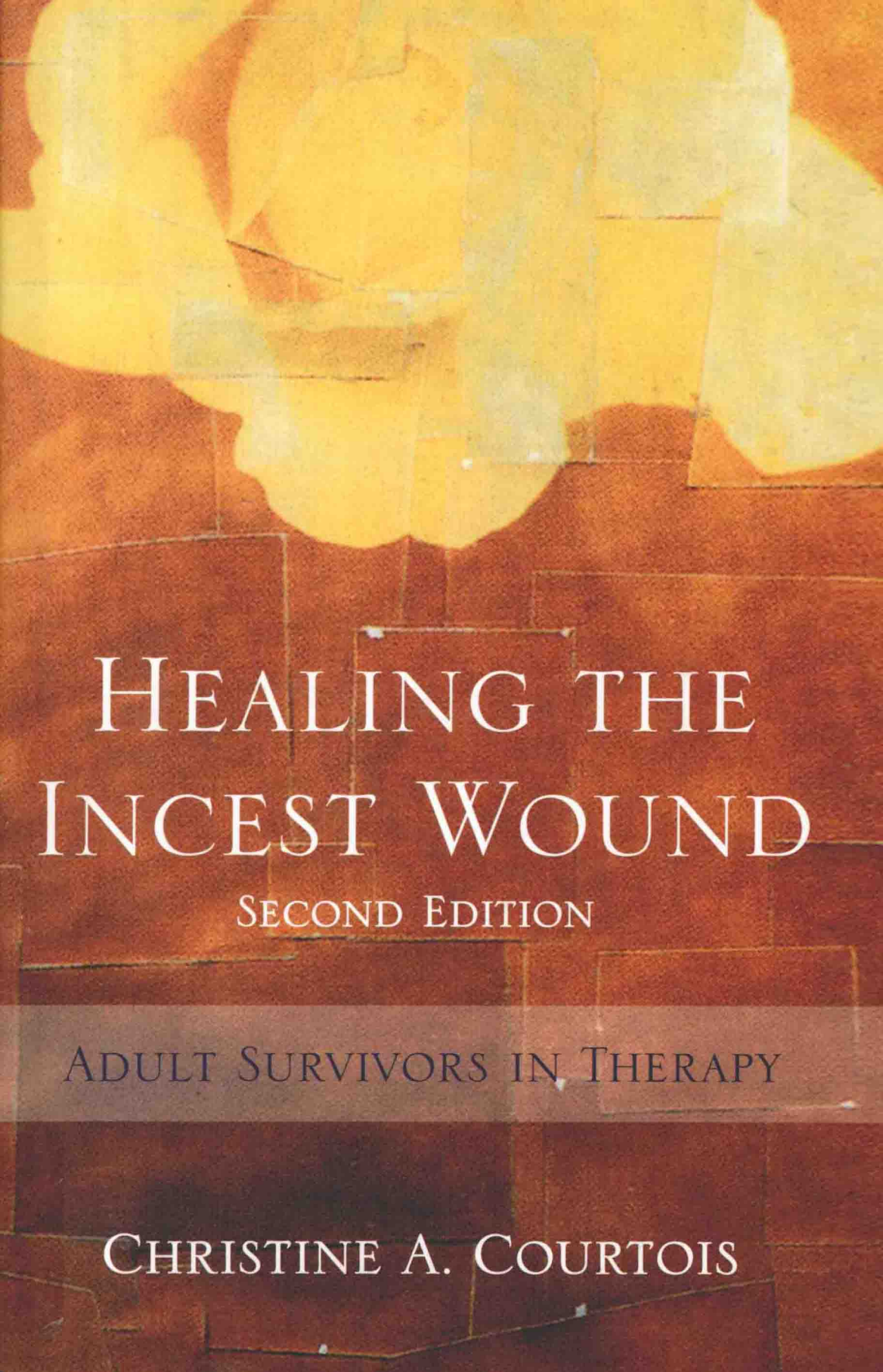
HEALING THE
INCEST WOUND
SECOND EDITION
ADULT SURVIVORS IN THERAPY
CHRISTINE A. COURTOIS

HEALING THE INCEST WOUND

Adult Survivors in Therapy

SECOND EDITION

CHRISTINE A. COURTOIS

W. W. Norton & Company
New York • London

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Manufacturing by Courier Westford
Book design by Jonathan Lippincott
Production manager: Leeann Graham

Library of Congress Cataloging-in-Publication Data

Courtois, Christine A.
Healing the incest wound : adult survivors in therapy / Christine A. Courtois. — 2nd ed.
p. ; cm.
"A Norton professional book"
Includes bibliographical references and index.
ISBN 978-0-393-70547-8 (hardcover)
1. Incest victims—Mental health. 2. Psychotherapy. I. Title.
[DNLM: 1. Incest. 2. Psychotherapy—methods. 3. Stress Disorders, Post-Traumatic—therapy. WM 610 C866h 2010]

RC560.I53C68 2010
616.85′83690651—dc22 2009046363

ISBN: 978-0-393-70547-8

W. W. Norton & Company, Inc., 500 Fifth Avenue, New York, N.Y. 10110
www.wwnorton.com
W. W. Norton & Company Ltd., Castle House, 75/76 Wells Street, London W1T 3QT

1 2 3 4 5 6 7 8 9 0

To Tom, my light
To Mom, always there

In Memoriam

Dad, always missed . . .
Tom Kocot, PhD, a special man and young professional who originally researched this revision—your loss was hard for us and for many others . . . you had many more contributions to make.
Debby Watts, PhD, a gifted and cherished colleague—also taken from us too soon and before your special gifts were fully applied.
Robbie Brockwehl, a valued sister, sorely missed.

Acknowledgments

Again, I have many to thank for ongoing support. To my patients and to all incest victims/survivors: You are profiles in courage and endurance. My most fervent wish is for your healing and peace. May the material in this book help make your struggle less arduous. Another thank you goes to the women and men who told me their stories in detail so many years ago and to the researchers who assisted me in listening and recording. What was shared then continues to inform us these many years later.

My personal support network has always sustained me, never more so than over the past 5 years. I love you all.

Tom has been front and center in keeping the home front going when my attention gets completely engrossed with writing and other activities. I am most grateful for his loving support (including his willingness to cook)!

To my mother, my sisters, Claire and Norma, and their husbands, Ron and Craig, and my brother, David, and his wife, Janet, and to my extended family: Tommy; Steve and Dawn, Lauren, Hailey, and Richard; Dennis and Gail, and Aunt Bea, who keep me well-attached and connected.

To my personal support system, Cathi and Leslie, faithful friends with whom I've met weekly for over 25 years (and counting), we've shared life events and transitions, along with professional support; special appreciation for your ongoing personal sustenance, peer supervision, love, and laughter. To Cherie and Jeb, Deb and Jim, Ellen, Jerry, Joan, Joelle, Joyce, Lynne, Evie, Florence, Gene, Jeffrey, Laurie, Philip, Mary Ann and Jean, Monica, Robin and Bruce, and Ruth Anne, with special thanks for all you've done for me over the years. I can never do enough to repay you.

My professional network has expanded considerably since the first writing of this book. In 1990, I cofounded The CENTER: Posttraumatic Disorders Program, an inpatient and partial hospital program specifically for adult survivors of childhood trauma that I codirected for 16 years. I wish to ac-

knowledge the multidisciplinary staff who worked at The CENTER over the years.

To the clinical associates in my private practice—Lisa Ades, Emily Bauman, Glenn Doyle, Nancy Hensler, Debbe Jacobs, Sylvia Marotta, and Kelli Sanness—thank you for all and for tolerating my constant juggling of clinical, administrative, writing, and training responsibilities. Thanks to Joanne Zucchetto for joining me as coleader of a special group. To colleagues I have worked with through the International Society for Traumatic Stress Studies, the International Society for Trauma and Dissociation, and Division 56 (Trauma Psychology) of the American Psychological Association, the dedication all of you show is inspirational. I especially thank members of the Complex Trauma Task Force of the International Society for Traumatic Stress Studies with whom I've had a close association for many years: Pam Alexander, John Briere, Marylene Cloitre, Julian Ford, Laurie Pearlman, Onno Van der Hart, Bessel van der Kolk, and Bonnie Green. In addition, thank you to Judie Alpert, Sandy Bloom, Bethany Brand, Laura Brown, Jim Chu, Jean Carter, Rich Chefetz, Constance Dalenberg, Steve Frankel, Lori Galperin, Bob Geffner, Steve Gold, Terry Keane, Kathy Kendall-Tackett, Phil Kinsler, Rich Loewenstein, Ellert Nijenhuis, Colin Ross, Mark Schwartz, and Kathy Steele for your individual contributions. To Ken Pope for his wonderful "Pope.net."

Several individuals have conducted research for this revision over the many years it took to get it underway. Long-term thanks go to Mary Ann Reilley, Jane McGoldrick, and Tom Kocot; more recently to Kelli Sanness—all for their in-depth research, discussions, and incisive commentaries. To David Hengerer for help with the bibliography, to Glenn Doyle for his research and analysis on complex trauma, and to Casssandra Spears for her good spirit with my computer ineptitude: All of you kept me going, and I'm sure you wondered if this revision would ever get done.

Another thank you to Norton Professional Book editors Susan Munro for believing in me way back then and Deborah Malmud and Andrea Costella for offering me the opportunity to revise this book.

Introduction to the Second Edition

Over the course of the past three decades, trauma has entered public awareness as never before, starting with attention to Vietnam veterans traumatized on the war front and by their pain-filled homecoming and to women and children traumatized on the home front and in the community. In 1980, the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-III*; American Psychiatric Association, 1980) included the diagnoses of post-traumatic stress disorder (PTSD) and the dissociative disorders (DDs), (including multiple personality disorder). The addition of these diagnoses spurred significant advances in theory, treatment, and research to such a degree that a new field of study, trauma psychology, emerged and has developed exponentially and creatively since then.

The study of child sexual abuse and incest and other forms of domestic violence, along with attention to the dissociative disorders, emerged in the 1980s, resuming areas of study that had been largely abandoned at the end of the last century. The media reported on these advances, and as a result, victims/survivors sought psychological help in unprecedented numbers, leading to the development of treatment strategies and programs. *Healing the Incest Wound* was originally published during this time period and, along with other publications, helped set the direction for treatment of adult survivors. Concurrently, changes in reporting mandates for suspected abuse and in police, social services, and legal procedures were developed to protect children caught in situations of abuse. Controversy in many state legislatures continues to surround the opening of statutes of limitations to adult survivors of abuse that occurred in the past, sometimes the distant past, to allow them to file civil suits.

As the initial and long-term effects of childhood and domestic trauma were researched, some were found to match the primary criteria for PTSD (intrusive and numbing symptoms and hyperarousal). The ability to recover

some memories of abuse that had previously been unavailable was identified. Yet, it soon became apparent that the diagnosis of PTSD was not encompassing enough to include all of the predominant initial and long-term symptoms of childhood abuse and trauma that were being identified in both research and treatment settings. In particular, the PTSD criteria did not represent the range of symptoms associated with trauma that occurred over the course of childhood (mostly in a closed family environment) and post-traumatic responses (including dissociation) that occurred in the context of the child's development and that both intertwined with and impacted it. The aggregate findings regarding child abuse trauma and intimate partner violence suggested a different type of post-traumatic disorder.

In 1992, psychiatrist Judith Herman published criteria for complex post-traumatic stress disorder or disorders of extreme stress, not otherwise specified (CPTSD/DESNOS) in her landmark work, *Trauma and Recovery*. This formulation stressed the developmental impact of ongoing abuse in the context of the family and related adverse impacts associated with other extreme and chronic stressors. This diagnostic formulation, which consisted of seven criteria (alternations in the ability to regulate emotions; in self-perceptions; in conscious awareness [dissociation]; in relations to others; in perceptions of the perpetrator; somatization and medical responses; and alterations in systems of meaning), was proposed to the committee charged with the development of *DSM-IV* (American Psychiatric Association, 1994), was successfully field tested, and yet was not included as a free-standing diagnosis when the new *DSM* was published. It was listed instead as an associated feature of PTSD, the result of chronic, pervasive trauma that often occurs in families (such as incest or intimate partner violence) or other extreme stressors such as hostage-taking and confinement.

Also in 1992, a backlash developed in response to the increased attention accorded to the study and treatment of incest and the dissociative disorders (multiple personality disorder, ritual abuse, and the use of hypnosis, in particular) and discussions regarding recovered memories of abuse. A huge controversy fomented around allegations of false memories of abuse (labeled *false memory syndrome*, FMS) that critics charged were encouraged by therapists who were using suggestive strategies with their patients to recall memories of abuse that had not occurred. The False Memory Syndrome Foundation was organized around a scientific and professional advisory board that actively challenged clinical and research findings regarding recovered memories of abuse. The media "bought the story," and survivors again found themselves disbelieved and discredited, this time caught in an academic and societal "memory war." The warfare has since subsided, and cooler heads have prevailed. At present, therapists must function with care not to act in

ways that are either suggestive or suppressive of abuse, a point made by many professional organizations that studied the issue and published guidelines (in 1999, I published a summary of these recommendations and a treatment guide for clinicians, *Recollections of Sexual Abuse: Treatment Principles and Guidelines*).

Other societal events and developments had an impact on social understanding of community-based trauma and post-traumatic impact. Public awareness of domestic terrorism increased in the aftermath of the Oklahoma City bombing and of international terrorism in the aftermath of the World Trade Center and the Pentagon attacks of 9/11 and of other terrorist bombings around the world (Lockerbie, Madrid, London, Mumbai, to name but a few). Natural and human-made disasters such as Hurricane Katrina, with its delayed and ineffective federal and state response, and the Indonesian tsunami showed other dimensions of trauma, labeled *disaster trauma*. The significant post-traumatic impact on victims and loved ones and on the entire community and especially emergency response workers has been increasingly identified. The world has learned that trauma has a wake, and that its impact does not recede when the flood waters do or when the debris is removed.

If all of this were not enough, other types of interpersonal trauma emerged painfully into public awareness during this period. The problem of priest abuse had received public mention sporadically during the 1980s and 1990s. It erupted in 2002 after a series of reports in the *Boston Globe* led to the opening of Catholic Church records supporting the existence of a cover-up of priest abuse reports at the highest levels of the Church and of a much more extensive problem than had been previously acknowledged. Abuse by other professionals (i.e., therapists, coaches, medical personnel) in other institutional settings such as schools, residential institutions, the workplace, and the military also received public exposure and scrutiny. In common with incest, when abuse occurs in an entrapping setting of dependence and power differentials and is perpetrated (usually repeatedly) by someone who has a duty of trust and protection, it involves betrayal of that relationship and that role, adding insult to injury in a concrete way. Freyd (1996) identified trauma of this type as "betrayal trauma," highlighting a dimension of the traumatization that has an additional impact, namely, its perpetration by a known and trusted person rather than by a stranger, making this form premeditated and planned rather than random.

This chronology would not be complete without mention of the development and impact of 24-hour instantaneous and pervasive media coverage (i.e., by CNN), the Internet, and all of the new modes of electronic communication. They can, at once, rapidly increase the public's access to information in ways that can be helpful yet can also rapidly overstimulate and flood

the unaware, immature, or previously traumatized user. Through the media, the public has become increasingly cognizant of pedophiles as never before. Cases of child kidnappings and murders have been publicized by John Walsh of The National Center for Missing and Exploited Children on his television show *America's Most Wanted.* Increased awareness has resulted in rapid response and alert procedures (i.e., Amber alerts), legal changes (i.e., Megan's law), and special registries for convicted sex offenders. Reports of cyberpredators (highlighted on the NBC *Dateline* series on child predators trolling for underage victims on the Internet and arranging to meet them in person) and cyberstalking have exposed the extent of the problem, both educating and alarming the public. Recent sensational cases of child sexual abuse involving kidnapping (the Elizabeth Smart case in Utah and the Jaycee Dugard case in California) and incest (the conviction of William Bevins, a prominent civil rights advocate in Virginia; the case in Austria in which a father kept his daughter hostage in a room under the family home for years during which he repeatedly raped and impregnated her, and killed at least one of the children; and most recently the report by McKenzie Phillips of a 10-year incestuous relationship with her celebrity father that resulted in a pregnancy and abortion) are all "pushing the envelope" of public awareness of the reality of such abuses (and possibly public tolerance, judging by some of the reactions and denials).

As all of this has developed on the social or public awareness front, scientific advances have been accruing in the behavioral and biological sciences. Ethologists studied animal attachment and animals in conditions of stress to learn more about human attachment and stress response. Fight, flight, freeze, and collapse responses observed in animals have been found to occur in humans as well. Studies of human development have returned to the findings of John Bowlby and Mary Ainsworth regarding attachment and its significance to healthy or problematic human development of offspring. The quality of the attachment bond between caregiver and child during the earliest years (and particularly the provision of a secure base of attachment and response) for the developing child has been found to correlate with later function or dysfunction.

Biological and neuroscience findings have provided the physiological substrate to the attachment findings and determined differences in brain structure and function between infants and children who are securely attached and those who are not (especially those whose attachment experience was disorganized or disoriented, the type most associated with all forms of child abuse and maltreatment). Interestingly, dissociation has been determined as an intergenerational transmission pattern of disorganized or dis-

oriented attachment in parents who abuse and neglect their children. The precursors of disorganized attachment in parents include unresolved experiences of trauma and loss in their lives that they coped with through dissociation of the events and their attendant reactions. Patterns of disorganized attachment and dissociation are then passed intergenerationally through childrearing, leaving the affected children to cope with their own experience of disorganized or insecure attachment to their caregivers by using similar strategies. In this way, the cycle continues.

Studies from the affective neurosciences have added another dimension in terms of attachment and its relation to the capacity for affective identification and expression. Securely attached infants whose parents are attuned and responsive to them help them to learn to identify their emotions and to regulate them, first in the context of the relationship and then independently (coregulation to autoregulation). Without such attunement and response, emotions remain unidentified and thus out of personal awareness and control. Affect regulation is an important capacity in human development. Disjointed experience and the inability to self-regulate result in disorders of the self and a disordered ability to relate to others. As the child and later the adult are alienated from their own body and psyche, they also learn not trust others or believe that they will respond to them in consistent and predictable ways. This becomes the work of therapy. All of these findings are pertinent to the study and treatment of incest and other child abuse and their effects as I explain in this text.

The issue is now coming full circle. Findings from these various fields of study are being integrated into a more synergistic and sophisticated picture of the traumatized child and how best to provide treatment at the time of the abuse and later. In the past decade, a Child Traumatic Stress Network has been organized in the United States, modeled in part on the National Center for PTSD of the U.S. Department of Veteran Affairs, the premier research center on military/adult trauma. The intent has been to parallel the National Center's success in studying traumatized adults to the study of traumatized children. Data sets on thousands of traumatized children have been accumulated and a new diagnosis of developmental trauma disorder developed (van der Kolk, 2005) and proposed to the committee in charge of revising the *DSM* for its fifth edition. As there is no current free-standing diagnosis of childhood PTSD in the *DSM-IV*, the hope is that this diagnosis or something like it will fill the gap. Complex PTSD has again been proposed, the adult correlate of the childhood model. At present, both of these new diagnoses are under consideration by relevant *DSM* revision workgroups. The inclusion of developmental trauma disorder and complex post-traumatic

stress disorder will have an impact on the ability to accurately assess and diagnose traumatized children and their adult counterparts, essential to treatment efforts.

On the personal and professional front, I have had the good fortune to witness or be involved in some of these important professional developments. The field of traumatic stress studies and psychological trauma has fascinated me and held my intellectual and personal attention for my entire career. As a member of the International Society for the Traumatic Stress Studies, the International Society for the Study of Dissociation and Trauma, and the American Psychological Association, I have participated with other colleagues in trying to bring professional attention to the study of trauma.

Back in the early 1990s, I had the opportunity to cofound and direct an inpatient program for adult survivors of childhood trauma. I jumped at the opportunity because by then I had learned how difficult hospitalization on a general unit could be for a trauma survivor, and I believed (and still do) that specialty programs are needed. We created such a unit, The CENTER: Posttraumatic Disorders Program in Washington, D.C., that, by dint of hard work and luck, withstood major changes in the health care and social environments to continue, one of only a few such programs that currently operate in the United States. In addition, I have been in private practice working primarily with traumatized individuals for better than 30 years, recently with clinical associates practicing with me. I have also conducted numerous professional development workshops during these years and through them have trained and met many dedicated professionals. In all of this, I hope to have made a dent in a huge social problem.

I have reflected in this introduction on clinical issues and challenges because this is a clinically oriented book directed at the amelioration of posttraumatic adaptations and aftereffects; however, much more than a clinical problem, incest is a social problem with a broad and pervasive destructive reach throughout society. Louise Armstrong (recently deceased), one of the early pioneers in "outing" incest with her 1978 book *Kiss Daddy Good-Night*, was outraged that the aftermath to the exposure of incest was medical/psychiatric rather than social. She decried the diagnosing of victims and survivors, believing the diagnosis put the problem squarely and unfairly again on the victim and not where it belongs, on the perpetrators and on society with its problematic cultural and gender norms. I am firmly in agreement with Louise that we must go way beyond the medical/ psychiatric to eradicate incest, but I nevertheless offer this book as help for those who have been scarred and are in need of specialized psychotherapeutic assistance to recover from its effects.

Introduction to the First Edition

I have been involved in the sexual assault field since 1972 when I cofounded a campus rape crisis center at the University of Maryland.

Although the mission of the center was to provide assistance to women immediately after a rape, it was not long before we started to get calls from women who had been raped in the past and had never before told anyone. Some of these callers confided that they had been assaulted not by strangers on the street but by men they knew and by family members, including fathers, brothers, uncles, grandfathers, and cousins. And for some of them, the assaults had never stopped—they were still caught in the situation. Our small crisis center mirrored what was happening across the United States. As rape crisis centers opened to respond to a growing awareness of stranger rape, they also were receiving calls from incest victims desperate for understanding and assistance.

We did not know how to help these women. Mostly, we applied the techniques that we had learned to use with rape victims: We accepted these women's stories, told them they were not to blame, and urged them to keep trying to disclose the experience and to find someone who would help them escape if their situation were ongoing. We realized that we were dealing with another type of rape, one even more taboo than stranger rape, one that was harder to talk about and harder to recover from. We began to conceptualize incest as a compounded form of rape.

We searched the literature for guidance and found articles highly biased against women—they were blamed or treated as though they were irreparably damaged, or their experiences were minimized. Fortunately, the related field of domestic violence was beginning to develop and offered some preliminary ways to conceptualize intrafamilial abuse and to help victims. Then, in 1977, we read Rush's now famous feminist analysis, "The Freudian Cover-up," which charged that Freud's change from the seduction to the Oedipal

theory had the effect of denying the scope of the problem and the reality of women's experience. Following close on this, in 1978 four books on incest were published: *Betrayal of Innocence* by Susan Forward and Craig Buck, *Conspiracy of Silence* by Sandra Butler, *Incest* by Karin Meiselman, and *Kiss Daddy Good-Night* by Louise Armstrong. Blair and Rita Justice wrote a fifth resource, *The Broken Taboo*, published in 1979.

In 1978, as my dissertation research and at the urging of Lenore Walker, Ph.D., who had just completed a similar study of battered women, I undertook an interview study of women who had been incest victims in childhood and adolescence. My intent was to learn firsthand about the experience of incest and to compare the responses of this group of women with the information in the literature. Many of the characteristics of the incest circumstances were consistent between the two data sources, but missing in the old literature was a description of the women's pain and the terrible toll the incest took on their lives. Also lacking was a description of the creative ways these women had devised as children and adults to cope with their experience and its aftermath. They were survivors in the truest sense of the word.

I came away from my research traumatized by what I had learned about the world of some little girls and the level of dysfunction and incredible selfishness of the men and women who abused and neglected them. But, I also felt enormous respect for the resiliency of the human spirit in the face of adversity, and I had learned a great deal about the variability in incest experience and its aftereffects. My subjects described many commonalities of response, but they also offered unique perspectives on their abuse experiences, families, and perpetrators. To the last one, however, they described predominantly negative aftereffects and complained that the incest had robbed them of their childhoods and *who they might have been*. In 1980, I replicated this research with very similar results.

As a practicing clinician, I speculated about the implications of my research and the new incest literature on treatment. There were no treatment guidelines available. My clinical exposure began with my very first client in my first professional position as a counseling psychologist at the Cleveland State University Counseling Center. A young and attractive new freshman entered my office, extended her arm, on which she had carved in large block letters "HELP ME," and handed me a letter detailing a history of horrendous multiple incest in her family. She had disclosed and sought outside assistance, and her father had been arrested, but he had been allowed to return to the home, where he continued his pattern of abuse. Her mother was a debilitated woman who was unable to consistently believe her daughters, much less offer them effective assistance. The family, solidly upper middle class and appearing to be well functioning to the outside community, was in reality rife with

serious problems and multiple losses. My client was so desperate that she repeatedly went to the police and the courts for assistance, only to be repeatedly frustrated. She moved to Cleveland on a scholarship, which allowed her to separate geographically from her family, a separation she was unable to make psychologically.

Needless to say, this young woman was highly traumatized. Our work together over the course of 2 years was an emotional roller coaster for both of us. Every time it seemed that we had her somewhat stabilized, a new crisis would erupt of either her own making or the family's. I did not know about traumatic reenactment at the time and so was thoroughly perplexed. Also, this client was highly anxious, depressed, strongly hysteric/borderline, self-destructive and self-mutilating, and very dissociative. She fainted regularly during the course of our sessions and when under greater-than-usual stress. It was necessary to hospitalize her twice when she could not ensure her safety and when she was so dissociative that she could not function. And yet, she was thoroughly engaging. Her symptoms needed to be understood in the context of her experience. In retrospect, I see her as a walking manifestation of the postincest syndrome described in this book.

I struggled with this case, combed the literature for information, and relied heavily on my colleagues for direction. Also, I began to apply what I had learned through my rape crisis work and through my research. I listened, I believed, I offered as much support and understanding as I could, and I worked hard to develop a therapeutic alliance. I took every opportunity to talk to other therapists working with incest cases; in this way, we cross-validated our work and supported one another.

Then, I began to present my research findings and conduct workshops on incest, including treatment approaches. I found that therapists were hungry for the information. They also were struggling with incest victims, but without the same wealth of information I had gained from my research. These workshops and the positive response to my approach strengthened and refined these early formulations. At this time, I was fortunate to begin to work with Dr. Judith Sprei, a psychologist with perspectives on sexual abuse very similar to mine. We provided mutual support for each other's cases and began to offer an incest therapy group. Together, we decided that the most accurate diagnosis for incest response was post-traumatic stress disorder (PTSD), an idea that seemed heretical at the time (1981) because PTSD was highly associated in the minds of clinicians with the Vietnam veteran. Judi and I began to write and conduct workshops and, again, found strong validation for our work. Meanwhile, a literature was developing that provided some substantiation and guidance.

This book is a direct outgrowth of all of these experiences and the thou-

sands of therapy hours I have spent with incest survivors in both individual and group treatment. I have made every attempt to present the state of the art in terms of treatment, but a strong caveat must be made that our information is preliminary, and much remains to be learned. At present, the therapy is grounded in available theory from the fields of feminism, traumatic stress, self-development, bereavement/loss, and relational psychotherapy. The effectiveness of this therapy has strong clinical support but remains to be empirically tested. Its effectiveness for all survivors is certainly not documented.

Nevertheless, this book provides a working model for incest treatment designed to provide healing for the incest wound and to move the victim from the status of victim to that of survivor and even beyond. The underlying philosophy of this book is that to heal, the survivor must acknowledge the reality of the victimization and betrayal, must understand it in the context of both the family and the larger culture, and must allow and experience the feelings associated with the trauma. The survivor must psychologically separate from the past to develop a unique self, separate from the abuse and its supporting family ethic. The therapy is similar to the cleaning and disinfecting of a wound, although the wounds of the incest survivor are primarily invisible (the clinician will occasionally see survivors bearing visible physical scars as well).

This book is deliberately written about the female survivor because available research indicates that females are incestuously abused far more often than are males; however, in no way do I wish to minimize the fact that males are so abused. The treatment approach described here is applicable to males as well as females, with some modifications.

This book is roughly divided into three sections. The first, comprised of Chapters 1 through 5, is a general introduction to incest by category, type, characteristics, and dynamics. To treat incest effectively, the clinician must be knowledgeable about how it develops in a family and its various permutations.

Chapters 6 through 8 make up the second section of the book, which outlines the predominant symptoms and aftereffects associated with incest and their secondary elaborations. These become the presenting concerns when a survivor initiates treatment. Aftereffects are discussed according to four theories—victimization/traumatic stress, feminist, self-development, and loss—which in turn focus and direct the philosophy, process, and goals of treatment. The issue of diagnosis is also addressed in this section.

The third section is devoted to a discussion of incest therapy. General treatment strategies and techniques are presented as they pertain to both individual and group treatment. Dynamics associated with past abuse are ana-

lyzed according to how they affect the therapy process and the relationship, and common transference and countertransference reactions are discussed. Incest experience often results in unique issues in the treatment, such as family disclosure, confrontation, dissociation, intrusive reexperiencing, and self-hurtful behaviors. These are discussed in conjunction with strategies for their management, as are special populations of incest survivors who may have unique needs due to their minority status.

My goal is to offer the clinician comprehensive guidelines for working with adult victims/survivors of incest. The more clinicians know about incestuous abuse and its consequences, the more comfortable they will be in offering effective and healing treatment. The need is great. Let us begin.