or more quickly through the plan. Any treatment plan should be flexible and should be individualized for the people involved.

Weekly Plan for Sex Therapy with Couples When There Is a History of Incest

SESSION 1 Intake and assessment

- Explore history in detail; this may require more than one session.
- Determine level of relationship strength and commitment.

- Outline sexual and general relationship ups and downs.
- Assess current stresses on relationship.
- Get specific description of sexual problems.
- Assess for possible medical factors.
- Describe treatment process.
- Develop treatment plan.
- Have individual sessions for information gathering and expression of personal frustrations, beliefs, and perceptions.
- Establish ground rule that couple can engage in sex only when survivor really wants to and initiates it. Deal with possible fears of partner that this may mean no sex for a given period of time.

SESSION 2 Explore what sex means to each partner by asking them to share their mental associations with the word "sex" and sexual activity.

- Go over "Guidelines for Healthy Sexuality" in chapter 10 and CERTS conditions in chapter 1 (does current sexual relationship meet these criteria?), concept of taking responsibility for own sexual needs, that is, not making partner responsible for one's own sexual fulfillment.
- Introduce concept of sex as shared fun activity.
- Discuss creating a situation in which there's no pressure to perform or engage in sex; discuss sex as a choice, not a duty.

SESSION 3 Influences of incest

- Discuss incest in general, along with the specific experiences of the survivor. Emphasis is on raising partner's awareness of what survivor endured and how it affected her or him.

- Discuss importance of nonsexual touch and nurturance.

- Discuss similarities and differences between partner and offender.

- Identify issues from partner's past that may be affecting current situation, for example, fear of abandonment, rejection, perceived sexual inadequacy.

SESSION 4 Relationship issues

- Introduce concept of working as equals in a team.

- Help couple avoid allowing themselves to become enemies to each other. Make the sexual repercussions of incest the enemy. Focus on inventing creative solutions together.

- Process current anger and resentments.

- Emphasize caring and contact.

- Deemphasize sex and encourage other forms of touch.

- Reframe sex as one of many forms for expressing positive feelings.

- Give assignment (three home sessions): hand holding, hand-foot massage, hugging, sitting close.

SESSION 5 List messages about sex from the offender. Explore offender's distorted thinking about sex.

- Find out about specific sexual experiences with offender, how survivor felt at the time physically and emotionally, and survivor's beliefs about what was happening and why.

- Have partner share how his/her thinking about sex differs from that of the offender.

- Explore body-image issues of survivor.

- Give assignment (three home sessions): Sensate Focus I—touch with clothes on, no genital or breast touching, emphasis on touch for the benefit and exploration of the giver; survivor goes first as giver.

SESSION 6 Concept of conditioning

- Introduce concept of conditioning and explain how to deal with challenges to undo it; associate new feelings with feelings of sexual arousal and pleasure.

- Introduce concept of dissociating.

- Reframe problem of dissociation as positive and important form of self-protection at the time of the incest.

- Discuss concept of triggers and flashbacks specific to survivor; focus on developing ways survivor and partner can work together to address these.

- Give assignment (three home sessions): Sensate Focus I—with touching of genital and breast areas included, clothes on.

SESSION 7 Discussion and reflection on male-female sex roles, family influences, role survivor played in original family.

- Look at current relationship dynamics.
- Discuss importance of equality in sexual contact, possibilities for stepping out of roles.
- Develop skills for each person to initiate or stop sexual contact.
- Give assignment (three home sessions): Sensate Focus with clothes off; two sessions with no touching of breasts or genitals; one session with touching of breasts and genitals included.

SESSION 8 Discussion of sensate focus exercises.

- Assess current concerns and accomplishments in making changes.
- Give assignment (three home sessions): Sensate Focus II—with clothes off.

SESSION 9 THROUGH LAST SESSION Ending treatment

- Discuss approaches to sexual contact, how to initiate sexual contact.
- Discuss importance of being direct and having clear communication.
- Deal with concerns brought out by Sensate Focus exercises, relationship dynamics.

- Explore concepts of sexual harmony and satisfaction. Discuss what couple will do to deal with problems that might resurface and need more work; point out that this is not unusual.

- Discuss and brainstorm to address hypothetical problems that could cause relapse.

- Give home assignment: Sensate Focus III—modify to specific needs of survivor; begin with her as receiver. Eventually focus on resolution of other sexual problems, such as difficulty in achieving orgasm. Begin to reduce frequency of sessions, then have follow-up visits only.

Treatment for sexual problems combines general counseling techniques, as described in the previous section on incest resolution therapy, with specific behavior-change techniques for treating sexual dysfunctions. Therapists need to be flexible in using and altering techniques so as to be sensitive to the needs of each individual client. When therapists exercise creativity in tailor-making interventions for incest survivors, they can generate an unlimited number of effective techniques. Many techniques can be adapted to address sexual concerns.

One incest resolution technique consists of finding the child within oneself and learning to listen to her and nurture her. This can be sexually focused by encouraging the survivor to discover and nurture her sexual innocence, playfulness, and ability to seek pleasure for pleasure's sake. This involves reeducating the body about physical innocence and safety.

By inventing their own personal cleansing ritual, survivors can reclaim their bodies for themselves. Similar to a baptismal ceremony, body cleansing can be coupled with a series of positive affirmations concerning each part of the body. Thus a survivor might hold up her arm as she soaps it and say, "Now I am reclaiming my arm for myself and my own pleasure. Every cell in my arm is now giving up its association with touch from the offender. I am in control. I have nothing to be afraid of anymore. I reclaim the innocence of this part of my body. I belong to me. I reclaim my body and my sensation for me. I reestablish the innocence of the skin, hair, and nerves of my arm. I go back to the innocence my skin had as a baby. My arm is mine, strong and pure."

Gestalt techniques work well in sex therapy for giving survivors insight into and the ability to assert their developing positive sexuality. In a technique developed to help treat inhibited sexual desire, the survivor tells the offender (imagined to be sitting in a chair) how his way of relating sexually was distorted and abusive. From that exercise the survivor can get in touch with her conditions for positive sexual relating. And in treating a couple in which the survivor is afraid of sex, a combined exercise of gestalt and psychodrama can work well to help the partner understand and empathize with the survivor's inner experience. The survivor stands behind her partner, who has assumed the role of the survivor, with her hands gently resting on her partner's shoulder. She then shares out loud her inner thought processes and physiological sensations as she imagines step-by-step her partner's sexual approach. The exercise can be built upon to allow the

survivor and her partner to create alternative means of sexual approach that would be more comfortably received.

Triggers can be treated by developing techniques that encourage the breaking of old associations and the establishing of new and positive ones. For example, a survivor who becomes upset by looking at or touching male chest hair can embark on a series of exercises in which she looks at and relates to her partner's chest hair in a totally new manner. She might, for example, repeatedly shampoo it and draw pictures in it with her fingers. Ongoing relaxation and massage techniques can be incorporated to gradually desensitize her to the old impact of the chest hair. Even a trigger such as heavy breathing can be addressed in therapy by having the survivor develop new associations with the sound. For instance, the survivor and her partner can repeatedly practice heavy breathing together during a nonsexual time. The survivor always breathes a little louder than her partner, increasing the loudness when possible. A song chosen by the survivor can be taped and played while the survivor practices heavy breathing to it.

Feeling upset with viewing and touching her partner's penis is a common issue for a survivor who was forced to masturbate the offender's penis, or who was sodomized or raped. Penis fear can be addressed using techniques that encourage control and a relaxed opportunity to begin thinking of her partner's penis in a new light. Partners must be willing to engage in these exercises

passively and without giving any suggestion that they want stimulation or orgasm to occur. One survivor and her partner worked out an exercise in which she covered her partner's penis with her favorite chocolate mousse and then touched the penis with her fingers and licked it off. Another survivor practiced sitting far from her husband as he sat with an erection (she began with sitting in the next room!), and then moved progressively closer. Seemingly silly techniques can be very effective, for instance, drawing a face on a partner's penis and then talking to the penis as if it were a puppet.

The key in creating techniques for triggers is to have the survivor gain control by actively, assertively, and creatively changing old associations to new ones. Incorporating humor can be wonderfully effective, as it encourages the survivor to experience sex as a relaxed, fun activity.

To be good at treating the sexual problems of survivors, therapists must be able to recognize survivors' special needs and alter established approaches accordingly. For survivors, sex is usually highly charged. As they let go of old methods of self-protection and focus on experiencing pleasure in sex, they invariably will feel vulnerable and emotional. Therapists have to find a balance between encouraging the survivor to open to sex more fully and respecting the survivor's need to withdraw and protect herself. New stresses can produce temporary setbacks that bring with them old feelings of hopelessness. This is the time to get back on track and have faith in the recovery process. Accepting the up-

and-down nature of sexual recovery is important so that survivors, their partners, and therapists can continue to focus on sexual concerns with persistence and optimism.

13 D. Gelinas, The persisting negative effects of incest, 326.

14 G. Faria and N. Belohlavek (October 1984), Treating female adult survivors of childhood incest, *Social Casework* 65, no. 8: 468-469. Used with permission of Family Service America.

15 Ibid., 469.

16 L. McGuire and N. Wagner (1978), Sexual dysfunction in women who were molested as children: One response pattern and suggestions for treatment, *Journal of Sex and Marital Therapy* 4: 14.

Bibliography

Becker, J., Skinner, L., Abel, G., and Treacy, E. (1982). Incidence and types of sexual dysfunctions in rape and incest victims. *Journal of Sex and Marital Therapy* 8: 65-74.

Carnes, P. (1983). *The Sexual Addiction* (Minneapolis, Minn.: CompCare Publications).

Faria, G., and Belohlavek, N. (October 1984). Treating female adult survivors of childhood incest. *Social Casework, 65, no. 8: 465*-470.

Finkelhor, D. (1979). *Sexually Victimized Children* (New York: Free Press).

Finkelhor, D. (October 1979). What's wrong with sex between adults and children: Ethics and the problem of sexual abuse. *American Journal of Orthopsychiatry* 49, no. 4: 694-695.

Forward, S., and Buck, C. (1978). *Betrayal of Innocence* (New York: Penguin Books).

Gelinas, D. (1983). The persisting negative effects of incest. *Psychiatry* 46: 312-332.

Gil, E. (1983). *Outgrowing the Pain.* (San Francisco: Launch Press).

Gordy, P. (1983). Group work that supports victims of childhood incest. *Social Casework* 64: 300-307.

Herman, J. (1981). *Father-Daughter Incest* (Cambridge, Mass.: Harvard University Press).

James, J., and Meyerding, J. (1978). Early sexual experiences as a factor in prostitution. *Archives of Sexual Behavior* 7: 31-42.

Johnson, R., and Schrier, D. (15 July 1985). Massive effects on sex life of sex abuse of boys. *Sexuality Today* 8, no. 39: 1.

McGuire, L., and Wagner, N. (1978). Sexual dysfunction in women who were molested as children: One response pattern and suggestions for treatment. *Journal of Sex and Marital Therapy* 4: 11-15.

Meiselman, K. (1978). *Incest: A Psychological Study of Causes and Effects with Treatment Recommendations* (San Francisco: Jossey-Bass).

Putnam, F. (Spring 1985). Pieces of the mind: Recognizing the psychological effects of abuse. *Justice for Children* 1, no. 1.

Sexual Assault Center, Harborview Medical Center, Seattle, Washington. Various handouts.

Tsai, M., Feldman-Summers, S., and Edgar, M. (1979). Childhood molestation: Variables related to differential impacts on psychosexual functioning in adult women. *Journal of Abnormal Psychology* 88: 407-417.

Tsai, M., and Wagner, N. (1978). Therapy groups for women sexually molested as children. *Archives of Sexual Behavior* 7: 417-427.

Van Buskirk, S., and Cole, C. (1983). Characteristics of 8 women seeking therapy for the effects of incest. *Psychotherapy: Theory, Research, and Practice* 20: 503-514.

Woititz, J.G. (1985). *Struggle for Intimacy* (Pompano Beach, Fla.: Health Communications).

Suggested Resources

Outgrowing the Pain, by Eliana Gil, 1983 (San Francisco: Launch Press).

A short, readable book for adult survivors of child abuse which clearly explains how early abuse affects self-esteem and relationships. Especially good for people who wonder whether they were actually abused.

Betrayal of Innocence, by Susan Forward and Craig Buck, 1978 (New York: Penguin Books).

Basic information on the history and dynamics of incest, including many

case examples. Sections on variations of incest, including mother-daughter, mother-son, father-son, and sibling.

Father-Daughter Incest, by Judith Herman, 1981 (Cambridge, Mass.: Harvard University Press).

A comprehensive book on how incest affects daughters, including a historical overview, research findings, and treatment concerns.

For Yourself: The Fulfillment of Female Sexuality, by Lonnie Barbach, 1976 (Garden City, New York: Anchor Books).

A good overview of sexual socialization and sexual pleasuring. Especially helpful for women resolving orgasmic difficulties.

For Each Other: Sharing Sexual Intimacy, by Lonnie Barbach, 1982 (New York, New York: New American Library).

Female perspective on healthy couples sexuality. Lots of exercises and suggestions for improving physical relationships. Contains basic sex therapy techniques.

Male Sexuality: A Guide to Sexual Fulfillment, by Bernie Zilbergeld, 1978 (Boston: Little Brown and Company).

Excellent section on male sexual socialization, harmful myths, and reasons for male sexual problems. Includes sex therapy techniques for treating common male dysfunctions.

Out of the Shadows: Understanding Sexual Addiction, by Patrick Carnes, 1983 (Minneapolis, Minn.: Comp-Care Publications).

Overview of common types of sexual addictions, including incest. Can help survivors understand why some perpetrators sexually molest.

Learning About Sex: The Contemporary Guide for Young Adults, by Gary F. Kelly, 1977 (Barron's Educational Series, Inc., 113 Crossways Park Drive, Woodbury, New York 11797).

A good book for teens over fifteen years old and their parents, in paperback. Straightforward sex education for older adolescents. Includes section on love, responsible sex, and decision making in relationships.

"Identifying and Treating the Sexual Repercussions of Incest: A Couples Therapy Approach," by Wendy Maltz, *Journal of Sex & Marital Therapy*, Vol. 14, No. 2, Summer 1988, pp. 142-170.

Primarily written for clinicians. Presents a model for assessing and treating the sexual effects of incest in couple relationships. Includes intervention strategies, techniques, and therapeutic considerations.

Partners in Healing: Couples Overcoming the Sexual Repercussions of Incest (VIDEO) produced by Wendy Maltz, Steve Christiansen and Gerald Joffe, 1988. (For information and to order, contact: Independent Video Services, 401 E. 10th St. Dept. L, Eugene, Oregon 97401, telephone 503-345-3455).

Hosted by Wendy Maltz, this video program helps couples identify sexual problems caused by incest histories, and journey toward sexual healing and emotional intimacy. Symptoms of sexual concerns and specific steps in the healing process are discussed. Features three heterosexual couples (one with a male survivor). Helpful to incest survivors as well as a resource for therapy, education and training.

Two major self-help organizations for adult incest survivors are *VOICES* (Victims of Incest Can Emerge Survivors) in Action, Inc., P.O. Box 148309, Chicago, Illinois 60614, and *ISA* (Incest Survivors Anonymous), P.O. Box 5613, Long Beach, California 90805-0613.

About the Authors

Wendy Maltz LCSW, DST, is an internationally recognized sex therapist, author, and speaker, with more than thirty-five years of experience treating sex and intimacy concerns. She authored a number of highly acclaimed sexuality resources, including the recovery classic, *The Sexual Healing Journey: A Guide for Survivors of Sexual Abuse*, as well as *Private Thoughts: Exploring the Power of Women's Sexual Fantasies*, and *The Porn Trap: The Essential Guide to Overcoming Problems Caused by Pornography*. Wendy compiled and edited two best-selling poetry collections that celebrate healthy sexual intimacy, *Passionate Hearts: The Poetry of Sexual Love* and *Intimate Kisses: The Poetry of Sexual Pleasure*. Her popular educational website, www.HealthySex.com, provides free articles, podcast interviews, posters, couples sexual healing videos, and more to help people recover from sexual abuse, overcome sexual problems, and develop skills for love-based sexual intimacy.

Beverly Holman holds an M.S. in counseling psychology from the University of Oregon, where her master's thesis was entitled "The Sexual Impact of Incest on Adult Women." She also holds an M.A. in human development from the University of Kansas. Beverly is currently in private practice in counseling and mediation,

specializing in incest and couples counseling. She is also a family therapist at a local agency, where she works with children and adolescents and their families. Previously she counseled in a family-oriented agency, where she led incest groups for adult survivors and worked with abused children and their parents. She is a member of the Oregon Counseling Association, the American Association for Counseling and Development, the Academy of Family Mediators, and the Executive Board of the Family Mediation Association of Lane County, Oregon.