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Behavioral Aspects of Systems Therapy in Conceptualization and Treatment of Male Perpetrators of Incest

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BEHAVIORAL ASPECTS OF SYSTEMS THERAPY IN CONCEPTUALIZATION AND TREATMENT OF MALE PERPETRATORS OF INCEST

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CHAPTER I

INTRODUCTION

Incest has been recorded for centuries and has gained more attention in the last twenty years. Much literature describes incest as a prevalent form of sexual abuse. Incest is reported as occuring across cultures and among all combinations of family members. Father-daughter incest has been a specific focus of much of the literature up to the present time. Treatment of father-daughter incest has generally addressed work with the incest victim or the non-perpetrating parent, rather than the perpetrator. This paper will describe work with the incest perpetrator from a systemic perspective. Behavioral techniques will then be described as a supplement to systemic work to help facilitate lasting change with both the individual perpetrator and the family system.

A summary of the data may be helpful in viewing the overall problem of incest in American and other societies. Before looking at actual statistics, however, it is important to be aware of certain problems inherent to the data regarding incest. Variability in the definition of incest is a problem (Dube & Hebert, 1988; Vander Mey & Neff, 1982). There is also lack of consistent reporting

(DePanfilis, 1986) because the American society supports the privacy and sanctity of the family (DePanfilis, 1986; Pierce & Pierce, 1985). Many studies lack representativeness (Kempe & Kempe, 1984) which can lead to problems in the generalization of the findings. All of these factors add to the complexity of interpreting incest research.

There are two statistical approaches used to investigate the occurence of incest. One addresses the prevalence of incest, while the other studies incidence. Prevalence studies address an "...attempt to estimate the proportion of the population that will be sexually abused during their childhood" (DePanfilis, 1986, p. 3). Prevalence can be difficult to estimate because of failure to report and problems in the investigation of abuse reporting (Oaks & Anspaugh, 1987). Herman and Hirschman (cited in Pierce & Pierce, 1985) state that approximately twenty million Americans were involved in an incestuous relationship at some time during their lives. Alter-Reid, Gibbs, Lachenmeyer, Sigal, and Massoth (1986) found incest to account for between 24% to 43% of sexual abuse. Swan (1985) reported incest to be 38% of reported child sexual abuse in one year.

Incidence studies represent the second approach to investigating incest. Incidence studies are those "...which attempt to estimate the number of new cases occuring in a given time period..." (DePanfilis, 1986, p. 3). In 1981,

the National Center for Child Abuse and Neglect determined that over 100,000 cases of incest occured per year (cited in Kempe & Kempe, 1984). The national incidence of incest in the United States was estimated at 250,000 in 1982 (Giarretto, 1982). The number of official cases of child sexual abuse was reported to be 100,000 in 1984 (England & Thompson, 1988) and 123,000 in 1985 (Finkelhor, 1987 cited in Simkins, Ward, Bowman & Rinck, 1990), although these numbers may reflect a great underestimate of actual abuse.

The most commonly reported form of sexual abuse is parent-child incest (Groth, 1982) or father/father figure-daughter incest (DePanfilis, 1986; Swan, 1985). Several writings state that father-daughter incest is the most prevalent form of sexual abuse (Courtois, 1988; England & Thompson, 1988; Vander Mey & Neff, 1984). This dyad represents from 75% (Kempe & Kempe, 1984) to 78.8% (Herman, 1981) of the reported cases of incest.

Vander Mey and Neff (1984) reviewed findings of seven studies. Father-daughter incest was reported primarily within the samples, with 53.8% reported. Twenty-three percent of incest was reported to involve a daughter and step-father or foster-father.

The literature also includes several authors who challenge the idea of father-daughter incest as the most prevalent form of incest. Swan (1985) reports that brother-sister incest occurs more often than father-daughter incest.

A reporting bias is suggested by several authors regarding the over-reporting of cases of incest involving natural fathers or father-figures (DePanfilis, 1986; Parker & Parker, 1986). Other researchers state that biological father-daughter incest is less likely to be reported than other forms of child abuse (Anderson & Shafer, 1978; Cohen, 1983; Williams, 1983, all cited in Oaks & Anspaugh, 1987).

Theoretical Background

A recent focus for both systemic and behavioral therapies is working with incest and other sexual concerns. Family systems approaches are often used with incest families and are seen to be clinically useful (Barrett, Sykes & Byrnes, 1986; Lanyon, 1986; Trepper & Barrett, 1986). These approaches address all of the systems involved in the incest relationship, including work with the individual, dyad, family, and larger systems outside of the family. In coordinating work with the various parts of the family system, change occurs in the system to confront and eliminate incest. There are several areas of concern with this approach. First, systemic therapy may underemphasize the need to address behaviors and thoughts directly. Second, this approach to therapy has been described as focusing on father-daughter incest within a more intact family structure. This may exclude many family systems found today. There is also a lack of empirical backing and ongoing research.

Behavior therapy has also been used in working with sexual concerns. The focus of the interventions is to reduce problem behaviors while increasing positive or adaptive behaviors. Behavioral interventions have also been used with thoughts or cognitions in the same manner. Therapy with the incest offender involves decreasing the thoughts leading to incest behavior and stopping the incest behavior. Learning more adaptive socialization skills and ways for the perpetrator to meet his needs more appropriately are also addressed. The focus on specific behaviors may be very beneficial in working with the incest offender. However, the behavioral approach also has several shortcomings with this population. Behavioral work often does not show enough attention to the interpersonal or interactive context of the offender.

There may also be a lack of awareness regarding the effect of multiple factors on beginning and maintaining symptomatic behavior within the family (Lanyon, 1986; Todd, 1981) and larger systems (Lanyon, 1986). Since both systemic and behavioral therapies have aspects that may be beneficial within treatment of the incest perpetrator, a combination of these therapies will be addressed. It is the thesis of this paper that the coordination of family systems theory and behavioral interventions could be used most effectively in the understanding and treatment of the incest offender.

Related Literature

Numerous attempts to combine systemic and behavioral theory have occured in the last twenty years. Todd (1981, 1988) has written about integration and need for increased communication between the two approaches. He stated that he found behavior therapy to be evolving toward the open-systems approach (Todd, 1981, 1988). These two approaches are described as compatible in several ways. First, observable behaviors and change in the present are the focus of both approaches. Second, interactions in the present are seen as maintaining symptomatic behavior. Third, explicit goals are established in therapy, and the resolution of presenting problems is seen as the criterion of success (Todd, 1981).

In addition, several therapeutic interventions are compatible between systemic and behavioral therapies. Behavioral language may be shared, including terms such as reinforcing positive behaviors or interactions, and ignoring/reframing/relabeling negative behaviors (Stedman, 1981). There is also a focus on practicing in-session change, with the assumption that practice out of session is also needed (Todd, 1981, 1988). Both therapies emphasize the importance of rehearsing a new pattern of behavior or interaction. This is called behavioral rehearsal in behavior therapy or an enactment in systemic therapy (Todd, 1981). The combination of behavioral and systemic therapies

is especially appropriate when working with the incestuous family system, as a focus on the target behavior of incest is needed while also looking for symptomatic improvement within the family system (Todd, 1981). A summary of some of the related literature will be given in order to help begin a discussion of the integration of behavioral interventions within systemic therapy.

Falloon and Lillie (1988) describe an open systems approach to therapy. The focus is on awareness of multiple aspects of systems that may affect the psychopathology of the identified patient. Secondarily, stresses or problems in the identified patient affect others in the family and reduce family stress. This reduction in family stress, in turn, positively affects the identified patient. Falloon and Lillie (1988) find that the current trend in some behavioral analyses is to explore systems outside of the family. By looking at outside systems, possible aspects of problem development, maintenance and resolution can be defined and addressed. The authors suggest that several methods that are integral aspects of behavioral therapy be used within systemic therapy. This would include concepts such as: generalization of behavior, a specific stepwise approach to proving a hypothesis, clarity of interventions and goals, and empirical testing (Falloon & Lillie, 1988).

Stedman (1981) suggests that behavioral interventions may be used successfully as strategies to aid in the

effectiveness of a structural-strategic approach to treating incest. Behavioral strategies may also be used when restructuring the family system. These include: 1) making a behavioral analysis of the situation; 2) making a clear statement of behavior changes that are needed by clarifying the behavioral excesses and deficits; and 3) designing specific interventions based on the behavioral analysis. Interventions would focus on moving the system toward change by altering family interactions and dynamics (Stedman, 1981).

Recent work in behavior therapy continues to create models which combine the concepts of behavior and systems therapy. Functional family therapy was initially seen as a systems-behavioral family intervention by Alexander and Parsons (1973) (cited in Morris, Alexander & Waldron, 1988). The focus of therapy includes several areas: communication skills, negotiation skills, interpersonal tasks, and the meaning of behavior. In functional family therapy, the function of a behavior is its unique meaning as defined within each relationship. The function of the behavior does not occur in isolation. The goal of therapy is changing behaviors, feelings and thoughts while maintaining the function of each of these areas in more positive or adaptive ways. Change is addressed within the family system to increase the likelihood of maintenance of these changes.

Schiller (1990) proposes the Multi-Element Treatment

Approach, a behavioral approach that moves beyond the confines of strict behavioral theory. The theory clarifies two main concepts: the procedure or organization of behavioral consequences and the function of behavior, or the "...effect that the consequence has on the behavior it follows" (Schiller, 1990, p. 3). A complete assessment and functional analysis of a behavior is primary for the effective resolution of a problem. Once the function of a behavior is found, a more adaptive manner of behaving may be learned that meets the functional meaning of the behavior in the individual's behavioral repetoire. The intervention plan focuses on several areas: minimizing risks, treating directly, changing the situation or structure in which the behavior occurs, and teaching new skills as needed. Schiller's approach focuses on behavior change within the scope of the individual's surroundings.

This work will describe the integration of behavioral interventions in the systemic treatment of incest perpetrators. Several different areas will be addressed. First, major theories of both theoretical schools will be briefly summarized. Systemic therapy, particularly the structural-strategic approach, will be described as the therapeutic basis of the current approach. Concepts and interventions of the communication model, structural therapy, and strategic therapy will be described to define the structural-strategic approach. Behavioral theory will

then be reviewed, summarizing the work of Rimm and Masters (1974).

Communication theory involves the work of the Mental Research Insitute of Palo Alto. Individuals known for their work with the communication model include: Haley, Madanes, Satir, Watzlawick, Weakland, Fisch, Jackson, Zuk, and Selvini-Palazzoli (Nelson, 1983). The communication model is addressed in this work as it is the theoretical base for work with both the structural and strategic approaches. The focus of communication theory is on the effect of communication patterns on positive or negative interaction within a family or other system.

Structural theory focuses more specifically on the hierarchy and structure of the family system. Minuchin is the major therapist associated with this area. The effect of specific roles and subsystems on interactions are explored in structural therapy. Communication is still an important aspect, as change in communication is seen as affecting change in the structure of a system. Structural therapy focuses on concepts of family structure, subsystems, subsystem boundaries, and adaptation to stress.

Strategic theory was developed through the work of Haley, Madanes, Weakland and Watzlawick. Again, this theory developed from communication theory. Organizational structure is a focus of the theory, with an emphasis on repetitive sequences.

The next chapter addresses the conceptualization of incest. The term incest is defined as specifically as possible, addressing five key elements. These include: a description of the sexual behavior, the age and developmental stages of incest participants, the relationship of participants, response of family members to the incest behavior, and the cultural response. The incest relationship and its dynamics are then described from the structural-strategic approach. Next, a more behavioral approach to viewing the incest relationship is explored. Aspects of the behavioral approach that may be integrated into the systemic framework are discussed. The primary focus is on techniques that may be used within the systemic framework during treatment of the incest perpetrator.

Next, specific treatment issues and interventions will be discussed. In addressing treatment of the perpetrator, systemic interventions and techniques are described first. Behavioral interventions with the perpetrator are then discussed. Next, supportive work with the family system and larger systems outside of the family is described. This focus on the family and larger systems is to help maintain a more complete systemic and integrative viewpoint even while focusing primarily on the perpetrator. Again, systemic strategies are addressed initially, followed by a description of behavioral interventions that support this work.

Research is then addressed. As specific research is not available regarding the integration of behavioral techniques in systemic therapy, summaries of research findings in three supportive areas are discussed. These areas include: incest treatment, structural-strategic treatment, and behavioral techniques. Research of incest treatment is initially addressed, with a review of current findings and problem areas. Next, a summary of research of structural-strategic work is given. Finally, behavioral research of specific techniques used in the treatment of sexual issues or incest will be summarized. It is believed that the discussion of research will support the theory that the use of behavioral interventions within the systemic framework could be more effective when working with the male incest perpetrator. Finally, a summary and conclusion of the information presented will be attempted as these support or negate the thesis of this work.

In summary, this work will focus on the use of behavioral interventions in the systemic conceptualization and treatment of the incest perpetrator. By reviewing the present literature, theories, goals, treatment issues and interventions, the goal is to support the effective combination of these therapies and to discuss suggestions for future research. The focus will be on the treatment of the incest perpetrator while maintaining a systemic perspective.

CHAPTER II

SUMMARY OF THEORETICAL BACKGROUND

To address the thesis of this work, both structural-strategic and behavioral theories must first be defined. Basic concepts, goals, and techniques of both theories will be specified. Defining essential concepts of both theories will provide the basis for the later discussion of how both theories address treatment of incest.

Systemic Theory

To define structural-strategic therapy, several theories affecting its development will be addressed first. General systemic concepts will be discussed as a basis of the approach. Communication, structural, and strategic theories will then be discussed. With this background of theory clearly established, the structural-strategic approach will then be defined.

Systemic theory focuses on the interaction and relationship among different units or people. Systemic theory moves beyond the stimulus-response model, looking at the reciprocity and interaction of relationships. The systemic approach shows a shift from studying the mind to "...the study of the observable manifestations and behavioral consequences of interpersonal relationships"

(Goldenberg & Goldenberg, 1985, p. 99). The entire system must be kept in mind when conceptualizing and working with one or more parts of the system.

There are several primary concepts of systemic theory. Organization is a systemic concept (Goldenberg & Goldenberg, 1985). A system is made up of a variety of different parts with two common themes. All parts of systems are "...interconnected and interdependent with mutual causality each affecting the other;" (Foley, 1984, p. 447). All parts are related to each other in a pattern that is stable across time (Foley, 1984; Goldenberg & Goldenberg, 1985). The system is further organized by rules of the system, boundaries of subsystems, and communication.

Wholeness is another primary concept of systemic theory (Goldenberg & Goldenberg, 1985). To fully understand a system, it must be broken down into its different parts or elements. In addition, no one part can be fully understood in isolation from the other parts of a system as it does not function independently. Interdependence and the interactive pattern of systemic parts defines the organization of a system. The concept of wholeness, rather than focus on the individual, is constantly kept in mind when working within a system.

Open or closed systems are additional systemic concepts describing the relationship between the system and outside systems (Goldenberg & Goldenberg, 1985). A system is

described as open or closed dependent upon the interaction of individuals in the system and the information exchange within the system and between the system and outside systems. An open system is defined as a system that has free exchange of information with outside systems while maintaining its own identity. The system is growth-oriented and is able to adapt and move toward change as needed from the information received by the system. A closed system has no information exchange with the environment and is characterized by a lack of organization and an inability to change. As a goal of therapy is movement toward an open system with information exchange, an open system will be described more fully.

An open system is defined by wholeness, relationship, and equifinity (Foley, 1984). Wholeness goes beyond looking at individuals or separate parts of a system, focusing on interaction and interdependence among parts and relationships. Relationship is the next aspect of an open system. The focus is on interaction among parts of the system. One looks at what is happening rather than why it is happening. What goes on between people rather than inside people is the goal (Foley, 1984).

Equifinity is the final aspect of an open system (Foley, 1984). Equifinity is the capacity of self-perpetuation within a system. While not denying the importance of the past, current interaction is seen as

perpetuating a problem. This concept explains the systemic focus on here and now.

Another concept of systems is one of interlocking triangles. Within a system, interaction between two people is regulated by introducing a third person when interactions are too close or too distant. The role of the third person is then one of stabilizing the system and restoring equilibrium (Foley, 1984).

Homeostasis is also part of systemic theory. Homeostasis is the tendency to maintain equilibrium or internal stability within a system (Goldenberg & Goldenberg, 1985). Behaviors of family members have homeostatic functions within the family system. Although homeostasis has a positive function of ensuring the continuation of a system, it can also perpetuate negative or destructive patterns in the system. Tension-reduction may be attempted by creating an identified patient or scapegoat within the system. By doing this, tension is released through the individual and the family experiences relief (Walsh, 1980). The effect of homeostasis on a particular system must be taken into consideration when working systemically.

Feedback is the process of self-adjustment in a system. Feedback loops circulate information through the system, adjusting as needed to provide systemic change. Negative feedback occurs when any change in the system is "corrected" and the system again experiences equilibrium. Positive

feedback forces a system to change, thereby destroying the original system. Instead of restoring balance, positive feedback goes with the absurdity of a symptom, gradually moving toward destruction of the present system (Foley, 1984). Each person's behavior is both "...caused by and causative of behavior in another part of the system" (Goldenberg & Goldenberg, 1985, p. 36).

Systemic theory is based on the concept of circularity (Hoffmann, 1981), from the systemic hypothesis of the Milan Associates (Selvini-Palazzoli, Boscolo, Cecchin & Prata, 1978, 1980). Systemic theory focuses on giving organization to the behavior and interactions of system members. The focus is on the circularity of system processes rather than problem etiology or cause-effect relationships. In family therapy, similarity between a symptomatic individual and other family members is sought by observing communication, behaviors, and relationships (Hoffmann, 1981). Behaviors are given meaning within a system and, therefore, the system is the treatment unit (Boscolo, Cecchin, Hoffman & Penn, 1987).

Family System Characteristics

Several aspects of systems are a particular focus when working with families and the family system. Structure is an important element of systemic work with families. The structure of a system involves subsystems and boundaries. Subsystems are formed "...by generation, by sex, by

interest, or by function" (Goldenberg & Goldenberg, 1985, p. 37). Examples of family subsystems include parental, marital, and sibling subsystems. Each subsystem has a different level of power and focuses on different skills (Goldenberg & Goldenberg, 1985). Complimentary or symmetrical relationships develop between and among subsystems and can be a focus within therapy.

Boundaries are an aspect of organization within a system. Boundaries have several functions. They can hold the system together as a whole and provide specific functions within the system. Boundaries also can regulate or protect aspects of the system. They provide specific identity to the system, while allowing information exchange both within and outside of the system.

Rules are another aspect of system organization. Rules are established in each system through repetitive patterns of behavior and interaction (Rohrbaugh & Eron, 1982), which then govern relationships and interactions. Explicit and implicit rules for behavior exist within the family system and define relationships (Goldenberg & Goldenberg, 1985). Recognizing the positive and negative effects family rules have on the family system is often a focus.

Another focus for work with the family system are changes in the roles held by men and women (Goldenberg & Goldenberg, 1985). Expectations and functional roles for men and women have changed over the years, and this has a

definite effect on the structure and interrelationships of the family members.

Dysfunction in the family system is characterized in several ways. Dysfunction occurs when a pattern of behavior is repeated over a long period of time. Several patterns characterize negative or problem behaviors. Enmeshment occurs when subsystems are not well differentiated, boundaries are blurred, and interactions are characterized by extreme closeness and lack of privacy. Disengagement is another pattern. This style is characterized by rigid boundaries, a lack of relating, and difficulty in communication. All family members are seen as having a role in the dysfunctional behavior of a family member. The role may be one of interactions or the family's perception of what is right or wrong. Developmental or situational changes with one or more members of the system may also be the basis of the beginnings of dysfunctional relating.

The role of the family therapist in systemic therapy is to intervene directly in the system as an active participant in the family system. The focus of therapy is on present behaviors and interactions rather than an individual's intrapsychic issues (Goldenberg & Goldenberg, 1985). By observing behavioral sequences or problem cycles in the system, the therapist moves beyond the system's inappropriate attempts to solve the problem.

In summary, several basic concepts are seen within

systemic theory. Homeostatic functions are present to assure stability in the system. Organization of the system is present through arrangements of subsystems and family rules. Boundaries and their effect on interaction within and outside of the system are also important in this view. In addition, changes of male and female role relationships and other cultural changes must be addressed when working with family systems in the present culture (Goldenberg & Goldenberg, 1985).

Communication Theory

Communication theory is a large part of the theoretical basis of structural-strategic theory. Communication theory is also the basis of several systemic theories including the interactional view of the Mental Research Institute, strategic theory, and systemic theory of Mara Selvini-Palazzoli. Communication theory was developed through work at the Mental Research Institute in Palo Alto by Haley, Watzlawick, and Weakland. Numerous other family therapists used the communication model, including Madanes, Satir, Fisch, Jackson, Zuk, and Selvini-Palazzoli (Nelson, 1983). The concepts of communication theory are the basis of structural-strategic therapy and therefore will be discussed here.

Communication theory defines all behavior and interaction as communication. Communication determines relationships in a circular manner, and specific statements

or manners of communicating affect its meaning (Goldenberg & Goldenberg, 1985). Problems are seen as "...interactional and situational" (Goldenberg & Goldenberg, 1985, p. 187). Communication theory focuses on all forms of direct and indirect communication.

There are several basic concepts of communication theory. Communication is defined as occuring on two levels. The first level is the direct or content message of the words. The second level is called metacommunication, with this information qualifying the information given in the direct message. Metacommunication is also seen as the command within a message.

Based on the two levels of communication, Mental Research Institute members developed the concept of the double-bind. A double-bind is created when the content of communication is negated by the command of the message. The receiver of this mixed message is in a situation where no choice is acceptable or correct, providing a no-win situation (Foley, 1984). Symptomatic behavior is often seen as arising from double-bind communication.

Clear communication is logical and aids in direct resolution of problems. Dysfunctional communication adds tension, confusion of expectations, roles, and alliances (Walsh, 1980). Communication theory defines problems as occurring when communication patterns support dysfunctional power arrangements within the family and create cross-

generational coalitions (Nelson, 1983). Although some needs of the family may be met through a dysfunctional system, clear communication is the goal.

Within a family system, rules are built out of positive and negative communication patterns. Communication patterns create alliances within the family (Walsh, 1980) which may be symmetrical or complimentary. A symmetrical relationship is characterized by equality and a minimization of differences between individuals. Complimentary relating occurs when one person assumes a superior, and the other an inferior, position in the relationship (Goldenberg & Goldenberg, 1985). Family rules and patterns of behavior define sequences of interaction and may support or negate whether needs of family members are met (Nelson, 1983).

There are several goals of communication therapy. First, communication therapy aids in clear family communication (Nelson, 1983; Rudestam & Frankel, 1983). Another goal is to increase awareness of oneself and others. Finally, communication therapy aids in changing family communication and interactions to rid a family of presenting problems (Nelson, 1983).

The role of the therapist in communication therapy is one of an outsider to the family system. The goal of the therapist is to help the family members experience their interactions in such a way as to change rules in a more positive manner (Goldenberg & Goldenberg, 1985). The

therapist focuses on present patterns of communication, content of communication and manner of expression to work toward change.

There are several techniques developed and used within communication therapy. Use of paradoxical and nonparadoxical tasks are well-known within communication therapy (Nelson, 1983). Some direct or nonparadoxical tasks are used in communication therapy. The therapist explains clear communication and models this behavior to the family. The therapist also clarifies what and how the family is communicating. Punctuation, or emphasis on different points of communication, is a strategy to clarify patterns of interaction (Goldenberg & Goldenberg, 1985).

Relabeling, similar to the structural technique of reframing, is another strategy of communication therapy (Goldenberg & Goldenberg, 1985). It is a form of a therapeutic double-bind. Relabeling changes the focus and meaning of interaction and behavior from a negative connotation to a more positive or normal meaning. The change in meaning can lead to the family's altered perception of behavior and, therefore, interaction within the family (Goldenberg & Goldenberg, 1985).

Paradoxical techniques, including the therapeutic double-bind, are a major aspect of communication theory. The paradoxical message given by the therapist mirrors the paradoxical communication of the family (Goldenberg &

Goldenberg, 1985). The therapist's message tells the family not to change, when the family members expect to be told that they must change. The family either supports the therapist's view by not changing, cutting down resistance, or the family defies the therapist, moving toward change. Paradoxical techniques have the goal of helping the family system to move toward change from its previous functioning where other, more direct, methods fail (Goldenberg & Goldenberg, 1985).

Prescribing the symptom is a paradoxical technique making use of the therapeutic double-bind. This technique sends the message "Stay the same" or "Don't change" to the family. This may function in two ways. First, it is a tool to help move the family toward some change. Second, the system is put into a situation where they are in some way cooperating or going along with the directive of the therapist (Goldenberg & Goldenberg, 1985). This also puts the behavior or problem under the control of the family system as it becomes something that may be done voluntarily.

In summary, communication theory focuses on communication as affecting system rules and interaction. Therefore, communication patterns are the primary focus of change. The therapist uses direct and paradoxical strategies to help the family move toward clearer, more positive communication.

Structural Theory

Structural theory is best known through the works of Salvador Minuchin. Structural theory focuses on hierarchy and organization within the family system (Madanes, 1981). Systemic rules are challenged by developing alternatives. Relationship patterns are also addressed as relationship patterns that are too close or too distant may show problem interactions. Communication patterns are important, especially as they affect the development and maintenance of structures in the family system.

Within Minuchin's structural model, the family is seen as the primary unit in which individuals are taught behaviors and where behaviors continue to be reinforced. The family unit is seen as the focus of change as individual learning occurs mainly within this setting. Family structure is the main focus of this theory. Restructuring of the family system in therapy also affects the behavior of the individual (Walsh, 1980).

Minuchin's theory of personality includes four major interdependent concepts: family structure, subsystems, subsystem boundaries and adaption to stress (Walsh, 1980). Family structure is defined as the ordered verbal and nonverbal transactions among family members. These transactions serve to regulate behavior by representing a hierarchy of power and mutual expectations of specific functions within the family. Functions are specifically

designated to differentiate subsystems and clarify roles and interactions within the system.

Subsystems further define family structure. Subsystems serve as regulators of division of labor and increase the efficiency and effectiveness of the system. Membership in a subsystem changes depending on the present need or situation, except in dysfunctional families where subsystems are rigidly defined (Walsh, 1980). Family subsystems include the marital, sibling, and parental subsystems.

Boundaries are the third structural concept and aid in effective use of subsystems by establishing limits. Boundaries define involvement among individuals, responsibility and authority of individual roles, and information exchange with other subsystems. Subsystem boundaries may be rigid, diffuse, or clear. Rigid boundaries restrict the flow of information between the system and outside systems, while diffuse boundaries fail to define any clear relationships or limits. Both styles may result in problems for the system. Although families may experience each boundary style periodically, the goal is to avoid getting stuck at either extreme (Minuchin, 1974; Walsh, 1980).

Information exchange within subsystems is also viewed on a range from enmeshment to disengagement (Byng-Hall, 1981). Enmeshment is a style where the system is too self-involved, characterized by a lack of privacy, and little or no information exchange with outside systems. Disengagement

describes a system where no concern is shown between family members and there is little or no effective interaction. A therapeutic goal would be to move toward a more effective middle ground.

Adaption to stress is the final structural concept (Minuchin, 1974; Walsh, 1980). The family system has response sets, defined as patterns of systemic response to stress. These patterns are repeated regularly and without variance in response to any stressors. A family system may have responses that are flexible or open to change, or may trap family members in a rigid, negative pattern of responding (Goldenberg & Goldenberg, 1985).

In a dysfunctional family system, adaptive coping mechanisms are overwhelmed. Pathology is seen in a family's reaction to stress where the family increases rigidity in transactional patterns, closing boundaries between subsystems and outside systems, and avoiding alternative behaviors, leading to negative homeostasis. Negative homeostasis is present when even needed or positive changes are met with increased rigidity from the family system. Maintaining a familiar pattern of interaction is more important to the dusfunctional family system than adapting toward change. The most effective manner to eliminate dysfunctional or symptomatic behavior is to change these transactional patterns (Goldenberg & Goldenberg, 1985). The therapist's task is to restructure the family system that

has set up these responses. The goal is family interaction that is less rigid and more accepting of input from outside the system (Minuchin, 1974; Walsh, 1980).

Other concepts that are part of the structural view are alliance, coalition, and hierarchy (Minuchin, 1974). Alliance occurs when parts of the system move together toward a goal. Coalition describes a situation where two or more parts of the system move together to work against another part of the system. Hierarchy refers to the structural boundaries of the subsystems, and the relationship of one subsystem to another. All of these constructs may be part of functional family interaction. Problems occur with cross-generational coalitions, or prolonged functioning of an individual in an inappropriate subsystem.

The focus of change in structural therapy is on family structure, changing the structure to more positive and supportive patterns. The basis of change in structural therapy is looking at normative family organization or interaction, and then noting which characteristics are present when a problem occurs. Change in communication is also seen as leading to structural change. As an individual's experience is determined by interaction with the environment, change in context or environment is seen as producing change in the individual (Minuchin, 1974). Although structure is generally the focus of change rather

than the presenting problem, this is not always true in life-threatening situations.

There are several goals of structural therapy. The first goal is clarification of boundaries (Goldenberg & Goldenberg, 1985). This involves differentiation of individual and subsystem roles, clarifying the roles and responsibilities of each person. Boundaries should be neither diffuse or rigid, allowing information exchange into and out of the system.

Another structural goal is increasing flexibility within family interactions (Goldenberg & Goldenberg, 1985). Flexibility is seen in an individual's increased ability to move between roles in different subsystems as needed. Boundaries may be strengthened or loosened depending on the family structure, encouraging more flexibility than in an enmeshed or disengaged system (Foley, 1984). Increased flexibility is also a goal within family communication, as repeated interactions may develop negative family rules and myths (Minuchin, 1974).

Finally, the dysfunctional structure of the system must be modified (Goldenberg & Goldenberg, 1985, p. 178). Inappropriate alignments or coalitions are addressed to move toward more appropriate interactions within the structure of the family. For example, triangulation of a child into a couple's problem is challenged, forcing the couple to address their own issues directly. Changes in structure

assure that subsystems function and that there is no inappropriate crossing of generations.

The structural therapist is an active contributor to the system and has an extremely directive style. The therapist initially establishes an affiliation with the family. Therapists join the family in a position of power, and then remove themselves while building up family members to handle their own concerns (Minuchin, 1974). By challenging the structure and rules of the family, the therapist looks for flexibility and possible change in the family to relieve the need for the symptom (Goldenberg & Goldenberg, 1985). The therapist essentially provokes a crisis within the family system. The therapist works with the principle of minimal intervention (Otani, 1989), seeing the system as generally positive and capable of change. In this way, the therapist avoids becoming part of the problem (Rohrbaugh & Eron, 1982).

Maintaining maneuverability is a primary focus of the therapist (Boscolo, Cecchin, Hoffman & Penn, 1987; Madanes, 1981; Minuchin, 1974). The therapist maneuvers in and out of the system to move the system toward change. An inside position is seen when the therapist joins the family system, creates coalitions, and intensifies or blocks different interactions. Distancing occurs when the therapist is more directive, such as restructuring (e.g. marking boundaries) or channeling communication pathways within therapy.

Ongoing supervision, consultation and use of a one-way mirror with team support may aid in working both in and outside the system.

There are several structural techniques that are used as a part of the therapy process. Techniques are used to work toward restructuring within the family system (Minuchin, 1974; Nelson, 1983; Walsh, 1980). Structural techniques address change within the present, starting in the therapy session.

Joining, or accommodating to the family style, is a therapeutic technique used when initial contact occurs with the family (Goldenberg & Goldenberg, 1985). By joining with the family system, the therapist does not start the relationship in as confrontive of a manner, which may reduce resistance of the system in working toward change. As therapy continues, the therapist maintains aspects of the family style while challenging family members to experience change.

Several techniques are aspects of joining (Minuchin, 1974; Walsh, 1980). Mimesis is joining the family system through imitating the affective range and communication styles of the family. Tracking involves adopting family symbols through communication, including values, life themes, or family historical events.

Restructuring occurs in structural therapy through a variety of different techniques. The goal of restructuring

is to change the structure of family relationships and interactions (Goldenberg & Goldenberg, 1985). One specific technique involves physical restructuring in session, such as changing in-session seating (Nelson, 1983). The therapist may also involve only certain subsystems in parts of therapy, supporting appropriate boundaries and interactions within the system. It is also possible to restructure activity outside of sessions by prescribing specific activities.

A structural map is used as a way of therapeutically mapping family structure (Nelson, 1983; Nichols, 1987). This technique clarifies the structure of the family at the beginning of therapy and is used as a tool to monitor change in interactions throughout the process of therapy. Although some distortion may be present, this tool may aid in maintaining continuity toward the therapeutic goal (Minuchin, 1974).

Enactments are often used within structural therapy. This technique involves family members re-enacting problem interactions (Nelson, 1983; Nichols, 1987). Use of enactments is a way of bringing "...an outside family conflict into the session so that the family members can demonstrate how they deal with it and the therapist can begin to map out a way to modify their interaction and create structural changes" (Goldenberg & Goldenberg, 1985, p. 183). Enactments also reframe family perspectives

leading to change in behaviors (Goldenberg & Goldenberg, 1985). Immediacy is brought to the situation through enacting problems in the therapy session (Minuchin, 1974).

Reframing is one of the most common techniques used. This technique is similar to the strategic technique of relabeling described previously. Enactments are a form of structural reframing. Utilizing the symptom is another manner of reframing. By exaggerating, de-emphasizing or relabelling symptoms or family interactions, the therapist brings different meaning to the situation (Minuchin, 1974; Walsh, 1980).

Several other techniques are used in structural therapy. The therapist may punctuate parts of interactions or communications within therapy, affecting the meaning or focus within therapy (Nelson, 1983). Therapists may assign tasks in and out of session (Nelson, 1983). The therapist may also manipulate the mood of the family (Minuchin, 1974; Walsh, 1980).

All techniques used in structural therapy work toward restructuring within the family system. Besides the techniques described above, techniques have been borrowed from other therapies to work toward the therapeutic goal of restructuring. Techniques are chosen by the therapist to best address the goal of restructuring the system.

Structural therapy is a challenging and highly directive style of therapy. Therapy is crisis-provoking and

action-oriented, with a variety of therapeutic tools to help toward systemic change. Therapy is focused on in-session change, although assignments may be given to work toward change outside of therapy. The focus of therapy is understanding the structure of the family including its subsystems, boundaries, alignments, and coalitions (Goldenberg & Goldenberg, 1985). The process of therapy helps the family system move toward more appropriate structure and boundaries and supports appropriate interactions.

Strategic Theory

Strategic theory developed from the work of the Mental Research Institute in the 1960's and gained much attention in the 1980's (Goldenberg & Goldenberg, 1985). Strategic theory has developed from communication theory and has a problem-oriented focus. In strategic theory, communication defines the style of relationships within the family system. Strategic therapy focuses on the repetitive patterns of behavior within the family, particularly focusing on the presenting problem. The therapist devises a strategy to solve the problem, shifting family organization so the problem no longer has a function within the family system (Goldenberg & Goldenberg, 1985).

There are three main theoretical groups in the strategic movement. These include: the Mental Research Institute, the Milan-based systemic model, and the work of

Don Jackson and Jay Haley. All three groups will be briefly described here to clarify strategic concepts.

The Mental Research Institute developed an another style of strategic therapy. Weakland, Fisch, and Watzlawick are involved in this approach. Rather than focusing on the structure of a system, the focus is on the problem or symptom as identified by the family. The symptom is defined as the problem. Problems develop when the system is not able to adjust to life changes. Attempts to solve problems fail because the attempted solutions are the same patterns of interaction that supported problem development. To break this pattern, the therapist intensifies the problem (e.g. prescribing the symptom) toward a solution of change (Fisch, Weakland & Segal, 1982; Foley, 1984).

The Milan-based systemic model is another strategic therapy. This approach was developed through the work of Selvini-Palazzoli, Boscolo, Cecchin and Prata (1978). The Milan-based systemic model is based on the theory that all family members want control of the family system without clearly stating this. Based on work by Bateson, Jackson, Haley, and Weakland (1956 cited in Goldenberg & Goldenberg, 1985) family causality is viewed as a circular, not linear, process. A focus is on the process and repetitive sequences of interactions. One main concept the Milan group added to the strategic movement is "...the need to devise strategies that involve all the family members and give each person's

motivation a positive connotation" (Foley, 1984, p. 456). The therapist must find tasks for the family that force systemic change.

Jay Haley is primary in the development of strategic therapy. His work is more of a structural-strategic approach. He focuses on both structural and strategic aspects in his therapeutic work (Haley, 1963). There are several primary issues in Haley's therapy. Control is a critical issue, as all family members are trying to gain power or control through their interactions. Another primary issue is changing the structure of the family system. Establishing appropriate boundaries is also addressed as a focus of Haley's approach. The therapist creates strategies to change the balance of power, restructure the system, and re-establish boundaries within the system (Foley, 1984).

Strategic concepts encompass a variety of different areas of focus and techniques, as characterized by the approaches of the Mental Research Institute, Milan group, and Haley's works. However, several concepts are primary to strategic therapy and part of all approaches. These concepts include: communication, organizational structure, structual components, focus on the present, and concepts of change. These concepts will be described next.

As strategic theory developed from communication theory, communication is a primary concept. There is

generally a focus on a dyad or triad within a system. The system's communication patterns are viewed to investigate communication patterns that support or negate problem behavior or result in alliance (Walsh, 1980). Conflicting communication is seen as creating problems (Haley, 1963).

Organizational structure is also a basic concept of strategic therapy. A particular emphasis is on family patterns or repetitive sequences of behavior which are the base of structure (Goldenberg & Goldenberg, 1985; Madanes, 1981). Symptoms are seen as interpersonal events and so communication and other forms of interaction are a focus of assessment and approach to therapy. A focus of therapy is change in the present organization of the system to reduce or eliminate the symptom (Madanes, 1981). Cross-hierarchy alliances or other dysfunctional patterns are also challenged (Walsh, 1980).

A secondary focus is on structural changes in the system. System hierarchy, alliances, and coalitions are assessed and challenged to result in positive structural change (Haley, 1963). Structural changes occur through escalating tension in an inappropriate dyad, then supporting positive structural alignments between appropriate boundaries. A dyad or triad is the focus of interventions and change.

Another concept of strategic therapy is working in the present, as opposed to focusing on the past (Fisch, Weakland

& Segal, 1982; Haley, 1963). The focus of therapy is on the presenting problem as defined by the family system. The therapist accepts symptoms as the family defines them, immediately beginning to establish a context of change. Goals are clearly set, with the therapist then creating a strategy to solve the presenting problem.

Change in problem or symptomatic behavior is another focus (Fisch, Weakland & Segal, 1982; Haley, 1963). Therapeutic change occurs through the process of the therapist entering a family system to create an imbalance and then moving on to another level of the system. The therapist enters the family to begin changing interactions, shifting responsibility back to family members to help them become "unstuck" (Nichols, 1987). The therapist pushes the family toward overt, rather than covert, actions and feeling expression. Although overt change can be more stressful to the system, it is the only way to move toward real change (Byng-Hall, 1981). Direct and indirect interventions are used to work toward change in strategic therapy.

Strategic therapy may be summarized as an action-oriented therapy focused on the present interactions in a system. Although family structure is viewed, there is more of a focus on family hierarchy, coalitions and manuevering for power in relationships. Strategic therapy is seen as more than a technique of change, but as an approach that is consistently integrated with "a theory of family process"

(Foley, 1984, p. 456).

The strategic therapist is directive, dealing with present interactions and behaviors. Although some believe strategic methods are manipulative, the family and individuals are not changing by themselves and some therapist influence must occur to begin systemic change (Nichols, 1987). By clarifying the presenting problem, the therapist chooses a manner of intervention in the family system. The therapist starts first by helping the family to act differently in the session. The second step is for the family to begin to integrate these changes into interactions outside of the therapy session, leading toward a secondary, systemic change. The goal is for family members to try new behaviors to become "unstuck" from the established patterns of behavior (Boscolo, Cecchin, Hoffman & Penn, 1987). A variety of direct and paradoxical techniques are used to have family members try new behaviors (Nelson, 1983).

The therapist tries to maintain a stance of neutrality when working with a system. This therapeutic style is called therapist maneuverability (Boscolo et al., 1987; Fisch, Weakland & Segal, 1982; Madanes, 1981). The therapist has maximum leverage in the system by remaining neutral and is able to move in and out of different alliances and coalitions rather than being caught up in the system (Goldenberg & Goldenberg, 1985).

The main technique used in strategic therapy is giving

directives to family members (Madanes, 1981). Directives have several therapeutic purposes. They alter people's behavior, therefore changing subjective experiencing. Directives also intensify therapeutic relationships. Finally, the family's response to directives give the therapist information regarding the system's response to change.

Since directives are planned specifically for an individual and his or her circumstances, there are no situations where this technique may not be used. Strategies are observed over a short period of time to see what change was induced. A new strategy is formed when the old one is not showing success or change in the system. Within the strategic approach and in using directives, the therapist may borrow techniques from other approaches to work with a symptom or presenting problem (Madanes, 1981). Working with individuals and relationships is done to combine work with the individual and the system, assuring lasting change (Nichols, 1987).

Within strategic therapy, both direct and indirect interventions are used. Direct or compliance-based directives directly address a symptom to change the system's interactional sequences (Madanes, 1981). Direct techniques are used when there is little resistance, high motivation, and flexibility within the family system. Direct, structured interventions are also used to work through a

crisis period. Initial contact with a therapist and other larger systems, such as social services, is a time where specific, direct communication between the therapist and system is particularly effective. In these cases, logical explanations, tasks, or suggestions are likely to produce change in the family system (Madanes, 1981; Nelson, 1983; Papp, 1981).

Indirect, paradoxical, or defiance-based directives are also used in strategic therapy. Paradoxical techniques are used in several therapeutic ways. First, they are used where direct strategies have had no effect. Second, paradoxical techniques are used when rigid, repetitious patterns of interaction have become established over long periods of time (Madanes, 1981). Third, this approach can be particularly effective in addressing resistance or denial in a system. Madanes (1981) defines a counterparadox as when a family's double-bind message is undone by a therapeutic double-bind, or counterparadox (Goldenberg & Goldenberg, 1985). A paradoxical intervention changes the meaning of the relationship between the client and therapist while addressing resistance (Papp, 1981).

Paradoxical techniques have three parts. A problem or symptom first must be clarified by family members prior to being redefined by the therapist. The therapist then gives a directive to the family, or prescribes the symptom. Finally, the therapist restrains family members and urges

them not to change too quickly (Haley, 1963). Paradoxical techniques work with the family system's natural resistance to change (Goldenberg & Goldenberg, 1985).

Several techniques are used to redefine the meaning of behaviors or interactions. Relabeling techniques are used in strategic therapy (Goldenberg & Goldenberg, 1985; Haley, 1963). This technique is also called reframing (Boscolo et al., 1987). Relabeling changes the meaning of behavior by describing the same behavior in a different manner.

Positive connotation is a form of reframing (Boscolo et al., 1987; Madanes, 1981; Selvini-Palazzoli et al., 1978). This technique redefines symptomatic behavior as "good" as it helps to maintain systemic homeostasis. As family members interpret the positive connotation as therapist approval, most agree with the therapist's interpretation. At that point, family members are placed in a paradox about why the symptom should be maintained as it is placed under their control. The entire family is placed in the paradox to avoid putting blame on one person (Goldenberg & Goldenberg, 1985).

Prescribing is another aspect of strategic directives. Prescribing a symptom is a technique that is often used. The therapist takes control of a symptom by telling the family to continue having a symptom with each playing a part. Family members are caught in a paradox, because whether they follow the directive of the therapist or change

their behavior, they are moving toward change (Haley, 1963).

Pretend and ordeal strategies are also used (Madanes, 1981; Selvini-Palazzoli et al., 1978). Pretend strategies are used as a less confrontational approach to overcome resistance of the system. The therapist gives a directive for the identified patient to pretend to have a symptom, while directing the others to help. The theory of the strategy is if a family can pretend to have a symptom, the symptom cannot be real and the family may stop (Goldenberg & Goldenberg, 1985).

Ordeal strategies were developed by Haley (1963). The ordeal is best if it is good for the person and is something that the person can do. The idea behind this concept is that an individual will abandon a symptom if it causes more distress to maintain the symptom than not to maintain the symptom.

Use of metaphor is another strategic technique (Haley, 1963; Romig & Gruenke, 1991). Metaphors are used as analogies to systemic problems. This technique is often used when there is a lot of resistance or denial in the system. By dealing with the symptom metaphorically, the family is more willing to discuss problems in this less threatening manner.

Restraining is another paradoxical technique. Therapists change dysfunctional family patterns by telling families or individuals not to change or restraining them

from change (Haley, 1963; Nelson, 1983; Rudestam & Frankel, 1983). The therapist uses restraining techniques when the system has begun to change. By giving messages of "go slow" or "slow down", the therapist creates a paradox where either way in which family members respond is positive and moves them toward change (Madanes, 1981; Nelson, 1983).

One restraining technique is the negative consequences of change (Fisch, Weakland & Segal, 1982; Haley, 1981). The therapist discusses all of the potential changes that could occur as a result of eliminating a symptom. All parts of the system take part in this discussion.

Use of a therapeutic team and a one-way mirror has been used within strategic therapy. A one-way mirror is used by a team of therapists to observe the interaction of therapy. A strategy conference is then held with the team and the therapist to come up with a prescription for the family. The Milan Associates also used the team as a forum for the active process of hypothesizing a theory of why the family keeps a symptom (Goldenberg & Goldenberg, 1985).

Techniques can also be used for information gathering. Circular questioning is used as a diagnostic and therapeutic interviewing technique (Boscolo et al., 1987; Goldenberg & Goldenberg, 1985; Madanes, 1981; Nichols, 1987). Circular questioning focuses on deriving differences, including now/then differences, hypothetical or future differences, differences in degree (are problems better or worse), and

differences in perceptions of relationships (Boscolo et al., 1987). This technique supports use of feedback from the family system in working toward change. Although placing the therapist in a power position, much can be gained from the family members' reports of perceptions or problem behaviors and coalitions in the system (Nichols, 1987).

Strategic therapy may be summarized as an action-oriented therapy dealing in the present. A variety of direct and paradoxical techniques are used to move the family system toward change. The focus of change is on communication and organizational structure. The therapist devises a strategy to move the system toward change.

Structural-Strategic Theory

The structural-strategic view was developed primarily through the work of Jay Haley. The structural-strategic approach focuses on the present, therefore looking at both problems and change in the present (Minuchin, 1974). The approach is process oriented and focuses on in-session process (Kadis & McClendon, 1981). Specific methods and timing of techniques are clarified. The family system is the focus and the target of interventions. Within the structural-strategic framework, the unique qualities of the individual are also addressed. The individual is seen as both affecting and being affected by his or her social context (Minuchin, 1974). As both structural and strategic concepts have been described above, a summary of

the focus of structural-strategic therapy and its techniques will be discussed at this time.

Structural-strategic theory combines the concepts of structural and strategic therapies as described above. A variety of structural concepts are addressed in therapy. The therapist looks for a breech of generational boundaries, coalitions within the system, and triangulation of a child into parental communication. The therapist also looks for the system's contact with other professionals and the involvement of the professionals in the family system (Haley, 1963).

Strategic aspects are also part of therapy (Haley, 1963). Goals are clearly set, and the therapist works with the family through planned stages of therapy. The therapist devises a strategy to address the presenting problem. Strategies often include paradoxical directives to deal with resistance to therapy (Goldenberg & Goldenberg, 1985). As interactions are a focus of therapy, two or three people are generally involved in therapy (Haley, 1963).

Communication is the final conceptual focus of the structural-strategic approach. Communication is seen as defining relationships. As in communication theory, both the direct or content and the relationship or meta-communication command of the communication are viewed by the therapist to see the effect of communication within the family system. Communication patterns are also a focus,

including symmetrical, complimentary, or double-bind communication.

A symptom is viewed as a strategy to control a relationship. Problems occur only when the symptomatic individual denies controlling the relationship. The symptom involves the entire family system and is appropriate within the system. Finally, by viewing a problem in context, the difference beteen individual and family therapy is irrelevant (Haley, 1963).

Structural-strategic therapy has several primary foci (Haley, 1963). The focus is on the entire family system, including as many people as possible who are involved in the problem. Therapy focuses on the symptom and is quite situation-specific. Communication and interaction in the present is the goal rather than insight and interpretation. By working in stages, failure is less likely.

Structural-strategic therapy uses techniques from both structural and strategic therapy. Directives are a main therapeutic technique, serving to intensify the therapeutic relationship and gaining information about the response of the family members (Haley, 1963). Use of the therapeutic double-bind and paradoxical interventions are also used. Creative use of crisis is another technique as structural change is more easily brought about during crisis (Haley, 1963). Other techniques from communication, structural and strategic theories, described previously, can also be used.

The specific techniques used are chosen to best address the symptoms of each family.

In summary, structural-strategic theory addresses change in the present. The therapist is directive, but accepts the symptoms of the family to establish a context of change. After defining the problem, the therapist makes use of a variety of directives and techniques to change symptomatic behavior.

Communication, structural and strategic theories have been described to establish a theoretical base for structural-strategic theory. Discussion of these theories is important to clarify therapist style, focus of therapy, and techniques of change in structural-strategic therapy. All behavior and interactions are defined and addressed systemically in therapy.

Behavior Theory

Behavior therapy has been used in a variety of therapeutic work for many years. This approach has developed into a variety of specified techniques to work with a variety of different focus behaviors. Although certain therapists are well-known for their part in the development of aspects of behavior therapy, such as Skinner and Wolpe, many theorists have been part of continuing development and use of behavior therapy.

Behavior therapy uses a variety of specified techniques to change maladaptive human behavior through use of learning

principles. Learning theory is the basis of this approach, and behavior is seen as being learned and capable of change through imitation and reinforcement (Corey, 1986). Present behaviors result from past environmental conditioning, including family relationships and the reactions of others in their environment (Papajohn, 1982). Abnormal behavior results from faulty learning rather than personality disturbance (Corey, 1986) and can be unlearned while more adaptive behaviors are learned (Berkowitz, 1982; Walsh, 1980).

There are several goals of behavior therapy. The primary goal of behavior therapy is lessening or eliminating maladaptive behaviors while learning or strengthing more effective behaviors (Corey, 1986; Papajohn, 1982). The newly learned adaptive behaviors must then be generalized and supported in interactions with other individuals and the environment (Papajohn, 1982). Although the therapy hour is used to begin this change between the patient and environment, the goal is for the patient to be able to use these new behavior patterns to create more positive and reinforcing interactions with the environment (Papajohn, 1982).

Behavior therapy has its own set of assumptions (Rimm & Masters, 1974). The first assumption is that behavior therapy focuses on maladaptive behavior, rather than causes of behavior. As learned behaviors are established in

predictable patterns, the therapist can anticipate and change future behavior (Walsh, 1980). Thoughts may be addressed through cognitive strategies as they affect perceptions of the environment and the manner of interactions. Overt and covert behavior are addressed (Rimm & Masters, 1974), with overt behavior change as the main evaluation criterion of treatment (Berkowitz, 1982; Corey, 1986).

A second assumption of behavior therapy is that all behaviors are learned. Behaviors show the learning history of an individual and the effect of the environment on what is learned (Rimm & Masters, 1974; Walsh, 1980). Human behavior is seen as the product of learning, with people both producing and being products of the environment (Corey, 1986). The therapist accepts the presenting problem as real and sees the client as a valued information source. Maladaptive behaviors are seen as resulting from faulty learning. Even psychotic behavior can be affected by applying learning principles, with appropriate behavior gained through reinforcement while ignoring negative or bizarre behaviors (Rimm & Masters, 1974).

Behavior therapy focuses on the here and now (Corey, 1986; Papajohn, 1982; Rimm & Masters, 1974). The focus is on current, rather than historical, determinants (Corey, 1986). Both in-session movement toward behavioral change and change in current behavior outside of the session are

manners in which change in behavior is monitored. In this way, insights in therapy can also be seen as verbal behaviors which can be affected by the same learning principles (Corey, 1986).

Behavior therapy focuses on setting clear treatment goals. The client is involved in goal selection whenever possible (Corey, 1986). Family problems can also be defined in concrete, observable, objective terms (Corey, 1986; Falloon & Lillie, 1988) to be then able to clarify specific goals. This supports the goal of relieving specific problems that interfere with the functioning of the client. Stimulus control is also seen as important, to both reduce specified responses to specific stimuli as well as focusing on specific situations (Corey, 1986; Rimm & Masters, 1974). This connects with the goal of objective treatment evaluation (Corey, 1986).

Finally, techniques used in behavior therapy are assumed to have gone through empirical testing, to be based on scientific method, to be objective, and to have some level of effectiveness (Berkowitz, 1982; Corey, 1986; Rimm & Masters, 1974). An empirical base is established through systematic observation, leading to predicting and establishing relationships among observables (Rimm & Masters, 1974). Replication of results is also a focus (Corey, 1986). Basic research is the source of hypotheses and techniques for treatment, with a strict focus on measurement (Corey, 1986).

Therapeutic strategies are planned in a specified manner based on the empirical theory of behavior change, and focus on the individual behaviors or the family (Falloon & Lillie, 1988). Empirical observation and controlled experiments are used in ongoing research toward the primary goal of accountability (Rimm & Masters, 1974). Accountability implies that each treatment strategy is defined in a manner that is clear, measurable, and is subject to repeated testing. Berkowitz (1982) summarizes behavior therapy as applying experimental findings to help design reinforcing positive living environments for individuals.

The relationship between the therapist and client is unique. The therapist is active and directive, relating to the client as a teacher, trainer, model, collaborator, or an expert consultant (Corey, 1986; Papajohn, 1982). The client takes an active part in therapy, tries new behaviors and takes part in development and evaluation of treatment goals. It is quickly established that the client needs to work, identify problems and investigate cognitive process. The therapeutic relationship is important, characterized by an atmosphere of warmth, concern and caring (Corey, 1986; Papajohn, 1982; Rimm & Masters, 1974). The therapist models this supportive style to the client, using the relationship to influence the therapist's reinforcing effect in a positive manner (Rimm & Masters, 1974).

Cognitive Behavior Therapy

Cognitive behavior therapy is also based on the principle of learning theory. The focus of change in cognitive behavior therapy is on feelings and thoughts. The concept of cognitive behavior theory is that changes in thoughts and feelings can affect behavioral change.

Cognitions can also be addressed within behavior therapy primarily or in a supportive manner with other behavioral strategies (Falloon & Lillie, 1988). All events experienced by the individual are mediated through cognitions, which give meaning to experiences. Cognitive processes are defined as behaviors which can be modified. Problems include "maladaptive thinking habits" experienced by individuals regarding their cognitive interpretation of events, whether or not the individual is aware of these cognitions. Affective problems may surface if a person is not able to respond with appropriate feelings (Papajohn, 1982). Cognitive change in therapy supports other behavioral change (Morris, Alexander & Waldron, 1988). Cognitive strategies include: relabeling negative attributions, getting rid of unrealistic expectations, and helping to create realistic positive expectations of change. Empirical support is lacking for cognitive strategies in family settings and reliable measurement is difficult (Falloon & Lillie, 1988).

Many techniques have been developed to use in the

practice of behavior and cognitive behavior therapy. Techniques are chosen according to the specific goals and treatment focus of each client. Some primary behavior techniques will be discussed here, as a complete discussion of techniques would be lengthy. Techniques are used for three therapeutic purposes: increasing adaptive behaviors, decreasing maladaptive behaviors, or learning new behaviors. Therapeutic goals may involve all of these aspects.

A variety of techniques are used to learn or increase adaptive behaviors. Examples of these techniques include: social skills training (Corey, 1986), relaxation training, cognitive restructuring, and self-management (Corey, 1986; Cormier & Cormier, 1985). Several techniques will be described to clarify the behavioral style.

Assertiveness training is often used in behavior therapy (Corey, 1986; Papajohn, 1982; Rimm & Masters, 1974). Behavioral rehearsal is the basis of assertiveness training. The therapist models appropriate behavior and gives direct feedback to the client. By working on successive approximations toward behavioral goals, the client increases verbal and social skills.

Self-control is another technique of behavior therapy (Rimm & Masters, 1974). When a problem occurs, both internal and external stimuli are defined to clarify the individual's reponse. The connection is strengthened between specific stimuli and positive behaviors. Thoughts

preceding behavioral events are also addressed through similar procedures, called coverant control (Rimm & Masters, 1974).

Cognitive modeling is another alternative (Cormier & Cormier, 1985). The therapist models to the client what self-messages to use. The client's thought process is targeted, and therapy involves the practice of specific positive cognitions and self-messages to result in change in cognitions.

Cognitive restructuring is another alternative. Cognitive restructuring is based on the concept that self-talk influences behavioral performance. Rather than use self-defeating self-talk, which affects emotions and behavioral performance in a negative way, positive self-talk is learned and practiced. Reframing, or altering irrational or negative beliefs, is often used at the same time (Cormier & Cormier, 1985).

There are also techniques that are used to decrease behaviors. Some of these techniques include: extinction, satiation, punishment, or time-out procedures (Rimm & Masters, 1974; Walsh, 1980). A variety of specific procedures are followed to result in lessening or termination of inappropriate behavioral responses.

Aversion techniques involve giving a negative response to the inappropriate response of the client. A shock or a bad smell may be used as an aversive stimulus. Covert

sensitization is a form of aversion therapy. Thoughts are changed by pairing the fantasizing of a problem behavior with a negative result (Mayer, 1988).

Flooding is another technique. The process of flooding involves exposing an individual to imagined phobic situations. Through long exposures to high anxiety situations, extinction of the inappropriate behavior occurs (Papajohn, 1982; Rimm & Masters, 1974).

Systematic desensitization is often used to reduce the frequency of avoidance behaviors (Berkowitz, 1982; Corey, 1986; Cormier & Cormier, 1985; Papajohn, 1982; Renvoize, 1982; Rimm & Masters, 1974; Walsh, 1980). Systematic desensitization makes use of the principle of reciprocal inhibition, where an individual can not experience two competing responses at one time (Mayer, 1988). Through a process of pairing relaxation with a hierarchy of anxiety provoking events, avoidance behavior of anxiety producing situations is lessened (Mayer, 1988). Systematic desensitization can also be used with thoughts (Papajohn, 1982).

Emotive imagery is similar to systematic desensitization in that it also focuses on pairing two competing responses. However, this technique involves use of cognitive processes. The initial step prior to using this technique is assessing clients to assure that they are able to fantasize. The focus is to think of positive thoughts or

images while imagining the anxiety of negative situations. Covert modeling is also used, where the client imagines someone modeling appropriate behavior (Cormier & Cormier, 1985).

Thought-stopping is a cognitive alternative used to stop or disrupt a negative thought cycle (Corey, 1986; Cormier & Cormier, 1985). The client practices interrupting negative thoughts by saying "stop" within the thought process. Clients practice thought-stopping to be able to use this naturally within their thought process.

There are several techniques that are part of all behavioral approaches. Modeling is integrated into many behavioral approaches (Corey, 1986). Appropriate behavior is learned by exposing the client to live or representative situations. Alternative behaviors are learned that are incompatible with problem behaviors (Cormier & Cormier, 1985; Rimm & Masters, 1974), as both behaviors can not occur at the same time.

Behavioral rehearsal is often used (Corey, 1986; Rimm & Masters, 1974). The therapist sets up situations where the client can practice new or alternate behaviors. The therapist reinforces positive attempts or approximations toward the goal behavior. Behavioral rehearsal is used both in and out of session and has been used with physical behavior, thoughts and feelings.

A variety of other tools may be part of behavior

therapy. Contracts and homework assignments are often used. Coaching may be used (Corey, 1986). Also, as clients are actively involved in therapy, part of the client role may be keeping a log to document change (Cormier & Cormier, 1985).

Behavior theory can be summarized as focusing on specific behaviors of individuals. The therapist and client work together to establish goals for behavioral change to address in therapy. From a wide array of behavioral techniques, the therapist chooses specific techniques that assist the client in moving toward the desired behavioral change. The process of therapy assists the individual toward a goal of lessening inappropriate behavior, increasing appropriate responding, or learning new and more positive skills. Specific data are received from the client's manner of following through with techniques, and these data clarify movement or lack of movement toward behavioral change. Systematic observation, research, and accountability are primary aspects of this approach. Behavior therapy has been used in a variety of counseling formats and in various applications (Corey, 1986).

From describing systemic and behavior theories, several similarities and differences are apparent. Both theories are similar in their use of a variety of techniques, focus on present behavioral change rather than insight, and use of feedback from clients. Differences in approach are also clear. Behavior theory works on linear behavioral change,

while systemic theory maintains a circular, interactional view of information processing and change. Behavior therapy is research based while systemic therapy is still developing ways of integrating research into therapeutic work. Also, behavior therapy works from a direct approach, whereas systemic theory may use paradoxical techniques to work toward the overall goal of change in the system. The following chapters will begin to clarify the benefit of using behavioral techniques in the systemic treatment of the incestuous family system.

CHAPTER III

CONCEPTUALIZATION OF INCEST

After defining both structural-strategic and behavioral theories, the current focus is on combining the two theories in the treatment of incest perpetrators. It is believed that integration of structural-strategic and behavioral concepts in treatment may result in a more effective manner of treatment with this group. The focus of this chapter is on the conceptualization of incest from both structural-strategic and behavioral perspectives. Prior to this discussion, incest must first be defined.

Definition of Incest

Before addressing incest treatment, it is first necessary to define incest. The definition of incest should be specific enough to aid in clarity of studies, but general enough to be able to describe the variety of situations that occur (Kempe & Kempe, 1984). A summary of meaningful aspects of incest definitions in current literature will be given. The clinical definition of sexual abuse as described by DePanfilis (1986) will be the basis of this compilation.

The first part of the incest definition is a description of the sexually abusive behavior (DePanfilis, 1986). Erotic action can be verbal, such as use of

suggestive language (Gallmeier & Bonner, 1987; Meiselman, 1979; Oaks & Anspaugh, 1987; Vander Mey & Neff, 1982). Nonverbal or physical actions are described most often (Alexander, 1985; DePanfilis, 1986; England & Thompson, 1988; Gallmeier & Bonner, 1987; Kempe & Kempe, 1984; Lanyon, 1986; Meiselman, 1979; Oaks & Anspaugh, 1987; Renvoize, 1982; Sgroi, 1982; Vander Mey & Neff, 1982). Visual depictions of any of these acts may also be described as sexually abusive behavior. The behavior described may be done to the victim or the perpetrator may instigate his or another person's stimulation from the child victim (DePanfilis, 1986; Vander Mey & Neff, 1982). The behavior may be an attempted or completed behavior, not only a fantasy (Meiselman, 1979). Any unwanted sexual activity is seen as abusive behavior (Salter, 1988) and is not restricted to sexual intercourse because of the physical limitations of younger children (Finkelhor, 1979 cited in England & Thompson, 1988). The victim perceives the contact to be sexual and intense enough to cause disturbance then or at a later time (Renvoize, 1982).

- The second aspect of the definition involves the description of age and developmental stages of the individuals who are involved (DePanfilis, 1986). Most sources describe the incest relationship as occurring between an adult and child (DePanfilis, 1986; England & Thompson, 1988; Finkelhor, 1979 cited in England & Thompson,

1988; Kempe & Kempe, 1984; Mrazek, Lynch & Bentovim, 1981 cited in Kempe & Kempe, 1984; Mrazek & Mrazek, 1981 cited in Kempe & Kempe, 1984; National Center on Child Abuse and Neglect, 1980 cited in Vander Mey & Neff, 1982; Oaks & Anspaugh, 1987; Sgroi, 1982; Vander Mey & Neff, 1982). Incest occurs when the perpetrator is significantly older than the victim (DePanfilis, 1986; Vander Mey & Neff, 1982), or when an older person disregards the developmental needs of the younger person (Kempe & Kempe, 1984; Oaks & Anspaugh, 1987). An individual's inability to give informed consent for the sexual relationship is another aspect (Kempe & Kempe, 1984; Mayer, 1988; Renvoize, 1982).

The incest definition also includes the nature of the relationship of the people who are involved (DePanfilis, 1986). The classic definition of the incest relationship is a sexual relationship between blood relatives or family members (DePanfilis, 1986; Gallmeier & Bonner, 1987; Kempe & Kempe, 1984; Meiselman, 1978 cited in Vander Mey & Neff, 1982; Oaks & Anspaugh, 1987; Renvoize, 1982; Sgroi, 1982). To address more recent changes in family styles, the incest definition has been updated to include involvement of any parental figure or significant other within the child's psychosocial "family" (DePanfilis, 1986; Gallmeier & Bonner, 1987; Oaks & Anspaugh, 1987; Renvoize, 1982; Sgroi, 1982; Vander Mey & Neff, 1982). Within the family system, the relationship is seen as involving three people: two

participants and one non-participating parent (Renvoize, 1982).

The use of force or coercion may also be a part of the incest dynamic. Threat of harm is often used to start the incest behavior (DePanfilis, 1986). Although a perpetrator may use physical force (Mayer, 1988; Renvoize, 1982), sexual contact without physical force is still a dynamic of power of the perpetrator over the victim (Mayer, 1988). Persuasion, enticement, coercion or inducements may be a part of these interactions (DePanfilis, 1986; Renvoize, 1982).

The responses, reactions, and attitudes of the family about the incest is another part of the incest definition (DePanfilis, 1986). Although incest violates social taboos toward the roles of family members, each specific case must be viewed regarding individual responses of family members and their response as a group (Kempe & Kempe, 1984). Generally, it is believed that all nonparticipating members have some degree of awareness of incest. When confronted with the occurrence of incest, the family members' belief or denial adds to the family dynamics that increase or reduce the chance of reoccurrence.

The final piece of the clinical definition of incest involves cultural beliefs toward sexuality (DePanfilis, 1986; Mayer, 1985). There are several primary cultural aspects to consider. First, incest violates roles and rules within the family (Kempe & Kempe, 1984). Second, it is an

expression of sexual and social deviancy (VanderMey & Neff, 1982). Finally, incest goes against our society's belief that sexual abuse is harmful and it is therefore appropriate to intervene to protect the child victim and stop or punish the adult offender (Sgroi, 1982; Vander Mey & Neff, 1982). Also, the father's legitimate power over his children as a parent is sanctioned within American society, although incest is also seen as a misuse of this parental or adult power (Sgroi, 1982). However, within present literature, there is still dispute as to whether this should be defined as a mental illness, crime or a major symptom of dysfunctional family interaction (DePanfilis, 1986). Further confusion is raised as states vary on the legal definition of incest (Vander Mey & Neff, 1982) so that incest is often defined finally within the individual interpretation in the judicial system (DePanfilis, 1986). As cultural groups may differ on the importance put on the incest taboo, the general societal view must have precedence.

Within American society, several differences have been reported in sex roles and expectations of men and women. Males are socialized to initiate sexual interactions in an aggressive manner (Murnen, Perot & Byrne, 1989) and have been found to see more importance than women in relieving sexual tension, conquest, and sexual pleasure as reasons for sex (Leigh, 1989). A greater fear of rejection is part of

the male cultural role of initiating sexual activity (Leigh, 1989). A patriarchal family structure is generally seen, with fathers seen as having more power within the family system (Herman, 1981). Male socialization often lacks affectionate relating and child care involvement which can be barriers to empathy development and support incest behavior (Finkelhor, 1984 cited in Alter-Reid, Gibbs, Lachenmeyer, Sigal & Massoth, 1986; Herman, 1981). Sexualization of emotions and attraction to partners who are smaller, younger and less powerful are often supported. Male sexual socialization is seen as a causal factor regarding male sex offenders (Finkelhor, 1984 cited in Alter-Reid et al., 1986). Fantasizing about a variety of female subjects during masturbation beginning in adolescence can support lessening of the social taboo toward sexual involvement with children (Renvoize, 1982).

The traditional female role is one of a caretaker and nurturer, characterized by submissive, passive, and helpless behavior. Societal rules often define the woman as less powerful within the family relationship (Herman, 1981). The female is often seen as an inactive receiver of a male's sexual approaches (Murnen, Perot & Byrne, 1989). Societal rules often support keeping sexual experiences private and do not support her in communication regarding sexual relationships (Murnen, Perot & Byrne, 1989). Emotional closeness is felt as more important to women than to men

(Leigh, 1989). Societal views often see seductiveness and encouragement as aspects of the female if she is victimized by a male (Pierce & Pierce, 1985).

Present cultural aspects may add to the risk of the sexualization of children. Those aspects to be considered include: child pornography, untreated sexual abuse, increased divorce, remarriage and cohabitation, the societal response against sexual equality (Russell, 1986 cited in Courtois, 1988), acceptance of corporal punishment or other physical violence, and rigid sex-role stereotypes (Biller & Solomon, 1986). Some authors suggest a relationship among gender roles and other issues such as child sexual abuse, family violence and rape (O'Neil & Carroll, 1988). Social policies may also contribute to child sexual abuse (Conte, 1984), including the lack of effective legal follow-up in work with sexual offenders (Mayer, 1985).

In summary, DePanfilis (1986) describes five primary aspects to define the incest relationship. The incest definition includes: a description of the sexually abusive behavior, a description of the age and developmental stages of the individuals, the nature of the relationship of those involved, the response of the family to the incest, and cultural beliefs toward sexuality (DePanfilis, 1986). Initially, this definition of incest may seem somewhat general or simplistic. However, by using these five areas as a basis of examining and understanding each different

situation, a good basis for an understanding of incest is provided.

Structural-Strategic Conceptualization of Incest

Historically, incest has been viewed in several ways (Trepper & Barrett, 1986). The victim-perpetrator focus is often most common, looking at problems from a linear perspective. In this view, a deviant adult is seen as hurting an innocent victim. This view can be beneficial for several reasons. First, it supports the child's cognitive inability to make an informed decision about involvement in incest. The linear approach is also simple to understand. Finally, use of the victim-perpetrator view allows all the people involved to be psychologically distanced from the incest behavior.

The family systems approach is another theory that is well known in the treatment of incest. The family systems approach sees incest as the product, rather than the cause, of a problematic family system. Incest development and maintenance involves all family members. Integrating family systems theory and looking at aspects of the individuals involved will be used to have an awareness of both systemic and individual factors involved in the dynamics of an incest relationship.

Within the structural-strategic approach, incest has a meaning or function within the context of the family system. The meaning of the incest behavior is created from family

interaction patterns and is the basis for other new behavior sequences, leading to new meaning. All family behavior is seen as attempts to solve problems (Madanes, 1981). Incest is an ongoing process within the family, with the family system being both a product and producer of incest behavior.

Incest is described as a symptom of a dysfunctional family rather than resulting from an individual's psychopathology (Fowler, Burns & Roehl, 1983; Larson & Maddock, 1983; Reposa & Zuelzer, 1983). Incest involves the entire family, being described as "...the result of a complex system of interaction between spouses, parent and child, child and environment, parent and environment, and parent and society" (Justice & Justice, 1979 cited in Larson & Maddock, 1983, p. 165). Incest is a distortion of the sexual aspect of the family (Larson & Maddock, 1983, 1986).

Primary Concepts

There are several primary concepts when working with incest from a structural-strategic view. First, incest must be seen as a primary dysfunction of the system and, therefore, a primary focus of treatment within the family system. This does not negate other numerous problems that may be occurring within the family system, but incest should be identified and addressed as a primary focus (Trepper & Barrett, 1986).

A second systemic concept is circularity. Systemic therapy looks at how the circular reciprocal process within

the family creates and maintains behavior rather than linear causality (Larson & Maddock, 1986). Incest is viewed from an interactional perspective, where all individuals are seen as receiving some reward for incestuous behavior, especially to be able to ignore the incest taboo (Swan, 1985). An interactional, systemic view is used to conceptualize and address all aspects of the incestuous family system and is used even when working in individual therapy.

As stated previously, all systems are known to work toward a state of homeostasis. In a healthy system, homeostasis is dynamic and allows needed change within the family system. Within the incest family, homeostasis is a negative and destructive aspect of the family, with aspects of enmeshment being integral within the family system to allow incest to occur. The incest family focuses on interconnectedness and homeostasis as primary functions rather than allowing new information to affect systemic change. The family views family survival as more important than changing or stopping the incest relationship. The goal is for the system to be able to show maintenance while still being able to respond and adjust to new information that is introduced to the system (Alexander, 1985).

Information exchange is another concept linked with homeostasis. The incestuous family has little or no information exchange with the environment or among the different subsystems. Although some maintenance is needed

in the system, the incestuous system needs to evolve in response to information change (Alexander, 1985).

The incestuous family system also lacks negentropy. Negentropy is defined as organization and elaboration of structure and roles within a system (Alexander, 1985). Rather than responding to change by showing an elaboration of structure, the incest family shows a loss of organization. The goal is to increase negentropy, involving "differentiation and specialization of functions and roles within the family..." as well as increased internal exchange of information (Alexander, 1985, pp. 80-81).

A final systemic concept when dealing with the incestuous family system is the concept of vulnerability to incest (Trepper & Barrett, 1986) or pre-conditions to sexual abuse (Finkelhor, 1984 cited in Finkelhor, 1986). Rather than seeing certain personality factors or interactions as always resulting in incestuous behavior, a focus is on a variety of factors that could increase the system's vulnerability to incest. This concept fits within the basic systemic concepts of circular, rather than linear, interaction. A variety of factors that are assessed as part of incest vulnerability include the following: family of origin information of the mother and father, individual personality factors, family system factors, socio-environmental factors, precipitating factors, and family coping mechanisms (Trepper & Barrett, 1986). Both of these

models look at incest in a more complex manner by looking not only a systemic factors, but also at aspects of individual factors, larger systems including culture, internal inhibitors, and the individual's response to sexual abuse or incest. By adding these concepts to the systemic view described above, a more complete conceptualization of incest can be made to address a variety of situations.

Several primary concepts are used to conceptualize incest in systemic therapy, including: seeing incest as a primary treatment need, circular processing, homeostasis, information exchange, lack of negentropy, vulnerability and pre-conditions of incest. These concepts are an important basis to begin an understanding of incest within the structural-strategic perspective. By starting with these assumptions, a clear conceptual base is established to understand incest within the family system. The concepts are used as a basis for any therapeutic contact with the family.

Family System Factors

Several family system factors may contribute to a family's vulnerability toward incest. Family system factors include: family style, family structure, and communication patterns within the family. Each of these aspects will be described to clarify specific factors that could make a family more vulnerable to incest (Trepper & Barrett, 1986).

Family style.

There are several aspects of family style that are seen within families where incest occurs. The concepts of family style are based on Larson and Maddock's theory (1984 cited in Trepper & Barrett, 1986). Family styles are characterized by the following names: affection-seeking, pansexual, hostile-negative, and violent rape. A family with an affection-seeking style is characterized by seduction, exchange of affection, "object connection", and positive intent. The pansexual style shows oversexualizing, where a family seems closest through overt or symbolic sexualizing. The hostile-negative style is characterized by anger displacement, and a desire to hurt others. Anger and sexuality are paired in this style. Finally, a family with a violent rape style is characterized by violence, poor reality testing, and paranoia. Over 94% of families seen by professionals fit within the first two family styles described above (Trepper & Barrett, 1986). Family style is viewed to see how incest is used in the family, and an awareness of family style clarifies the meaning of incest within the family system.

Family structure.

Although multiple reasons contribute to incest within the family system, family structure strongly affects inception and maintenance of this problem. Therefore, working with the structure of the family system to eliminate

the system's need for the symptom of incest is an important aspect of treatment with the incest family (Alexander, 1985). Although all family members have important roles in improving family functioning, the offending parent has the ultimate responsibility for the inappropriate sexual behavior (Trepper & Barrett, 1986). Family structure is another aspect of family system factors that are viewed as part of incest vulnerability.

One aspect of family structure is shown by Olson's circumplex model (Olson, et al., 1982 cited in Trepper & Barrett, 1986). The focus is on the two interacting dimensions of adaptability and cohesion. Adaptability describes the degree of a system's adaptation to change and flexibility. Adaptability is seen on a continuum ranging from rigid to chaotic. Cohesion describes the degree of how parts of the system are separated or connected from each other. Cohesion is described on a continuum from enmeshment to disengagement. Those who are most vulnerable to incest are those who are characterized as rigid and enmeshed or chaotic and enmeshed. Families with these styles are generally isolated, suspicious of outsiders, and come together even more when feeling threatened (Trepper & Barrett, 1986).

Another aspect of assessing family structure is looking at the interactions among subsystems in incestuous family systems. Barrett and associates developed a manner of

conceptualizing incestuous family structures through years of work with incestuous families and based on structural family therapy. Incestuous family structures include: father executive, mother executive, third generation, chaotic, and estranged father structures (Trepper & Barrett, 1986).

In the father executive style, the father is in the executive subsystem along with the daughter as surrogate mother. The mother is physically or emotionally absent from the family, and the daughter takes over the mother's family responsibilities. Responsibilities for the daughter in this role include child care and emotional and sexual closeness with the father.

The next family style is mother executive. The mother is the only one in the executive subsystem, while the father or father-figure joins the sibling subsystem with the children. In his role, the father has little parental responsibilities and gets his needs met by a child, who is his generational peer in the skewed system. A daughter may be a co-executive in the system. The mother executive style is often seen in step-families or with boyfriends.

Third generation family style may also be present. In third generation structure, the mother is part of the third generation or grandparent subsystem. Her role varies from parenting the father in the executive generation or moving forcefully into the family. She is generally more distant

from the children. The father moves back and forth between the executive and sibling subsystem. The daughter also moves between subsystems, taking the role of the mother when she is gone, and moving back to the sibling subsystem when the mother returns.

Another family style is called a chaotic style. The system is characterized by having no executive subsystem with parents and children functioning on the same level. No one within the system sets rules or enforces boundaries. Most system members have immature emotional judgement, a lack of impulse control, and want immediate gratification. Within the chaotic sytem, incest appears to be "sibling" sexual exploration.

The last family style is characterized by the father being estranged from the family and is called the estranged father style. The mother is alone in the executive subsystem. Although the father is generally not part of the system, when he joins the system, it is at the level of the children in the sibling subsystem.

A structural analysis of incest behavior is another tool used to clarify structural aspects of the incest system. The structural analysis focuses on the differences among boundaries in the incestuous family system and systems where incest is not present. Incest is described as a complex combination of mutually influential variables, including: the family/society boundary, intergenerational

boundaries, interpersonal boundaries, and intrapsychic boundaries (Larson & Maddock, 1986). Each boundary will be described to clarify how it can affect incest occurrence.

The boundary between the family system and society is often rigid, with distancing between the two systems (Courtois, 1988; Imber-Black, 1988). Isolation is supported as the rigid boundary reduces information exchange between the family and society (Larson & Maddock, 1986; Vander Mey & Neff, 1982), increases enmeshment of family members (Larson & Maddock, 1983; Renvoize, 1982) and can enhance power distortion within the family (Sgroi, 1982). This self-perputuating cycle of isolation may lead to a lack of stimulation toward adaptive change, growth, support, or coping mechanisms (Beaver, 1976 cited in Sgroi, 1982).

The rigid family/society boundary also insulates and isolates the family system from social feedback that could influence behavior change within the family. Enmeshment is reinforced by the system's isolation from outside information. Reality-testing occurs only within the family, as any information exchange from outside the family is seen as threatening. Isolation can create a separate reality within the family with its own rules, family myths and secrets, which increases the risk of initiation and maintenance of incest (Courtois, 1988).

Fear of authority is characteristic of these families (Sgroi, 1982). Exploitive power is often used and the

incest family may perceive authority figures to be threatening and hostile and expect encounters to be oppositional. If family members cannot avoid these encounters, they will respond with denial, evasiveness, suspicion, hostility, and anxiety. Any attempt for an outside system to reach the family system must be indirect as direct approaches would fail (Alexander, 1985).

The rigid family/society boundary also enhances the family's isolation. Extreme social isolation or withdrawal from others is often seen in incestuous family systems (Alexander, 1985; Beaver, 1976 cited in Sgroi, 1982; De Panfilis, 1986; Larson & Maddock, 1983; Mayer, 1988; Oaks & Anspaugh, 1987; Renvoize, 1982; Salter, 1988; Sgroi, 1982). Isolation is supported through family interactions in several ways. First, powerful family members, often perpetrators, discourage contact with outside systems, preferring to be the only link with the outside world as this enhances their position of power (Sgroi, 1982). Threats may also be used to isolate family members. Physical isolation may also be present (Vander Mey & Neff, 1982). Isolation can lead to a dependency on family (Courtois, 1988; Renvoize, 1982). The family itself is seen as a break against outsiders (Larson & Maddock, 1983). The ongoing cycle of isolation leads to lack of stimulation and support, lack of adaptive change, and lessening of growth and coping mechanisms within the family system (Vander Mey &

Neff, 1982).

Intergenerational boundaries are often unclear in the incest family, and different styles of interaction can increase the risk. Abuse of power is described as part of incest dynamics (Oaks & Anspaugh, 1987; Sgroi, 1982) and is a primary treatment need. The parental and spousal power imbalance (O'Leary, 1990; Parker & Parker, 1986) leads to both inappropriate parental role structure and lack of clear set boundaries for the children regarding their roles (Larson & Maddock, 1986). Inappropriate intergenerational boundaries are shown also in incestuous contact between different generations of the nuclear or extended family. This is further confused by distortion of "erotic potential" of family members, such as fostering in-home but restraining out-of-home sexual behavior at the same time. The children's developmental needs and readiness are not considered by the parents in this manner (Larson & Maddock, 1986).

There is a general blurring of boundaries between adult and child subsystems. Family members are made to meet each others' needs regardless of age or developmental needs. All family members may experience role confusion and role exchange. Children do not receive nurturance that would assist in healthy development. "Parentified" children often show pseudo-mature behavior that they have learned within the family system. These behaviors help children to meet

the short term need of the family, but hurt them in the long term as they have learned to meet others' needs without having their own needs met. Children often maintain an incest/victim relationship as this is the only manner of relating which they have learned.

Role reversal is another problem with the inter-generational boundaries of the incest family (Alexander, 1985; Courtois, 1988; Larson & Maddock, 1983; Mayer, 1983; Oaks & Anspaugh, 1987; Renvoize, 1982; Salter, 1988; Sgroi, 1982; Vander Mey & Neff, 1982). Role reversal typically occurs between the mother and one or more of her children, serving a purpose for those involved (Alexander, 1985; Larson & Maddock, 1983). The mother may be physically or psychologically absent (Meiselman, 1979; Renvoize, 1982; Sgroi, 1982; Vander Mey & Neff, 1982), may relieve herself of an unwanted sexual relationship with the father (Renvoize, 1982), or may relinquish her parental or spousal responsibility to meet her own needs (Courtois, 1988; Frances & Frances, 1976 cited in Vander Mey & Neff, 1982; Renvoize, 1982). In either way, the mother encourages or colludes with the role reversal in some manner as she is primary in stopping the incest behavior (Meiselman, 1979; Renvoize, 1982; Sgroi, 1982).

Role reversal also satifies some needs for the child (Kempe & Kempe, 1984; Meiselman, 1979; Swan, 1985). Reinforcement for role reversal includes assuring the child

her family role, receiving parental attention, intimacy, power, or other favors. Some of the child's behaviors, such as natural sexual exploration or acting out, are changed through learning to fit her role as the father's sexual partner (Larson & Maddock, 1983). The child learns a variety of behaviors from her parents, including sexual behaviors, which are reinforced in overt or covert manners by all family members. The child also feels a form of intimacy in the incest relationship which, although inappropriate, helps to meet some of her needs and may be the only form of intimacy that she knows.

The interpersonal boundaries of the incestuous family are generally enmeshed (Alexander, 1985; Larson & Maddock, 1983; Mayer, 1985, 1988; Renvoize, 1982). Several different dynamics are aspects of enmeshment. Enmeshment is a lack of independence, privacy or separation with regards to property, thoughts, personal space, and feelings, leading to a perception of mutual dependence and secrecy (Alexander, 1985; Sgroi, 1982). In families with incest, the lack of limits and privacy also crosses over to the inability of individuals to set a limit regarding the privacy of their bodies (Sgroi, 1982). Blurred boundaries within the family add to enmeshment (Alexander, 1985; Larson & Maddock, 1983; Mayer, 1988; Renvoize, 1982). In incest families, a higher degree of overinvolvement was found between fathers and daughters and underinvolvement was found between mothers and

daughters (Serrano, Zuelzer, Howe & Reposa, 1979 cited in Reposa & Zuelzer, 1983). Although seeming close in some ways, family members actually know very little about each other (Alexander, 1985). Fathers may be socially distant while sexually familiar with their daughters (Weinberg, 1955 cited in Vander Mey & Neff, 1982). The family rule of extreme and pervasive closeness supports the lack of sexual limits within the family (Alexander, 1985). Family enmeshment and community isolation becomes an ongoing cyclical process of isolation, with the family becoming dependent upon itself to meet all individual's needs (Courtois, 1988).

Lack of established limits is shown by blurred boundaries, crossing of intergenerational boundaries, role reversal, and enmeshment. Adults and other family members do not set clear, consistent generation and role boundaries. Individual roles tend to be defined differently than the societal norm, as parents involve the children in meeting their adult needs, including sexual relationships (Courtois, 1988). The incest relationship involves role confusion by definition, with family interactions inappropriately continuing in a self-reinforcing pattern (Sgroi, 1982). Within the family, each member has a specific role. The roles feel extremely important to each member and are vital to the survival of the family. Renvoize (1982) states that "...the demands of the roles to be played may be satisfying

to the extent that they set boundaries within which the players can live and survive without rocking the stability of the family as a unit" (Renvoize, 1982, p. 103). Family stability is seen as more important than individual needs (Renvoize, 1982).

The family also tends to define roles of family members differently than other families. Low parental self-esteem and lack of support of the parents on an adult level creates a situation where the parents involve their children to meet each of their needs as adults. The stability of the family as a unit becomes even more important because of this, as losing one member of the family from the system creates a hole which other pieces of the system can not replace. Family members (especially adults) are also seen as unable to set clear, consistent generational and role boundaries.

Another focus is the lack of limit-setting and inadequate controls within the family. There is a lack of clear rules and limits or expectations within the family. Only powerful individuals in the family system can set limits, which generally excludes the child from setting family limits (Sgroi, 1982). Family rules and expectations may also be quite rigid, and often form a separate reality within the family (Larson & Maddock, 1986; Renvoize, 1982).

Personal boundaries are also affected. Within the incest family, personal boundaries are diffuse. Relationships within the family are characterized as symbiotic,

where family members feel dependent upon the others for survival. Differentiation or independence from others at any level is felt as disloyalty. Enmeshment is often present, characterized by lack of growth and lack of information exchange. Enmeshed interaction is supported by the rigid family/society boundary and the lack of personal role boundaries. Although enmeshment initially appears to show much involvement between family members, there is still a lack of internal information exchange, privacy, and little respect for personal space (Alexander, 1985).

A secondary part of personal boundaries is the fear of abandonment that may arise when an individual may attempt to differentiate from others. An example of this would be if one member of the system would try to disclose information about the incest relationship to someone outside of the family system. This fear of abandonment may lead to defense mechanisms, low self-esteem, shame, and double-bind interactions. All interactions within the family system show support only for behaviors that maintain the negative patterns of homeostasis within the system (Alexander, 1985).

Abuse of power is often seen in the incest family (Oaks & Anspaugh, 1987; Sgroi, 1982). Incest itself is an abuse of power where a more powerful family member crosses the personal boundary of a less powerful member. Since incest and other family interactions involve an imbalance of power in the system, this should be addressed as a primary

treatment need (Sgroi, 1982).

The final structural aspect to be discussed is the intrapsychic boundaries of the family members. An important aspect of intrapsychic boundaries are parts of the personality structure. Individuals within the incestuous family system rely primarily on defense mechanisms. As many parents involved in incestuous family systems have come from backgrounds of abuse or incest, they may have also experienced a lack of nurturance. The lack of nurturance would be noted through the parents' attempts to meet their needs through their children.

Faulty thinking is a coping skill often used by the incest family (Mayer, 1983; Sgroi, 1982). There are several styles of faulty thinking, including denial, rationalization, and magical expectations. All family members have some awareness of the abuse, with collusion shown by those who have awareness of abuse without stopping this behavior (DePanfilis, 1986; Larson & Maddock, 1983). Looking at family culture and rules established within the family may clarify unusual tolerance of sexual activity and minimal privacy, where the meaning of incest may be diluted (Meiselman, 1979).

Denial is integral to the incest family system (Mayer, 1983; Sgroi, 1982). Denial is used to address problematic aspects of the family's functioning, such as sexual abuse, abuse of power, problems of isolation, and blurred role

boundaries (Sgroi, 1982). Denial occurs on several levels within the family. Parents often use denial and rationalization regarding the blurred generational boundaries and abuse in their families. They rationalize using their children to meet their own needs both emotionally and physically, as well as rationalizing that sexual abuse teaches the child about adult sexuality (Larson & Maddock, 1983). Another aspect of denial involves collusion of the non-abusing parent and other family members who are aware of the abuse but do nothing to stop it (DePanfilis, 1986; Larson & Maddock, 1983). Denial may be motivated by several factors, including fear that the family will break up if the incest is acknowledged by others, loss of reputation, loss of financial support, a feeling of recrimination within the home and the possibility of a prison sentence (DePanfilis, 1986). Denial is used as an aspect of coping within the family, as well as another expression of secrecy regarding the abuse (Sgroi, 1982). All of these possible consequences may add support to the denial of problems such as sexual abuse within the family.

Rationalization is also used (Larson & Maddock, 1983; Swan, 1985). As the family may develop their own culture of attitudes and behaviors, individuals may rationalize their behavior within the family culture. Faulty beliefs from the parents' families of origin may be part of this style of thinking.

Magical expectations are another aspect of the thoughts and coping skills of the incestuous family system (Sgroi, 1982). Magical expectations are shown in a pattern of choosing inappropriate ways to meet needs, leading to failure. As family members do not know how or have the skills to get their needs met in more successful ways, they may hold beliefs of magical solutions. Faulty thinking must be challenged within the family, as well as helping the family members to learn more positive alternative behaviors.

Communication styles.

Styles of family communication are also an important aspect of conceptualization of the incest family. Several types of communication are characteristic of the incest family. Although basic communication is present, the family's communication tends to involve conflicting and dysfunctional patterns. Communication generally involves conflict-avoidance, hostility, double-binds, and secretive styles (Alexander, 1985; Mayer, 1983; Renvoize, 1982; Sgroi, 1982). Just as there is a lack of information exchange between the incest family and outside systems, there is little direct communication among family members (Alexander, 1985). Communication is limited by avoidance behaviors (Renvoize, 1982; Sgroi, 1982), lack of sexual or other knowledge (Larson & Maddock, 1986), lack of empathy, and inability to be aware of and express feelings (Sgroi, 1982). Often, dysfunctional communication patterns that begin

between parents begin to permeate communication with the children in the family (Trepper & Barrett, 1986).

In summary, there are many structural aspects to be considered when working with an incestuous family system. The family is generally isolated from other systems, with minimal clarification of family roles and subsystem functions. There is an extreme emphasis on homeostasis within the system. There is a general lack of clear communication, and inappropriate crossing of generational boundaries and subsystem interaction. The focus is on changing family structure to eliminate the function of incest within the family system (Alexander, 1985).

Incest Vulnerability

Another aspect to be addressed while conceptualizing incest is incest vulnerability. Several different characteristics affect whether a family system is more or less vulnerable to incest. The different areas to be discussed include: parental family of origin, individual personality factors, environmental aspects, precipitating factors, and lack of coping mechanisms.

Family of origin.

The first aspect of incest vulnerability is looking at historical aspects that could affect vulnerability in the present. Looking at the family of origin of both parents may clarify some parenting styles and family norms that they learned in their own families. Aspects to be considered

include: presence of physical, sexual, or emotional abuse, abuse of power, expression of conditional love, and expression of sex or intimacy. Again, the focus is on patterns of behavior learned within the family of origin, but which do not cause incest in the next generation in a linear manner.

Extreme emotional deprivation and neediness is often an aspect of family dynamics (Courtois, 1988), based in the parents' past experiences of emotional abandonment, neglect, physical abandonment (Renvoize, 1982; Sgroi, 1982), or victimization (Mayer, 1983). Both parents may have experienced sexual abuse. Parental style often involves exaggerated dependency needs, low self-esteem (Larson & Maddock, 1983, 1986; Mayer, 1983), a shame-based view of self (Larson & Maddock, 1986) and includes a pattern of failure or dysfunctional attempts to meet needs (Sgroi, 1982). Both the adults and children in these families want and need nurturance and comfort (Renvoize, 1982). This style also encourages lack of development of empathy as individuals do not have their own needs met and have not learned how to empathize with others (Sgroi, 1982).

The perpetrator's family of origin often included physical abuse or neglect (Fowler, Burns & Roehl, 1983; Maltz & Holman, 1987; Mayer, 1985, 1988; Renvoize, 1982), emotional abuse (Maltz & Holman, 1987; Renvoize, 1982) and emotional or parental deprivation (Meiselman, 1979; Parker &

Parker, 1986). Parents are described as dominant (Oaks & Anspaugh, 1987), punitive, and distant (Maltz & Holman, 1987). The relationship of the perpetrator and his father may be nonexistent or quite poor, with the perpetrator often feeling hatred, fear, and admiration for his father (Meiselman, 1979).

The absence of a parental figure in the perpetrator's family of origin may enable the perpetrator to avoid internalization of the incest taboo (Riemer, 1940 cited in Meiselman, 1979). A correlation has been described between the quality of the perpetrating father's attachments with his family of origin and the age that he would initiate incest with his own daughter. The healthier his own relationship is with his family of origin, the older his daughter would be when the incest originated (Meiselman, 1979). Parker and Parker (1986) report most abusers were not involved with child care, nurturant tasks or were not often home within their child's early years. Early involvement and development of a parent-child relationship has been found to decrease risk of sexual abuse as the father is more likely to see his child as a daughter rather than a sexual partner (Kempe & Kempe, 1984). This relationship is also supported by other work on how infant-caregiver relationships affect behavior (Biller & Solomon, 1986).

Incest offenders often are victims of sexual abuse

(Fowler, Burns & Roehl, 1983; Groth, 1982; Lanyon, 1986; Maltz & Holman, 1987; Mayer, 1985, 1988; Renvoize, 1982; Sgroi, 1982; Taylor, 1986). Child sexual abuse is reported in 36% to 75% of sexual offenders (Foster, 1981 cited in Mayer, 1988). Some sources report that childhood sexual victimization increases the risk that an individual will later be a perpetrator of a sexual offense (England & Thompson, 1988; Sgroi, 1982; Taylor, 1986). The offender may experience many feelings from his abusive background, such as fear, guilt, anger, pain, and excitement. Internalization of these feelings, lack of nurturance, and few chances to deal with the incest experience may lead to identification with abusive behavior (Taylor, 1986). This background of sexual abuse adds a developmental component to the problem (Lanyon, 1986). The perpetrator functions as a needy child, which helps him to conceive of and follow through with incestuous impulses (Taylor, 1986).

The perpetrator's style of anger expression is learned and affected by his family of origin. Feelings of anger are often repressed, and the perpetrator may show displaced anger by identifying with the aggressor from past abusive relationships (Mayer, 1988). The parents of incest offenders often have an authoritarian style which supports suppression of anger and aggression (Bach & Goldenberg, 1975 cited in Mayer, 1988; Miller, 1983 cited in Mayer, 1988). Many incest perpetrators have experienced "double-bind

parenting", as described in the work of Bateson, Jackson, Haley, and Weakland (1956). By simultaneously receiving two opposing messages regarding appropriateness or acceptance of behaviors and emotions, the perpetrator experiences increased confusion of how to express and experience anger in an appropriate manner (Mayer, 1988).

Individual personality factors.

Individual personality factors are another area to be investigated when assessing a family system's vulnerability toward incest (Trepper & Barrett, 1986). As stated previously, different family and individual characteristics may increase the risk of sexual abuse within the system. Individual characteristics are not seen as the cause of incestuous behavior, but are part of the entire equation of systemic, family, and individual factors that may increase the risk of incestuous behavior. Individual personality factors that may affect incest vulnerability will be discussed for the perpetrator, mother, and child.

The perpetrator often lacks communication skills (Mayer, 1985, 1988; Taylor, 1986). He often has problems expressing feelings, as the perpetrator often lacks an understanding of his feelings and has not learned how to express feelings through words or age-appropriate behaviors (Annis, 1982; Taylor, 1986). As he is unable to understand his feelings or needs, the perpetrator does not have the means to gain satisfaction of needs, moving instead toward

use of anger, substance abuse, and inappropriate manners of interacting with other family members.

Much of what the perpetrator knows and experiences deals with feelings of anger. Anger may be part of the perpetrator's commission of sexual offenses, where anger is displaced onto sex, sex is substituted for anger, or anger is expressed in a sexualized manner (Taylor, 1986). The tie between anger and sex is strengthened because of the physiological similarity between sexual arousal and anger (Kinsey, 1953 cited in Mayer, 1988). The offender often does not feel control when expressing anger, nor has he learned to vent anger in positive or acceptable ways (Mayer, 1985; Taylor, 1986). The perpetrator may express anger in an explosive manner, or through antisocial behaviors (Mayer, 1988). Although anger may give the perpetrator feelings of power or control, it often masks other feelings, such as guilt, anxiety, or fear. Suppression of anger may lead to overt forms of rage, suicidal ideation, displacement, projection, or passive-aggressive behaviors. These behaviors help the perpetrator to avoid self-examination and allow him to remain distanced from responsibility for his feelings or actions. Perpetrators may show passive-aggressive, regressive, or defensive reactions of anger (Mayer, 1985, 1988). Anger should be kept in mind as a motivator for the perpetrator to be involved in incestuous behavior and should not be minimized.

The perpetrator lacks knowledge regarding interpersonal skills. Overholser and Beck (1986) report that child molesters are less assertive and less skilled in social behavior and conversational skills. The same group showed significantly higher fear of negative evaluation and were more conservative in sex-role stereotyping than control groups (Overholser & Beck, 1986). Lack of appropriate socialization may leave the perpetrator with little knowledge of or commitment to interpersonal relationships (Annis, 1982; Mayer, 1988), no skills or confidence in relating to adult women (Fowler, Burns & Roehl, 1983) and fear of rejection (Annis, 1982). He lacks the skills to relate intimately with another individual and does not trust others (Annis, 1982; Mayer, 1988). He tends to objectify others, relating only on superficial levels, and lacks empathic responding to others (Taylor, 1986). If the perpetrator lacks understanding of interpersonal relations, he often does not get his emotional needs met through nonphysical needs (Oaks & Anspaugh, 1987).

The perpetrator often lacks problem-solving skills and skills of conflict resolution (Maltz & Holman, 1987; Mayer, 1988; Taylor, 1986). He may be unable to identify problems to share with another adult, which continues a pattern of emotional isolation. He may try to avoid or overpower problems instead of addressing them directly, which often results in more feelings of stress, frustration, anger, and

powerlessness (Taylor, 1986).

The perpetrator tends to have a negative self-concept. Past abuse experiences may lead to low self-esteem (Annis, 1982; Fowler, Burns & Roehl, 1983; Maltz & Holman, 1987; Mayer, 1988; Patterson, 1988; Renvoize, 1982). He may experience feelings of emotional isolation and have few peer friends (Groth, 1982; Maltz & Holman, 1987; Mayer, 1985; Renvoize, 1982; Taylor, 1986). Maltz and Holman (1987) report that a perpetrator may experience feelings of chronic resentment, and seek self-punishment through hostile responses and rejection.

The incest perpetrator often grows up with little knowledge of sex or sexuality (Mayer, 1988). Lack of knowledge of sexual relationships may contribute to incestuous behavior. If he experienced molestation in his past, the experience may also skew his understanding of sexual and other intimate relating. He may desire intimate relationships with a sexual release, but his insecurity with adult peers may effectively keep him from creating a positive, intimate sexual relationship (Taylor, 1986). He also may sexualize relationships and hold rigid sex-role stereotypes (Mayer, 1988; Overholser & Beck, 1986).

The perpetrator seeks and abuses power within the family system (Alter-Reid, et al., 1986). He may have an authoritarian style (Maisch, 1973 cited in O'Leary, 1990; Maltz & Holman, 1987; Meiselman, 1979; Oaks & Anspaugh,

1987). He often controls other family members through isolation (Maltz & Holman, 1987), discipline, or violence (Maltz & Holman, 1987; Mayer, 1988; Meiselman, 1979; O'Leary, 1990; Renvoize, 1982). The perpetrator may also gain power by acting needy or helpless (Maltz & Holman, 1987). He may be highly dominant in his own home, while appearing to be a mild, weak, or likable person in other situations (Fowler, Burns & Roehl, 1983; O'Leary, 1990; Renvoize, 1982; Sgroi, 1982).

The role of sex in the incest relationship can have a variety of meanings for the abuser, although it often is not motivated primarily by sexual desire (Groth, 1982; Renvoize, 1982; Sgroi, 1982). The sexual relationship often serves as an attempt to fulfill other needs for the perpetrator. He may attempt to meet emotional and self-esteem needs (Groth, 1982; Maltz & Holman, 1987) or needs of closeness, validation, affiliation, or power (Groth, 1982). The perpetrator may express feelings of anger, powerlessness, and frustration through this relationship (Annis, 1982; Renvoize, 1982). The primary sexual orientation of the incest offender is generally toward adult women, with the child being used as a substitute when other relationships are blocked (Mayer, 1988).

The perpetrator has often been described as having an external locus of control (Groth, 1982). Past abuse experiences teach the offender non-assertive responding or

feelings of helplessness (Annis, 1982). As an adult, the offender may take little or no responsibility for himself, instead believing that outside forces make him do bad things (Renvoize, 1982). The offender's denial and lack of remorse or guilt for antisocial behavior all support his lack of taking responsibility or seeing any ability to control his actions (Fowler, Burns & Roehl, 1983; Mayer, 1988).

Patterns of compulsive behavior are often found with this population. Examples of this include addictive or dependent behavior, such as incest behavior (Mayer, 1985; Renvoize, 1982), workaholic behavior (Mayer 1988), and abuse of drugs or alcohol (Annis, 1982; DePanfilis, 1986; Lanyon, 1986; Maltz & Holman, 1987; Mayer, 1985, 1988; Meiselman, 1979; Oaks & Anspaugh, 1987; Parker & Parker, 1986; Renvoize, 1982; Salter, 1988; Sgroi, 1982; Weinberg, 1955 cited in Vander Mey & Neff, 1982). Chemical abuse lowers inhibitions, impairs decision-making, and reduces self-control or inhibitions, all of which can contribute to the risk of initial incest occurrence (Maltz & Holman, 1987; Meiselman, 1979; Renvoize, 1982). Incest behavior is also seen as addictive, with the dynamics of the incest relationship fitting within the perpetrator's pattern of compulsive behavior (Taylor, 1986).

In summary, there are many varied characteristics that may describe the incest perpetrator. Although not necessarily present, they are factors possibly contributing

to the risk of incest and which describe some perpetrators in some circumstances (Oaks & Anspaugh, 1987; Trepper & Barrett, 1986). Behaviors of the perpetrator may be quite varied, and the perpetrator may appear to function well in other areas while experiencing deviant sexual behaviors or relationship problems (Gallmeier & Bonner, 1987; Lanyon, 1986). It is important to remember that although early experiences may be different for an offender, a variety of circumstances plus his own response affect whether he makes the relationship with his children a sexual one (Kempe & Kempe, 1984). His response, as well as the response of his daughter and other family members, affects whether incest occurs.

The reponse of the non-perpetrating parent is also primary in the outcome of the situation. In father-daughter incest, the mother is often absent in a physical or psychological manner (Meiselman, 1979; Renvoize, 1982; Sgroi, 1982; Vander Mey & Neff, 1982). She may be absent, oblivious, or collusive (Vander Mey & Neff, 1982). The mother generally has some awareness of abuse occurence and she may deliberately set up abuse situations (Sgroi, 1982) or see incest as normal if she herself grew up with sexual encounters in her family (Renvoize, 1982; Vander Mey & Neff, 1982). The mother often uses denial to avoid cognitive dissonance as she could have an effect on stopping the incest behavior (Meiselman, 1979; Renvoize, 1982; Sgroi,

1982). Denial helps her to ignore her responsibility in the situation.

Another aspect of the mother's dynamics is her passive or complementary behavior to the perpetrator (Meiselman, 1979; Parker & Parker, 1986; Sgroi, 1982). The mother may have some problems with self-esteem, dependency, and passivity (Trepper & Barrett, 1986). She often has a history of emotional deprivation (Meiselman, 1979; Renvoize, 1982). Within her family of origin, the mother may not have learned the incest taboo or the maternal role (Meiselman, 1979). She also has many feelings of wanting to be mothered herself (Renvoize, 1982), allowing her daughter to assume the role of "wife" and "mother" in the family (Meiselman, 1979). The mother's role may become more of a sibling relationship with the children, or she may be alone in the executive subsystem.

Within the incestuous family system, the child learns sexual behavior from interaction with the adult perpetrator (England & Thompson, 1988; Mayer, 1985). The child may encourage or willingly participate because of a reward within the family system (Swan, 1985). The child's reaction can affect whether incest will occur and should be considered as part of the system's vulnerability toward incest (Finkelhor, 1986). Dependency and passive behavior have been found with some incest victims (Finkelhor, 1986; Maisch, 1972 cited in Vander Mey & Neff, 1982; Meiselman,

1979; Trepper & Barrett, 1986). The child may show some degree of passivity prior to incest, but this is generally strengthened through the incest relationship. The child's involvement in incest or pseudo-mature behavior shows learned behavior, as well as meeting some needs of the child. The daughter may exhibit extreme behaviors, sacrificing herself to fit the negative homeostasis of the family system (Alexander, 1985). In the family system, the child is triangulated into the problematic relationship of the parents. A child's problems are seen in systems therapy as a result of some incongruity in the organization of the hierarchy of the family. The two parents of the same level of the hierarchy draw in the child, then creating the incest relationship that includes the offender and child, excluding the non-offending parent. The child may show symptoms to protect the parents, metaphorically expressing the parents' difficulties while gaining interpersonal benefits within the system. When disclosure of the incest occurs, the victim may be blamed and possibly rejected from the family system to try to maintain homeostasis (Sgroi, 1982).

The child also may receive rewards from this incestuous relationship (Meiselman, 1979; Swan, 1985). Parental attention may be attractive when not received in other manners. The child also receives power in the family system from the incest relationship. Although children may seek out power when parents do not maintain the marital power

hierarchy, the offender gives extra power to the child through the incest relationship, where the child often receives special favors. As children also look for love, acceptance or nurturing in ways that they are taught, they may initiate or more actively take part in incest to meet their needs or to fulfill the family role that they have been taught (Larson & Maddock, 1983). In this way, their natural sexual exploration and acting out are changed to fit the perpetrator's or family's needs instead (Sgroi, 1982).

The daughter may show pseudomaturity in a variety of ways, including: open expression of sexuality, awareness or development in sexual areas, promiscuity, attention-seeking behaviors, and seductiveness. She may receive privileges as a result of this behavior. Although she may assume some aspects of the parental subsystem, she has not yet reached the appropriate developmental stage. Also, she is in a position where, rather than destroy the entire family, she may become the identified patient or scapegoat, possibly even being sacrificed to keep the remainder of the family intact and trying to return to homeostasis (Renvoize, 1982).

Environmental aspects.

Environmental aspects are also considered in the vulnerability equation. Chronic stress is often a part of system dynamics. Several environmental aspects may also affect opportunity. Opportunity may be increased by the non-offending parent not being psychologically or physically

present, sharing sleeping quarters, etc. Cultural and community tolerance, as described earlier in the incest definition, may also be an aspect of environmental vulnerability.

Cultural factors are another aspect of this system affecting incest (Mayer, 1985). These include several societal misconceptions: society's focus on sex as important, dynamics of power and control, and few socially acceptable outlets for showing anger are all parts of this. Changes of society in recent years to less of a family-rooted focus, more divorce, permissiveness when bringing up children, and seeing children as possessions of adults have all left the situation open for supporting this incestuous behavior. The lack of effective follow-up by the legal system in working successfully with offenders compounds this societal problem.

Precipitating factors.

Another aspect of incest vulnerability is looking at precipitating factors within the family system. Family members may abuse alcohol or drugs, and substance abuse has often been one of the precipitating events leading to the initial instance of sexual abuse. The non-offending parent's absence may be another occurrence prior to incest. A major acute stressor may also occur that may increase the likelihood of initiation of an incest relationship (Trepper & Barrett, 1986).

Lack of coping mechanisms.

The incestuous family system is also characterized by a general lack of coping mechanisms. It is believed that if a family has a variety of supports, there is less vulnerability toward incest. Coping mechanisms may include: extended family, religious beliefs and involvement, problem-solving skills, social networks, and past therapy experiences. As the system's degree of coping skills lessens, vulnerability to incest may increase (Trepper & Barrett, 1986).

In summary, the structural-strategic view of incest focuses on the circular, interactive aspects of the individual family members, subsystems, family system, and larger systems outside of the family. Although the interactions of the entire family affect initiation and maintenance of the incest relationship, the primary responsibility is with the perpetrator. The structure of the family system is changed to no longer allow or support incestuous behavior. This is done by increasing functional communication and teaching additional skills so that individual family members may learn more positive alternative behaviors (Barrett, Sykes, & Byrnes, 1986). Vulnerability factors are not seen as providing motivation or willingness to offend, but increase the opportunity for incest occurence. One must look at individual, family, and environmental, or larger systems factors to get a complete

overview of interactions that may increase risk of incestuous behavior (Trepper & Barrett, 1986). Specific therapeutic work should, therefore, address all of the parts described above to be able to move toward systemic change. Specific structural-strategic techniques, as described previously, are chosen by the therapist to affect this systemic change.

Behavioral Conceptualization of Incest

The next area of discussion is conceptualization of incest from the behavioral perspective. Behavioral theory may be used to change behavior in a variety of applications. Although behavioral work has been recorded for use with sexual deviations, there is less material available regarding behavioral work with the incest offender. However, basic behavioral concepts may be easily applied to incestuous behavior. Also, the variety of specialized behavioral techniques may be used to change incestuous behavioral patterns.

From a behavioral perspective, incest is defined as difficulties in interpersonal relationships seen due to behavioral deficits and overlearned maladaptive behaviors (Annis, 1982). Behavior therapy conceptualizes sexual deviations as "...bad habits resulting from skill deficits" (Marshall, Earls, Segal & Darke, 1983, p. 169). Although there are innate aspects of sexual arousal, behavior therapy states that one can learn and unlearn arousal to stimuli

that were initially neutral (Rimm & Masters, 1974).

Past work with sex offenders has often been from a behavioral perspective, using techniques based on learning theory. This approach focuses on lessening deviant arousal patterns while developing or increasing socially appropriate behaviors, thoughts and feelings. The focus is seen on the sexual problem rather than psychopathology or character disorder (Lanyon, 1986).

Primary Concepts

Behavioral concepts may be used to change incestuous behavior. First, the focus is on the maladaptive incest behavior that is currently occuring. The goal will be overt change in this specified behavior. Second, all sexual and social behaviors that are aspects of the incestuous relationship have been learned, and therefore may be unlearned. Each family member has learned specific behaviors that allow continued incestuous behavior. Maladaptive behavior, such as incest, is seen as a result of faulty learning. Present behavior is the focus of therapy rather than historical determinants. Clear treatment goals are established to relieve specific incest behaviors. Finally, techniques are chosen to change the behaviors that have been targeted. There is a focus on using scientific method, and determining effectiveness of specific techniques toward the goals of change.

There are several general goals in behavioral work with

the incestuous family. First, the incest behavior must be stopped. This may occur through therapeutic work with the offender and family, or may need support of outside systems, such as law enforcement and social systems. Next, inappropriate sexual and social behavior that support the incest relationship must be unlearned. Finally, inappropriate behavior is replaced by learning more appropriate sexual behavior and other more appropriate social behavior. Treatment involves blocking regular stress responses while building positive problem-solving skills and stress management techniques.

The offender's past learning experiences are examined through observations of his present behavior. Past experiences of strong emotional deprivation are seen as decreasing the offender's opportunities to learn active responding with the environment. This may lead to continued problems in the present as he attempts to meet his emotional needs in interpersonal ways (Papajohn, 1982). Also, by eroticizing the child and receiving both physical and cognitive reinforcement for this behavior through sexual excitement, ejaculation, and fantasy, the offender continues to strengthen his sexual response, regardless of the child's needs (Maltz & Holman, 1987). The offender must learn new skills to control his sexual behavior and increase satisfactory social adjustment.

Papajohn (1982) discussed how an offender's compulsive

behaviors may be supported by those around him. The offender may also be making lifestyle choices that will not interfere with the compulsion. These environmental aspects also support or reinforce the behavior and need to be a part of the focus when looking at change. Papajohn also describes how the lack of opportunities to learn effective daily living skills in childhood and during development may add to the likelihood of feelings of lack of trust and helplessness, where individuals will often try to avoid anxiety-provoking situations, fearing abandonment or being trapped.

The mother's behavioral response also affects the incest relationship. Her learning history may affect her present interactions with her husband. Past abuse experience may also affect her present behavior. Her availability to her children as well as her response to the incest relationship may affect whether the incest relationship continues.

The child is seen as learning some acceptance or involvement in the incest behavior. In some way, the interaction is rewarding and helps her to meet some needs. Her behavior is supported in several ways. First, her body's physical response to the incest may be reinforcing. Second, the support of the incest relationship and non-reporting by a significant adult in her life does not indicate any need for change (Kempe & Kempe, 1984). The

child's own response to the initial incestuous contact may help determine whether or not the relationship will continue.

Specific Techniques

Several particular techniques within behavioral therapy may benefit treatment of the incestuous family. Again, the purpose of choosing particular techniques is to stop the incest behavior while gaining skills in other areas that are not congruent with sexual abuse, such as social skills and assertiveness. As a variety of applicable techniques were described earlier, this discussion will focus only on techniques particular to the sexual offender population.

Mayer (1988) desribed several behavioral techniques used with sexual offenders. The first technique is called orgasmic reconditioning or masturbatory reconditioning (Abel & Blanchard, 1974; Marquis, 1970). The offender is instructed to have a deviant fantasy to the point of orgasm, but is to change to a socially acceptable fantasy at ejaculation. This technique does not have a sound theoretical basis as it pairs a nondeviant and deviant stimulus (Mayer, 1988). Covert sensitization, a form of aversion therapy, involves directing the offender to fantasize about the deviant behavior with a negative result. Boredom aversion (Laws & O'Neil, 1979; Marshall & Lippens, 1977) is a technique where the offender is instructed to masturbate to orgasm while fantasizing a socially

appropriate scenario, followed by a period of an hour where he would record his deviant fantasies. With the modified aversive behavioral technique, offenders repeat former sexual offenses on mannequins while being videotaped. This is later replayed, sometimes in a group setting, to give the offender the feeling of shame as well as giving him a view of the absurdity and destructiveness of his behavior (Mayer, 1988).

Assertiveness training is another technique that is beneficial for sexual offenders. Rimm and Masters (1974) report that clinical experience suggests that individuals deficient in verbal skills are more likely to threaten or use physical violence. Many males in American society also see high verbal skills as non-masculine. Empirical findings also report positive results with this technique including increase in positive heterosexual relations in one study and above 50% maintenance in a one-year follow-up from another study (Rimm & Masters, 1974). Groups can also be a good learning situation for behavioral rehearsal of assertiveness training.

In summary, behavioral theory has been used in a variety of situations. Although behavioral methods have been used with some sexual deviations, there is little literature describing behavioral work with an incestuous family system. Behavior theory has a linear view of problems, with a cause-effect relationship between the

learning history of the client and present behavior. The focus of therapy is on behavior change as specified within particular goals established by the client and therapist. Therapeutic resistance is not considered a concern as the therapist and clients mutually define the goals of therapy. Behavior therapy is often the approach of choice as it is a time limited approach, there is a specific focus on definable goals, and techniques are fairly easy to learn. One of the possible drawbacks includes the need for a "laboratory" of equipment (Mayer, 1988). Behavior therapy is a well-defined and easily understood approach to change in therapy.

Aspects of Behavioral Theory in the Systemic Perspective

Several behavioral aspects are part of systemic therapy with the incest perpetrator. The perpetrator must stop incestuous behavior immediately, with a focus on restructuring and learning more positive coping and problem-solving patterns within the family. Although past patterns regarding incest behavior are explored, these are assessed and movement toward change is in the present. Many skills that the perpetrator has never learned can be taught through established behavioral techniques and may be integrated in an ongoing manner within the interactions of the family.

Several concerns have been raised when looking at incest from only the systemic perspective, such as applying only to father-daughter incest, and the exact distinction

between intra-and extrafamilial abuse. Lack of attention to other possible sources of offender behavior is also seen as problematic as empirical evidence does not support that this behavior arises only with family behavior and dynamics. There is the concern that an adequte account of sources of offender behavior may not be given within systemic therapy. Also, there is a tendency to place more blame with the mother for her part in the abuse than may be appropriate (Finkelhor, 1986). There is a need to conceptualize newer family styles, such as single-parent or shared households. However, using the same structural constructs, one is able to define the interactive structure of the system to be able to clarify a manner of approach for treatment of incestuous relationship. While the proposed focus of therapy is structural-strategic, other interventions may also be used, including behavioral, modeling, insight or paradoxical strategic techniques (Trepper, 1986). Finkelhor (1986) recommended the use of both family systems analysis and individual analysis of the offender to get the most complete and appropriate view for treatment of incest.

In summary, it is a complex combination of techniques and multiple challenges to the system that are needed in treatment of the incestuous family system. The entire system is the focus of therapy even while dealing with smaller parts of the system. All aspects of the family system are addressed in a variety of individual, dyad,

subsystem, family, and group work. All therapy works toward goals of restructuring, increasing functional communication and changing specific behaviors and interactions among the members of the family system. The next chapter will address the specific treatment aspects of the incest perpetrator from the structural-strategic perspective with behavioral components.

CHAPTER IV

TREATMENT INTERVENTIONS AND TECHNIQUES

This chapter will involve a more specific discussion of treatment interventions and techniques for the incest perpetrator. Individual perpetrator treatment issues will be discussed. Specific structural-strategic aspects of perpetrator treatment will be described, followed by behavioral interventions that support systemic work. Aspects of family treatment that directly involve the perpetrator will be discussed as an important and integral aspect of the systemic approach to incest.

Involving all family members in treatment is advocated for the incest family (Oaks & Anspaugh, 1987). Therapeutic treatment of the incest family should include individual, dyad, group (Barrett, Sykes & Byrnes, 1986; DePanfilis, 1986; Giarretto, 1976; Groth, 1982; Kempe & Kempe, 1984; Mayer, 1988; Sgroi, 1982), and family sessions (DePanfilis, 1986; Giarretto, 1976; Groth, 1982; Mayer, 1988; Sgroi, 1982). Aspects of all these different therapies combine to affect system change (Sgroi, 1982).

Assessment and flexible use of multiple modalities are both important in addressing the unique needs of the individual and family and change within the system (Bander,

Fein & Bishop, 1982; Sgroi, 1982; Taylor, 1986). Family therapy aids in working with nonsexual problems that may be part of the family's dynamics making the system more at risk for sexual abuse (Salter, 1988). Individual therapy aids in relationship-building, beginning trust, and challenging denial, which increases the therapist's ability to affect system change within different parts of the system (Sgroi, 1982). The focus of this work is primarily addressing work with the offender.

Systemic Aspects of Perpetrator Treatment

Working with the sexual offender has been described as one of the least addressed areas of sexual abuse (O'Leary, 1990). Offender treatment initially involves individual work. Working with the family is often done concurrently to integrate information from individual therapy toward systemic change (Fowler, Burns & Roehl, 1983; Sgroi, 1982). Although family work is used for a minimum of assessment and consolidation, offender involvement with the family in therapy is often conditional on making progress in other areas of treatment. In this way, family involvement is seen as a privilege, not entitlement, for the father.

Several authors describe programs for sexual offenders that incorporate a variety of techniques that complement each other in the treatment of sexual offenses (Salter, 1988; Trepper & Barrett, 1986). All treatment should be tailored to the individual's needs with family, group, and

behavioral therapy incorporated to address different issues (Salter, 1988). Elements should be selected pragmatically, modified to individual needs or problems, making the approach fit the family and individuals involved (Annis, 1982; Kempe & Kempe, 1984; Renvoize, 1982; Salter, 1988; Taylor, 1986). Individualized assessment is greatly needed (Overholser & Beck, 1986) as all possible contributing factors and systems must be considered (Imber-Black, 1988; Trepper & Barrett, 1986). Even while working with the individual, there is a continuing awareness of family structure and other individuals, aiming interventions "at the family system in absentia" (Kadis & McClendon, 1981, p. 147). The focus in individual work is still the context of the family system, with family and individual work seen as interconnected and developing together (Kadis & McClendon, 1981).

Treatment of the Incest Perpetrator

Systemic therapy with the incest perpetrator deals with several main concepts. First, individual factors are addressed. Second, systemic therapy addresses the interactive aspects of the family within the work with the individual perpetrator. Individual therapeutic work with the perpetrator also serves a secondary systems function as a structural move that places responsibility for abuse on the perpetrator, rather than the child or other family members. Barrett, Sykes and Byrnes' (1986) model for

therapeutic treatment will provide a basis for the discussion of treatment here.

Systemic treatment of incest addresses aspects of family and their interactions. The focus is on restructuring all family members to move away from homeostasis toward change or more flexible responding (Barrett, Sykes & Byrnes, 1986; Sgroi, 1982). Family sessions address the family's repetitive dysfunctional interactions that aid in symptom maintenance (Barrett, Sykes & Byrnes, 1986). Additional therapeutic situations, such as group, marital, or subsystem sessions also support systemic change and growth.

Creating a Context for Change.

The initial stage of therapy involves developing a context for change within the family system (Barrett, Sykes & Byrnes, 1986). Initially, the family may be seen as a whole, in dyads, subsystems, or individually to go through the process of assessment and establishing a therapeutic relationship. Several aspects are involved in this initial stage.

The first and primary aspect of treatment is to stop incest behavior. Initially, behavioral controls must be established (O'Leary, 1990) using the external authority of larger systems, such as the courts, to reinforce this change and as incentive to enter treatment (Groth, 1982; Herman, 1981; Sgroi, 1982; Swan, 1985). The father may be removed

from the home, structurally supporting his responsibility for abuse while removing him from his power position within the family. Also, immediately addressing issues of limited confidentiality regarding abuse clarifies several issues (Groth, 1982). This is a clear statement regarding involvement of outside systems with the family. Also, discussing mandated reporting of abuse shows that secrecy and abuse of power, especially incest, will no longer be allowed.

The initial crisis of abuse reporting interrupts the patterns of behavior within the family system. At this point, the family system may be flooded with outside information through coordinated service systems (Bander, Fein & Bishop, 1982; Barrett, Sykes & Byrnes, 1986; Giarretto, 1976; Imber-Black, 1988; Lyon & Kouloumpos-Lenares, 1987; Mayer, 1983; Renvoize, 1982; Sgroi, 1982; Wagner, 1987). All of these steps move the system toward change, called creative use of crisis (Barrett, Sykes & Byrnes, 1986).

Assessment of the family system occurs at the beginning of the therapeutic process. Information about the individuals, subsystems, and family interactions are observed through work with the entire family system and extended family, when possible. Additional information may be gained through work with individuals or smaller parts of the system. Assessment includes the areas of family style, structure, communication, the individual functioning of

individuals, and any relevant or abuse history (Barrett, Sykes & Byrnes, 1986). Once the assessment has been completed, a specific discussion of prioritized treatment goals occurs with the family. If denial is a strong aspect that is present for the perpetrator, this must be addressed with him on an individual basis prior to his continuing with other aspects of therapy. In cases of continuing denial, legal, rather than therapeutic intervention, may be needed (Barrett, Sykes & Byrnes, 1986).

The family structure session occurs next. This technique has several purposes when used with the family and individual members. First, it helps to clarify the family structure which supported the occurrence of sexual abuse. Second, it emphasizes generational boundaries, clarifying the difference in roles and responsibilities of the parents and children. Third, the discussion of family structure is a starting point to move toward a more strength-oriented or positive approach in therapeutic work, beginning the process of empowering the family to move toward changing the system (Barrett, Sykes & Byrnes, 1986). Often, individual sessions, especially with the perpetrator, may need to occur prior to this session.

The apology session is the next therapeutic intervention in the first stage of therapy. The apology session is planned only after the perpetrator is addressing his denial of the abuse. Within the structural-strategic

perspective, the apology session is a technique of behavioral enactment that further addresses appropriate responsibility within the family system (Barrett, Sykes & Byrnes, 1986; Herman, 1981; Sgroi, 1982; Trepper, 1986). This is a therapeutic enactment within the family session, with the family members expressing their current feelings regarding incest as well as their look toward the future of family functioning.

The apology session has several purposes. First, the responsibility for abuse is taken by the parents. Second, it supports the abused child in experiencing less guilt or feelings of responsibility for the abuse situation. Third, clearer communication patterns are begun within the family. Finally, the apology session begins the process of restructuring the family hierarchy in a more appropriate manner.

The apology session is an important structural move, showing the new strengthened boundary of the marital/ parental relationship to the children (Herman, 1981; Porter, 1984; Sgroi, 1982; Trepper, 1986). The parents sit together facing the children, with each making a specific statement of apology and responsibility. Each must state what they are willing to do to make the situation better, and what they expect from the chidren. This process shows the parental alignment and new family functioning and clarifies that there will be no more secrets tolerated in the family.

The focus of this entire session is only on the apology and reassuring the child that abuse will not happen again. The session also focuses on a more positive family plan for the future.

There are several aspects that should be considered prior to planning the apology session. It is important that the apology session does not take place until the therapist believes it to be supportive to the child. Also, timing is dependent upon the ability of the parents to take appropriate responsibility for their part of the abuse (Barrett, Sykes & Byrnes, 1986). The perpetrator takes the sole responsibility for the incest (Groth, 1982; Porter, 1984), while the non-offending parent takes responsibility for not protecting the child (Sgroi, 1982). The apology session also clarifies that although the entire family should work toward change, responsibility for the sexual abuse should not be diffused (Nichols, 1987).

In summary, the first stage of therapy involves clearly assessing and defining specific issues as the focus of therapy, including the area of incest. A second aspect is the development of a workable plan for the family to continue to work toward in the following stages of therapy. Initial denial of all of those in the family system, but especially the perpetrator, must be dealt with at this time to begin the process of positive change within the family system.

Challenging Patterns and Expanding Alternatives.

The second stage of therapy involves challenging patterns and expanding alternatives within the family system (Barrett, Sykes & Byrnes, 1986). Multiple modalities are used during this time with all aspects of the family system to move toward positive change. Although all aspects of family treatment will not be described, those which involve the perpetrator will be discussed for a more comprehensive view of perpetrator needs.

There are several different aspects that are addressed in this stage of therapy. As many behavioral patterns have been established and become rigid and difficult to change within the family system, the second stage of therapy involves work to change those negative patterns and begin to understand the large amount of alternative behaviors that are available within the family system (Barrett, Sykes & Byrnes, 1986).

Individual Therapy

Individual sessions are integral to incest treatment for all parts of the family system. These sessions allow each individual to explore personal issues while coordinating with family therapy (Barrett, Sykes & Byrnes, 1986). Individual therapy supports relationship establishment (Bander, Fein & Bishop, 1982; Barrett, Sykes & Byrnes, 1986). Working with an individual supports the concept to "divide and conquer" within the family system, working with

smaller family units to break down denial (Alexander, 1985; Fisch, Weakland & Siegal, 1986 cited in Hoke, Sykes & Winn, 1989). There are several issues that are addressed within individual therapy for the perpetrator. These include: denial, family of origin issues, psycho-social development, developing a working hypothesis of how the abuse took place, current concerns, and factors contributing to abusive behavior (Barrett, Sykes & Byrnes, 1986).

As the dynamics of the incest offender include addictive or compulsive aspects, starting from this perspective is helpful in beginning treatment with the offender (Mayer, 1985; Salter, 1988). The immediate focus is on abstinence, especially in the area of sexual abuse. Other areas to address include substance abuse or addiction, controlling access, and later working on insight regarding dependence and addiction (Annis, 1982; Groth, 1982; Valle, 1991). The general treatment focus for incest offenders is on long term workable controls, awareness of continuing risks, and realistic self-control (Renvoize, 1982) rather than curing the offender (Groth, 1982; Mayer, 1988; Vander Mey & Neff, 1986). The goal is management through life long abstinence (VanderMey and Neff, 1986). Often, the combination of offender motivation, decision of personal responsibility (Groth, 1982) and external control are employed when working with the incest offender (Herman, 1981).

The sole responsibility for abuse is with the offender

(Groth, 1982; Porter, 1984) with the goal of his full acceptance of responsibility for abuse (Annis, 1982; Giarretto, 1981 cited in O'Leary, 1990; Groth, 1982; Mayer, 1985; Oaks & Anspaugh, 1987; Renvoize, 1982; Taylor, 1986; Vander Mey & Neff, 1986) and the consequences of behavior (Annis, 1982). This is a linear view and must be dealt with primarily with the offender before continuing with this theme within the family system. Some see admission of behavior needed prior to therapy (Giarretto, 1976), although others see therapy as possible even when denial is present (Barrett, Sykes & Byrnes, 1986; Mayer, 1983 cited in O'Leary, 1990). The adult is seen as responsible to establish appropriate sexual behavior patterns within the family (Oaks & Anspaugh, 1987), with the child able to learn stylized sexuality as a norm within the family system (Groth, 1982).

The offender's responsibility for abuse is supported through systemic therapy. This is first addressed through assessing and challenging the offender's need for denial (Barrett, Sykes & Byrnes, 1986; Conte, 1984; DePanfilis, 1986; Gaines, 1981; Groth, 1982; Sgroi, 1982). The function of the denial for the offender and the context of the behavior must be defined, with the therapist using this energy toward more positive change within the system (Hoke, Sykes & Winn, 1989). The meaning of denial may vary for each individual, but is viewed generally as a protective

device. The therapist is supportive of emotional needs while challenging the perpetrator to accept the reality of the abuse (Barrett, Sykes & Byrnes, 1986). Four styles of denial include: denial of the facts, denial of awareness, denial of impact, and denial of responsibility, all of which must be addressed prior to other therapeutic work (Hoke, Sykes & Winn, 1989).

When working with the perpetrator, challenging denial takes place primarily within individual sessions. The reality of the abuse is focused through telling the victim's story, the apology session, and by confronting the offender with the evidence of the situation. The purpose of this part of therapy is to facilitate awareness while beginning to show the offender alternative behaviors (Fowler, Burns & Roehl, 1983). By helping the offender see that he is putting his own needs ahead of those of his child, he can begin to identify the reasons for his behavior and begin to see the consequences of his behavior for the child victim and family (Fowler, Burns & Roehl, 1983; Groth, 1982).

The second area to address in therapy is perpetrator issues that stem from his experience in his family of origin. If the perpetrator experienced sexual abuse as a child, his feelings toward this experience, such as excitement, pain, guilt, anger, or fear and his own victim experience must be addressed in therapy (Taylor, 1986). By dealing with this experience, he can begin to see how his

past experience relates to his adult deviant behavior (Taylor, 1986) and begin to experience the impact of his behavior on the victims (Renvoize, 1982). It is also important to look at sexual offenses, sexual deviations, victimization or other traumas (Groth, 1982). Other aspects of the style and interaction within his family of origin are explored and challenged to help him begin to understand and take control of his present situation.

Aspects of male socialization and psychosocial development must also be addressed with the perpetrator. The perpetrator must be assisted in moving toward affiliation with others, helping him to learn how his actions affect others. This is especially true in seeing the effect of incest on his victims (Swan, 1985). The task of therapy is to aid the perpetrator in learning empathy and to begin building relationships and positive alliances with others (Papajohn, 1982). This work is done with the individual perpetrator while keeping the family system a part of the work.

Development of empathy addresses several systemic functions. The offender's abuse of power is challenged by helping him to begin thinking of his daughter's specific developmental needs and appropriate role within the family. The offender's work on empathy further supports establishing appropriate subsystems within the family by strengthening the boundary between parental and child subsystems,

discouraging further sexual involvement with his child.

Another focus involves working with the perpetrator to develop more positive thought patterns and a more positive sense of self (Annis, 1982; O'Leary, 1990). It is important to aid the client to recognize in himself the capacity for change, improving self-esteem and self-concept (Fowler, Burns & Roehl, 1983; Giarretto, 1976), while encouraging self-control. Taking part in this process aids the offender in moving away from rigid patterns toward more flexible responding, while addressing his internal definition of power and manliness. The systemic goal of differentiation and individuation from other parts of the family is also addressed. This is often dealt with by developing graduated tasks, initiating positive reflection, practicing empathetic listening, and using position confrontation (Taylor, 1986). Although the therapist may not condone the incest behavior, the therapist offers hope toward change (O'Leary, 1990) and helps the client define the problem as solvable and, therefore, within his control (Imber-Black, 1988).

Another part of therapy is helping the perpetrator to develop insight into the sexual nature of deviant behavior and cognitions (Annis, 1982). The offender needs to work on developing mutual empathy and seeing sexual abuse as inconsistent with his basic experience or sense of self (Annis, 1982). One aspect involves aiding the offender in differentiating from the victim without disassociating so

that the offender can experience himself separately as well as in relation to the victim. This supports the systemic goal of separation or individuation. Secondly, the offender is supported in working through development of an appropriate relationship with the victim. He practices not objectifying or silencing the victim working individually with a "victim's chair" or in supervised visits with the child, reestablishing appropriate role understanding. The therapist must use the child as a consultant/witness, integrating the child's account during therapy. Working in this area further supports appropriate parental and child subsystem boundaries.

A secondary aspect of responsibility is learning empathy expression. This process starts by helping the offender to begin seeing the connection between his behavior and his affect on individuals and relationships around him. After the initial focus on accepting responsibility, this area is addressed by defining lack of empathy in the perpetrator's approach to others in the incest and other relationships (Taylor, 1986). The cycles of deprivation, abuse, and lack of nurturance should be addressed. If the perpetrator experienced abuse, he may identify with the "strong" abuser. Since parental empathy is seen as a strong inhibitor of incest (Taylor, 1986), this is an important area to intervene. Empathy expression begins with assisting the offender through his developmental tasks, supported with

repeated teaching and shaping of behavior to work toward empathy or the development of emotional awareness on the part of the offender (Taylor, 1986) and added sensitivity to others' needs (Groth, 1982; Sgroi, 1982). Although difficult, this is central to interrupting molestation as parental empathy may more strongly affect the offender's behavior (Nichols, 1987).

The function of the incest behavior is addressed through viewing the incest symptom and assessing its meaning within the family system. It is important also for the perpetrator to address his perceptions of the causes of the incestuous behavior. This may take place with self-exploration, understanding and self-trust (Vander Mey & Neff, 1986). The offender begins to discover the nonsexual needs that he has been attempting to meet through incest by identifying unmet needs and feelings (England & Thompson, 1988; Groth, 1982; Papajohn, 1982; Taylor, 1986) and finding out some information about motivation to abuse (Renvoize, 1982). Since incest is a form of sexuality, both sexual and nonsexual aspects should be taken into consideration (Conte, 1986).

Determining the function of abuse may be explored in several ways with the offender. The offender's experiences and feelings may be addressed, often involving fears, feelings of loss, anger, inadequacy, guilt (Kempe & Kempe, 1984), and stress (O'Leary, 1990) that the individual

experiences. Helping the offender to learn about his feelings is done by clarifying the names for different feelings and reflecting these back to him (Taylor, 1986). Secondly, the offender works on connecting his feelings with needs and learns other adaptive ways of meeting these needs (Groth, 1982; Papajohn, 1982; Taylor, 1986). Through individual counseling, the offender works on increasing feelings of self-worth and independence (Groth, 1982), building realistic expectations, and gaining an awareness of acceptable alternatives to meet need gratification (O'Leary, 1990; Sgroi, 1982).

Another focus in individual therapy for the perpetrator is developing a better understanding of the pattern of sexual abuse and identifying factors that could contribute to the abusive behavior. The perpetrator gains awareness of precipitating factors and background stressors that may affect the development and maintenance of the incest behavior (Taylor, 1986). Stresses within the family system are one aspect that is considered, as the perpetrator may experience feelings of abandonment from past and present experiences (Meiselman, 1979), leading to panic impulses in the present. Current stress issues are addressed as the offender often feels overwhelmed by life's demands (Groth, 1982; Papajohn, 1982; Vander Mey & Neff, 1986). Stress is often an aspect of the incest dynamics, where ineffective subsystem functioning and coalitions or other negative

communication patterns adding to his perceived stress. As the perpetrator also has negligible stress management capabilities, he is more likely to turn to a child for feelings of power, to meet his needs for nurturance, and to escape from his perceived stress.

The perpetrator's abuse of power within the family system and other relationships is also challenged in individual therapy (Annis, 1982; Taylor, 1986). Patterns of abuse behavior must be explored, clarifying needs or inadequacies leading to this behavior. More positive ways to feel or express power are explored (Taylor, 1986). The perpetrator's rigid sex role expectations must be challenged to allow him to begin to experience caretaking, redefining caretaking as powerful and manly (Annis, 1982). Increasing information exchange with other systems and helping him to learn how to gain information and support from other systems is a focus. Redefining power is an integral part of this, helping the perpetrator to move from an idea of control or mastery to connection and collaboration with others, such as caretaking, sensitivity to others, and cooperation. The offender may initially feel that joining therapy and acknowledging abuse is a sign of weakness. However, when addressing denial, the therapist changes the idea of power, stating that when the perpetrator is stronger, he will remember the abuse.

Power issues must be dealt with as they occur in therapy

for both the perpetrator and the family. This is addressed further in family therapy (Taylor, 1986) and is supported during and after treatment by access to group therapy (O'Leary, 1990). The therapist should operate from a directive power base with support of a team and supervision to change the power base within the family (Bander, Fein & Bishop, 1982; Barrett, Sykes & Byrnes, 1986; Schwartz, 1987), keeping the therapist from becoming part of the isolated and disordered family power system (Barrett, Sykes & Byrnes, 1986).

Unclear communication, especially regarding needs and feelings of the offender must also be addressed (Groth, 1982; Taylor, 1986). Clear communication in the area of feelings would naturally come after first working on describing unmet needs so that the offender is more open to trying new patterns of behavior (Taylor, 1986). The goal of communication with the perpetrator is on direct expression of statements or needs. As patterns of communication in the family system often focused on double-bind messages and power imbalances, more direct relating would be at odds with the dynamics that supported incest behavior. Communication in individual work focuses on individual responsibility (e.g. using "I" statements), clarification of faulty thought patterns or family rules, and begins the breakdown of the isolation and double-bind communication through increased information exchange.

Part of treatment and growth with the incest offender is helping him to become aware of positive aspects of himself. One way of doing this is to help the individual offender begin to identify different parts within himself, or his own internal system (Romig & Gruenke, 1991; Schwartz, 1987). The concept of the internal system describes the many parts of each person and the multiplicity of aspects of the mind or subpersonalities. The internal processing of the individual is seen as a system that works under the same guidelines or rules as the family or larger systems, and can be addressed in the same manner. The self leads and mediates among the parts, with problems occurring when polarization occurs, breaking away from self-leadership. The task is then to depolarize or lessen rigidity of these parts through reshaping the relationship among parts or finding better roles for them. Each person is responsible for his individual parts once he has knowledge that he can and should control the individual parts and learns how to do this. Change is seen as more attainable in addressing change in smaller parts of one's self.

To use the concept of internal systems as a part of therapy, the therapist first needs to assess the parts system and the relationship among parts. Second, the focus is on elevating the self in the internal system, as well as addressing the extreme points of any part. This model can be used with the perpetrator to challenge negative or

destructive parts while encouraging and providing a focus for the other more positive parts of the individual.

Group therapy with other offenders is also used as an aspect of offender treatment (Barrett, Sykes & Byrnes, 1986). Group sessions are used to directly address issues of denial and isolation (Bander, Fein & Bishop, 1982; Fowler, Burns & Roehl, 1983). Other issues are also addressed, including cognitive distortions, breaking down isolation and secrecy, and increasing compliance (Salter, 1988). The group becomes a context in which to challenge the offender to begin using new skills and relating in positive ways to other individuals.

In summary, therapeutic work with the offender addresses a variety of issues. Although a primary focus is on immediately stopping incest behavior, additional work with the offender deals with other past or present issues that have increased the likelihood for the offender to choose incest as a behavioral option. It is important to remember that the offender's denial regarding the incest is a primary issue that must be addressed immediately and throughout therapy.

Treatment Aspects of the Incestuous Family System

In addition to the treatment of the individual perpetrator described above, there are factors of the incestuous family system that must be addressed in therapy. Although these areas are assessed in the first stage of

therapy, issues of cohesion, adaptability, hierarchy, and communication must be addressed at this stage of therapy. Issues of the family system are dealt with in all aspects of therapy, as all individuals have taken part in creating or maintaining their own family system.

Cohesion

The first area to be addressed is cohesion within the family system. One area of systemic treatment is setting internal and external boundaries. As the incest family members have created a system characterized by isolation and lack of environmental interaction, a treatment goal is to enhance environmental interaction and to build social support systems (DePanfilis, 1986; Sgroi, 1982). Flooding the system with a variety of outside resources is a strategy to begin this process, starting with the initial family crisis of reporting. This also begins the restructuring of the family system to incorporate increased environmental interaction and reduce enmeshment. This is supported in treatment through the physical intervention of in-home family therapy, therapist mediation with the family and other systems (e.g. school, community agencies, etc.), and is supported through group involvement (Alexander, 1985).

Secondly, individual roles of family members must be clarified (Reposa & Zuelzer, 1983). This is important as many incestuous family systems are enmeshed, which supports the incest behavior. The focus is on helping the family to

restructure role reversals back to appropriate relationships and aiding the children in establishing age-appropriate behaviors (Sgroi, 1982). Therapy also involves working with different aspects of the family to see the uniqueness of each role and how the different roles of various family members may aid in more appropriate subsystem interactions in the future. Working on conflict resolution, interaction, and communication among the appropriate individuals and subsystems is an integral part of this work. The goal is to "...highlight and elaborate differences and specialized functions within the family" (Alexander, 1985, p. 87).

Adaptability

Family system boundaries are addressed as an issue within the incestuous family with both family and individuals (Larson & Maddock, 1983; O'Leary, 1990; Reposa & Zuelzer, 1983). Extremely rigid or chaotic boundaries are often a part of incestuous dynamics. Within this perspective, goals include: increasing interchange between the family and society by increasing flexibility of this boundary, restructuring parental and child roles to be more age-appropriate, aiding the family members to increase individuation, and establishing a consistent family structure for reality-testing (Larson & Maddock, 1983). Appropriate boundaries must be established within the family and for the father (O'Leary, 1990) beginning by clarifying roles and supporting the functioning of subsystems through

in-session and directive techniques. Establishing appropriate roles for all family members, restructuring the family hierarchy, and redefining appropriate parental/ marital boundaries also aid in appropriate parental responsibility.

The next aspect involves breaking down the inappropriate coalitions within the family (e.g. the incest relationship) while strengthening appropriate coalitions, such as the parental and spousal relationships (Reposa & Zuelzer, 1983; Swan, 1985; Taylor, 1986). Establishing joint parental responsibility for raising children is one aspect (Porter, 1984), as well as establishing more growth-oriented and flexible family rules. Therapeutic work involving the adult couple will be described more in the following section.

Another area of adaptability is challenging the abuse of power and control within the family (Reposa & Zuelzer, 1983; Sgroi, 1982). This is initially addressed with the perpetrator, but the roles of the other family members in further allowing the skew of power is also addressed. Power must also be reinstated within the parental dyad (Swan, 1985) if the couple decides to stay together (Taylor, 1986). Focussing on marital conflict or other problem areas aids in reestablishing appropriate power in the parental coalition while supporting this dyad, rather than removing power. The parental dyad works toward developing an agreement of

acceptable and unacceptable behaviors, as well as clarifying more growth-oriented family rules. The parents also learn to offer reasonable choices to the child, maintaining power within the parental coalition while respecting the child's ability to make a decision. This supports the parents in staying away from a more authoritarian stance. By giving the child clear expectations and consequences, there is movement toward more direct information exchange (Swan, 1985).

Empathy is addressed within the family to further support more positive power balances within the family (Nichols, 1987). By first siding with one family member and then another, the therapist may aid the family in using more statements of feelings, initially creating more tension and crisis within the family, but then helping them to acknowledge this and work toward resolution. The family learns empathy partially through the modeling of the therapist. Therapeutic use of empathy within the here and now of the therapy session begins this process with the family. Techniques include role playing, family sculpting, guided fantasies (Nichols, 1987) and increased direct communication.

Separation and individuation are addressed within family therapy, encouraging each person to share his views (Reposa & Zuelzer, 1983) and move away from enmeshment in the system. This is consistently addressed through

interactions in therapy which stress the uniqueness of each person's role within the family. Privacy issues are discussed, and privacy boundaries are reestablished through clarifying physical boundaries and interaction (Alexander, 1985; O'Leary, 1990). This supports work done with the different family subsystems and further challenges the family to increase effective interaction among individuals. The specialized function of roles and aiding all to increase their sense of self is an important aspect; this is supported with individual sessions. Finally, the family's perceived need for consensus must be challenged, freeing the family system to better deal with change from within or outside of the family system (Alexander, 1985). All of these issues are further supported by individual therapy.

Hierarchy

Family hierarchy is also addressed within treatment (Barrett, Sykes & Byrnes, 1986; Reposa & Zuelzer, 1983). Hierarchy takes into consideration the roles, power and age of participants in the family system (Barrett, Sykes & Byrnes, 1986). The therapist challenges inappropriate hierarchies, with the goal of creating solid boundaries between generations. This may be done by giving disciplining tasks to parents, and aiding children and parents to stay within their appropriate hierarchies during in-session interactions. The therapist predicts resistance to change, as the new roles will be difficult initially for

family members to try, but this change is supported through assignments both in and out of session. This begins change in behavior patterns (Barrett, Sykes & Byrnes, 1986). Secondly, the therapist assists the parents to assume parental roles to follow through with tasks such as setting limits (Sgroi, 1982; Swan, 1985). By working with sub-systems, setting and maintaining appropriate boundaries is addressed (Sgroi, 1982). This initially involves the restructuring of dysfunctional coalitions that supported incest behavior (Reposa & Zuelzer, 1983).

Communication

Increased communication is another aspect of work with incestuous family systems as patterns of poor communication, double-bind communication, and poor conflict resolution often occur within the incest family (Barrett, Sykes & Byrnes, 1986; Groth, 1982; Reposa & Zuelzer, 1983; Sgroi, 1982; Taylor, 1986). Communication of feelings may also be addressed within this same framework (DePanfilis, 1986). The therapist punctuates negative communication interactions to aid the family in changing these patterns. Incest and other family issues are directly addressed within therapy to aid in conflict resolution, compromise, and negotiation, while discouraging secrecy (Barrett, Sykes & Byrnes, 1986). Strategies include: explaining how to communicate clearly, modeling of behavior, exploring needs and feelings of individuals, reframing negative patterns as more positive or

normal, and using directive tasks to explore new patterns of communication (Nelson, 1983). Again, work with other family members is necessary to change and support the individual work done in this area.

In summary, the issues of the family system are involved in all aspects of individual, subsystem, dyad, or family therapy. As different factors of the system make it possible for the incest relationship to occur, the system is addressed throughout all aspects of therapy. Issues of cohesion, adaptability, hierarchy, and communication are addressed with the offender, as well as all other parts of the system to move toward complete systemic change.

The Marital/Parental Dyad

A primary part of systemic work with the incestuous family system is working with the marital and parental dyad. Although this work involves the same two people, it is clarified into these two parts and the marital and parental dyad are two different aspects of their relationship. Work on the marital/parental dyad is also a very important part of organizing the family system and restoring an appropriate hierarchy between the adult and child subsystems.

Marital work is important especially if seeking reconstitution (Barrett, Sykes & Byrnes, 1986; Swan, 1985; Taylor, 1986; Vander Mey & Neff, 1986). The focus in on the couple establishing boundaries around their marital relationship, addressing issues such as: sexuality, intimacy,

conflict resolution, communication, and decision-making regarding their relationship. The focus is problem-oriented, addressing sharing of affection and sexual functioning, as well as growth-oriented, to enhance marital functioning and de-triangulate the child from the parental/ spousal relationship. Seeing how the dysfunctional marriage relationship has added to the risk of sexual abuse in the family must also be addressed. Both sexual dysfunction and themes of sexual abuse are addressed throughout therapy. It is important to deal with marital issues separately from the rest of the family as these are the only two family members appropriately involved in making these decisions. This separate time together in therapy also supports establishing some time alone as spouses (Swan, 1985).

Establishing the parental dyad begins when the parents acknowledge their responsibility for the abuse to the family in the apology session (Larson & Maddock, 1986; Papajohn, 1982; Porter, 1984; Reposa & Zuelzer, 1983; Sgroi, 1982; Swan, 1985). This shows the parental dyad reconstructing their responsibility for the children (Porter, 1984). As described earlier, both parents also need to work together to establish new rules regarding interaction and organization within the family as the two members of the adult subsystem. Parenting classes may also be used to increase parental knowledge and greater awareness of the developmental stages and needs of children (Groth, 1982;

Sgroi, 1982). This also supports the uniqueness of functions of the parental and child subsystems.

Parent education may also include "empathy for the child as a child" (Swan, 1985, p. 72). Empathy must be taught at the level the parents can understand, and starts with the idea of direct communication between parents and the parent and child. Developing empathy involves modeling, encouraging, disciplining, and rewarding, moving toward a child-centered concern (Swan, 1985). Swan (1985) describes the Cognitive Affective Small Group Parent Training Method. This training gives parents the opportunity to share their feelings of their past experiences, and learn to separate them from the role as a parent to the children. This training may also help them to address control within the family in a more appropriate manner.

In summary, the second stage of therapy involves challenging the family members to change the patterns of behavior that have been established, leading to incest or other problems. By breaking the present behavior patterns and making those in the system aware of functional alternatives, a more positive manner of functioning and interactions is the result. Individual, family, group, and dyad or subsystem sessions may all be a part of this work to address change within the entire family system.

Consolidation.

The third stage of therapy is consolidation (Barrett,

Sykes & Byrnes, 1986). The focus of this final therapeutic stage is on coordinating and supporting all of the changes that have taken place in the family system and its members. Up to this point, the therapist has been moving in and out of the family system to facilitate change. However, the current goal is to support the family system in increasing self-sufficiency and assuming responsibility for decision-making, problem-solving and conflict resolution. The focus continues to be on supporting appropriate hierarchies, flexible but organized relationships among individuals and subsystems, and clear communication. By comparing present decisions and choices to those of the past, the family system must practice functioning in more independent and growth-oriented ways. The therapy situation becomes more of a helpful support or resource, rather than an ongoing process.

Systemic therapy addresses all aspects of the incestuous family system. Although work with the incest perpetrator has many aspects that are addressed through individual and group sessions, the family system must be kept in mind even while working with the individual. It is important to consider the family system at all times, as the system, not any one individual, combined to make the incest situation possible.

Behavioral Aspects of Perpetrator Treatment

In this work, behavioral interventions are addressed as

a supportive aspect of systemic therapy, challenging behaviors that support incest within the family system. The offender learns alternative behaviors in specific skill areas which help him to meet his needs in a more positive or acceptable way. Cognitive changes are also addressed, as cognitions that support more positive perceptions, communication and interactions among family members may be addressed directly through behavioral work. Although specific behavioral techniques are used, these are kept within the context of the interactive nature of the family system.

Behavioral rehearsal and support of new behaviors and interactions within the family are practiced in therapy. An example of this is the apology session. More functional communication patterns can be learned and supported through therapeutic interactions. Learning new behaviors is important to address with individuals, subsystems, and the family system. Prevention may also be addressed with guided rehearsal, role playing, and exposure to simulations.

Cognitive-behavioral approaches are another aspect of offender treatment. Ross, Fabiano and Ross (1988) describe the offender's thought process as a primary aspect of how he feels and his behavior. They report evidence supporting a relationship between cognitive deficits and a higher risk of behavior problems or likelihood for criminal behavior. Empirical evidence has also shown that the offender has

often experienced developmental delays in cognitive skills with regard to social adaptation. The offender may show behavior such as acting before thinking, seeing the world in absolutes and may show an inability to creatively problem-solve (Ross, Fabiano & Ross, 1988).

There are several primary goals within this cognitive approach. First, the offender works on gaining impulse control. Second, he increases his awareness of others' thoughts and feelings. Third, he learns to acknowledge the consequences of his own behaviors. He also works on increasing his problem-solving skills while challenging faulty thinking. Finally, the offender works with the therapist on gaining an accurate interpretation of his environment. Effective programs address rational self-analysis, self-control training, means-end reasoning, and critical thinking. Thought stoppage and fantasy interruption are techniques to address this area (Vander Mey & Neff, 1986). These goals may be reached through classroom teaching, discussion within small group, audio-visuals, reasoning exercises and games, modeling and role-playing, as well as individual work.

Stopping Incest Behavior.

The first behavioral aspect of treatment with the incest perpetrator involves stopping the incest behavior. This behavioral work would be coordinated within the first stage of therapy, where the initial work is done to create a

context for change. Deviant arousal patterns are reduced (Annis, 1982; Renvoize, 1982; Salter, 1988) while increasing arousal to appropriate themes (Annis, 1982). Methods address avoiding both deviant erotic stimuli and normal stimuli to which the offender responds deviantly (Vander Mey & Neff, 1986). Altering the arousal valence of the deviant behavior and increasing personalization of the victims aids in this goal (Annis, 1982). Even while addressing family issues, sexual attraction or arousal to children must be addressed individually with the father (Renvoize, 1982). Establishing a backup system to report any additional abuse should be in place to support this change (Larson & Maddock, 1983).

A variety of behavioral techniques have been used to aid in decreasing deviant arousal quickly to avoid reoffense. Aversion therapy involves administering an aversive stimulus, such as electrical shock or noxious chemical, when an offender experiences sexual reponses to inappropriate stimuli. The goal is to reduce the deviant behavior and impulses (Marshall, Earls, Segal & Darke, 1983; Mayer, 1988; Papajohn, 1982; Renvoize, 1982; Vander Mey & Neff, 1986). Olfactory aversion may also be used, where offenders administer the aversive odor of ammonia to themselves when experiencing a deviant impulse (Mayer, 1988).

Satiation therapy has also been used with this

population (Berkowitz, 1982; Marshall, Earls, Segal & Darke, 1983; Vander Mey & Neff, 1986). Satiation therapy is reportly used only when aversion therapy has failed. The client masturbates continuously for one hour, concurrently talking through all aspects of his deviant fantasy. This process is continued long past orgasm, where the fantasy loses its erotic meaning. The technique can also be used at home and the progress recorded to show to the therapist (Salter, 1988). This is helpful in monitoring and emphasizing the importance of changing behavior outside as well as inside the therapy session. Satiation therapy is especially useful with high risk outpatients to help bring about rapid loss of interest in the inappropriate behavior (Vander Mey & Neff, 1986).

Some behavioral techniques used in the reduction of incest behavior involve cognitive strategies to control impulses. Thought-stopping involves the offender learning to self-instruct to repeat a cue such as "Stop!" when he begins to have a deviant impulse (Berkowitz, 1982; Mayer, 1988). With thought shifting, the offender substitutes a negative picture or thought in his mind when aroused. Impulse charting is also used to control impulses. The offender begins to control or lessen his deviant behaviors by charting every deviant impulse and the level of intensity, leading to the point where the recording becomes aversive, decreasing deviant impulse frequency (Mayer,

1988). Boredom aversion is a technique where the offender is instructed to masturbate to orgasm while fantasizing a socially appropriate scenario, followed by a period of an hour where one would record deviant fantasies (Laws & O'Neil, 1979 and Marshall & Lippens, 1977 cited in Mayer, 1988).

Covert sensitization or covert aversion is also used to eliminate deviant behaviors and thought impulses (Berkowitz, 1982; Lanyon, 1986; Marshall et al., 1983; Mayer, 1988; Papajohn, 1982; Salter, 1988). This technique is similar to aversion therapy except that deviant thoughts are paired with an imagined aversive event when prompted by the therapist.

Learning Appropriate Behavior.

A second behavioral goal involves learning appropriate or more acceptable behavior. The first element of this goal is to increase arousal to appropriate stimuli. One way of doing this is called masturbatory retraining or organismic reconditioning (Abel & Blanchard, 1974 and Marquis, 1970 cited in Mayer, 1988; Marshall et al., 1983). Masturbatory retraining involves fantasizing appropriately while masturbating and then taking time to enjoy the positive physical feelings as a reinforcement. Papajohn (1982) also reports the use of covert positive reinforcement. This technique is approximately the opposite of covert sensitization. In covert positive reinforcement, the

frequency of positive or desired behavior is increased by having the offender first imagine an appropriate scene in a step-by-step manner. Next, the offender reinforces himself by imagining a pre-arranged positive reinforcing scene.

Learning functional skills would also benefit the incest perpetrator. This includes learning in such varied areas as sexual information, social skills training, and assertiveness training. A variety of behavioral techniques may address these issues within systemic treatment.

Sex education is seen as an integral part of treatment for the sexual offender and family (Annis, 1982; Lanyon, 1986; Salter, 1988; Taylor, 1986). Sex therapy may be part of this (Groth, 1982). Sexual knowledge and a sexual history of the individual offender is helpful in establishing a background which led to the person's present sexual understanding and experience. The emotional meaning of sexual behavior should be explored in the offender's past experiences (Finkelhor, 1986). A non-judgmental approach is primary when teaching sexual information as well as providing information regarding generalized sexual experiencing. It is often helpful for the offender to learn sexual and social norms of the society, as this is often different from his own experience (Salter, 1988; Taylor, 1986). Group sex education may be used to assess, teach, and modify attitudes through discussion and sharing of information (Marshall et al., 1983). Lanyon (1986) further

suggests that development or continuation of an appropriate adult relationship be suggested in this case for the offender, and if the necessary skills are not available, issues such as anxiety and skill development should be addressed.

Work with the perpetrator must focus on helping him to understand the impact of stress molestation cycle. He must learn stress management skills, as well as learning to perceive and control his stress. An initial focus is on helping the perpetrator identify his specific life demands (Papajohn, 1982). The habitual stress response is then blocked, while building problem-solving and stress-handling skills (Salter, 1988). Techniques to be used include biofeedback/relaxation, assertiveness training, and parent effectiveness training (Groth, 1982). Relapse prevention is used later in therapy to aid the perpetrator in long-term follow through (Vander Mey & Neff, 1986). This aspect of treatment allows the offender to become more aware of antecedents or precursors to incest (Papajohn, 1982) and to gain more control of situations through practicing relaxation, behavioral and escape techniques (O'Leary, 1990).

Increasing positive socialization and communication skills may also be addressed through a behavioral approach. Conversational skills are addressed through role playing, modeling, discussion and feedback, both regarding physical

behaviors and stated information (Marshall et al., 1983). These techniques are used in other social skills areas also. Clear communication may be taught through individual and group settings, with various techniques such as assertion training, responsive listening, and use of "I" messages. Previous findings in behavioral family therapy with schizophrenics by Falloon (1985) has shown how communication problems may be dealt with by training those involved in directly expressing negative feelings and learning how to make positive requests (cited in Liberman, Mueser & Glynn, 1988). This skill is then used to help problem-solve in and out of the family system (Taylor, 1986).

Social incompetence is often an aspect of the offender's dynamics (Marshall et al., 1983). Lack of appropriate social skills limits the offender's access to appropriate partners and sexual behavior, which may increase feelings of stress. Therefore, interpersonal socialization skills and heterosexual skills that aid in development and maintenance of appropriate relationships need to be addressed (Annis, 1982; Groth, 1982; Marshall et al., 1983). Learning social skills also reduces stress, anxiety, and negative coping responses which may be part of a cycle adding to the risk of reoffense (Marshall et al., 1983). A variety of skills may be addressed, including: conversational skills, assertiveness, sexual skills, and personal management skills. Through education and role playing, the

offender can define alternative behaviors to help him express himself, meet needs and manage impulses (O'Leary, 1990; Taylor, 1986). Social skills packages have been produced including a generic approach (Curran & Monti, 1982 cited in Salter, 1988) or with more of a focus on social skills for offenders (Abel, Becker, Cunningham-Rathner, Rouleau, Kaplan & Reich, 1984 cited in Salter, 1988).

The offender's arousal to appropriate heterosexual themes should be increased. This involves several steps: desensitizing the individual to having contact with consenting women, reducing fear of rejection and performance panic, and learning positive responses for appropriate sexual and heterosocial behaviors (Annis, 1982; Overholser & Beck, 1986). This could be generalized beyond the hetero-sexual orientation by using the steps described above to developing appropriate adult relationships. Appropriate conformity to social norms is another aspect, involving increasing assertive responding, expressing anger positively through appropriate channels, and enhancing frustration tolerance (Annis, 1982). Cognition change addresses increasing non-criminal thoughts and modifying negative cognitions that could interfere with satisfactory hetero-sexual encounters (Annis, 1982; Overholser & Beck, 1986). These skills are learned and practiced to an appropriate level within a safe setting.

Social problem-solving skills can also be addressed

through a cognitive-behavioral approach (Berkowitz, 1982; Larson, 1988). By practicing patterns of behavior in dealing with various problems, more adaptive skills are learned through a series of trained successes (Berkowitz, 1982). Many individuals with emotional or behavioral disorders have been found to lack problem-solving skills; these may include poor impulse control, inability to come up with several effective solutions and inability to see others' views. Research shows offenders generally lack positive effective social problem-solving and gaining these skills can affect behavior in positive ways. Using the Social Thinking Skills Curriculum to aid in addressing thinking errors can be beneficial in this area, as well as use of techniques such as modeling, demonstration, role-play and group resources (Larson, 1988).

Looking at the precursors leading to feelings of isolation and how this affects interaction with others should also be addressed with the perpetrator (Taylor, 1986). Through awareness of past experiences and how the perpetrator internalizes this information, the therapist may help the perpetrator to see his likelihood of moving toward isolation, increasing the risk of incest behavior. Social skills training in both individual and group settings may set up situations for learning, practice, and reinforcement of social skills (Taylor, 1986). Through these different sources of interaction, he can establish a support system

first in and then out of therapy to support this change (Fowler, Burns & Roehl, 1983).

Assertiveness training is addressed with the offender (Annis, 1982; Rimm & Masters, 1974; Salter, 1988). This is recommended when individuals have learned to feel anxious when attempting to meet social needs (Papajohn, 1982). The goal is to increase appropriate assertive responding in social situations. In assertiveness training, the offender learns how to desensitize himself progressively to inhibit anxiety while gradually asserting himself in social settings, following systematic desensitization concepts (Papajohn, 1982). Assertiveness training has been found to be especially effective when addressing several different issues. First, this technique is effective when dealing with people unable to express anger directly. Often, the offender approaches anger or hostility in passive-aggressive ways. Learning more positive ways of expressing anger may also aid in the person building more satisfying and longer lasting relationships. This may also be effective if anxiety is connected to the offender's inability to comfortably express his feelings (Rimm & Masters, 1974). Second, assertiveness training may help an individual begin to express positive feelings, such as praise or affection. Learning these skills may help the client experience greater feelings of well-being or satisfaction in social interactions (Rimm & Masters, 1974). A third component of

assertiveness training addresses the offender's fear of authority (Sgroi, 1982; Taylor, 1986). The perpetrator first learns to identify his fear and then learns assertive, rather than aggressive, ways of dealing with this feeling. Assertive responses are practiced in a variety of ways and situations, using role-playing or behavioral rehearsal in session (Mayer, 1988; Papajohn, 1982; Rimm & Masters, 1974), coaching, modeling (Mayer, 1988; Papajohn, 1982), and homework assignments (Mayer, 1988).

Another treatment issue involves helping the offender to learn alternative manners of anger expression. This is important as anger is often a primary aspect of offender dynamics when acting out a sexual offense (Mayer, 1988). Increasing awareness of anger and working on appropriate anger expression is a focus whether passive or aggressive anger is shown by the perpetrator (Taylor, 1986). Anger is addressed through work with the offender, groups, and couples (Taylor, 1986). The therapist aids the offender in understanding how his unexpressed response to anger can build to outbursts, which defines the outburst as under the control of the offender (Mayer, 1988). Increasing awareness regarding anger and stress adding to anger arousal are addressed first, with anger expression training supporting this behavioral change (Groth, 1982; Mayer, 1988). The perpetrator learns to identify stressful situations and then to establish a plan to avoid them, while building coping

skills to deal with feelings of frustration or stress (Groth, 1982).

Rational behavior therapy is also used to help the perpetrator increase anger control. This process helps the perpetrator identify his perceptions and self-talk as leading to his choices of anger expression rather than expressing himself in another way (Nauth & Edwards, 1988). One aspect of anger is control, and the offender often believes that everything should be in his control. The perpetrator may use anger to try to gain control when other methods have not worked.

Rational behavior training is used as a part of working with offenders. Rational behavior training involves increasing awareness of defeating self-talk and gaining control over one's feelings and actions, therefore moving toward more positive self-talk and behaviors. This works within the concept of "emotional choice and responsibility". The focus is on reducing or eliminating anger feelings and challenging the offender's thought process, so he sees anger expression as a choice he makes, not one which is out of his control (Nauth & Edwards, 1988).

Male emotional expressiveness is another area to be addressed (Moore & Haverkamp, 1989). Expressing emotions is not culturally supported as an aspect of the male role, and men are generally not taught or reinforced to be emotionally expressive. Therefore, learning how to express emotions may

help the offender to increase communication with others, changing the pattern of behaviors and interactions that initially led to the abuse. There are four essential steps involved in assertiveness and expressiveness training. These steps include: 1) response acquisition and reproduction, 2) modeling response shaping, 3) cognitive restructuring, and 4) reponse transfer operations (Moore & Haverkamp, 1989, p. 513). There are also several scales that are used to measure emotional expressiveness. In a group setting, skill building, sharing of concerns and feelings, and learning through modeling of behavior is effective. When involved in this group, verbal expressiveness, identification and expression of emotion must be reinforced as they occur in the process of the group.

Another behavioral aspect of treatment involves a cognitive-behavioral parenting group for abusive parents to improve adaptive problem solving skills. Ambrose, Hazzard and Haworth (1980) describe a group model that works with cognitive-behavioral training. The focus of this group is that changing the parents' attitudes and thoughts to a more positive, adaptive stance may positively affect their emotions and behaviors. Four areas are addressed within this group: child development, teaching skills, managing problem behaviors, and anger management. Learning in the area of child development is important, as it aids abusive parents in learning more realistic expectations of age-

appropriate behaviors for the children and suggests interactive activities for them to do together. By learning and practicing teaching skills, parents learn to establish appropriate learning situations to encourage the children's compliance, deal with noncompliance, and teach in a manner that the children can understand. Dealing with problem behavior is also addressed in order to aid the parents to move away from an overly punitive and inconsistent approach. The parents learn to find the functional use of behaviors in order to understand how to work with the children in the most effective manner. There is also a focus on attending to and rewarding the child's appropriate behaviors, following the A-B-C model (antecedent-consequence-behavior). Managing anger is addressed by moving from anger-producing cognitions to coping cognitions. Specific behaviors and physical feelings or sensations are identified as cues to anger first, followed by a discussion of strategies to cope with these. The idea of how one's thoughts affect feelings and the manner in which one approaches a situation is brought up, then discussed with specific examples from each parent to begin practicing this cognitive anger-management technique. The authors also suggest that more time be spent on anger control so as to aid the parents in generalizing this information to their real-life situations. The new skills are learned and practiced in the group through modeling, discussion, role-playing and using video feedback

(Ambrose, Hazzard & Haworth, 1980).

Consolidation.

Redecision work is an aspect of the final stage of therapy (Kadis & McClendon, 1981) and involves cognitive restructuring. This involves looking at the present behavior which represents the old decisions from past information. The systemic process is interrupted, taking the person back through his past decision, and helping him to make a new decision with his present knowledge and information (Kadis & McClendon, 1981).

Relapse prevention is another focus near the end of treatment to aid the offender in gaining problem-solving and coping skills to prevent remolestation (Neidigh, 1991; Salter, 1988). Relapse prevention supports previous therapy issues and aids in the maintenance phase of behavioral work (Pithers, Kashima, Cumming & Beal, 1988). This cognitive-behavioral prevention model addresses self-control issues as well as aiding the perpetrator in abstaining from mal-adaptive behavior on a long-term basis (Neidigh, 1991). In describing the efficacy of this model for a range of behavioral control problems, Neidigh sees this as relating also to gaining self-control or eliminating maladaptive behaviors and impulses with children. Empirical evidence shows that many sex offenders can learn how to control themselves with treatment (Pithers et al., 1988). Lapse rehearsal further aids the perpetrator in addressing and

learning control of his behavior (Pithers et al., 1988).

A variety of techniques may aid the perpetrator in gaining more control to prevent relapse (Groth, 1982; Salter, 1988; VanderMey & Neff, 1986). He can be taught stimulus control techniques, including avoidance and escape strategies, coping and interpersonal skills, anger and stress management, stress inoculation, problem-solving, self-control skills, coping with urges for immediate gratification, as well as helping the client learn to intervene early on in the relapse process (Pithers et al., 1988). Other techniques used to minimize the extent of relapse include contracting, cognitive restructuring, and lapse rehearsal. It is important for the therapist to predict that the offender will experience urges again and aid the offender in practicing problem-solving skills to deal with the situation.

In summary, incest involves a set of dysfunctional behavior patterns that have been established over some time. Behavioral techniques are used to break these behavior sequences as well as giving the offender and family system access to a variety of behavioral alternatives which are functional in a much more positive way. Both behavioral and cognitive-behavioral techniques are used to help the offender stop incest behavior, gain more positive sexual and socializing skills, and maintain the new behaviors within his environment.

This chapter explores the integration of behavioral techniques within the systemic treatment of the incest perpetrator. Since a variety of sources aid in establishing and maintaining the incestuous behavior patterns, therapy addresses a variety of areas including individual personality, society, family of origin and family system (Barrett, Sykes & Byrnes, 1986). Use of various modalities may aid in the institution of behavioral change, as well as exploring affective states and examining roles and relation-ships within the family (Mayer, 1983). By integrating a variety of behavioral techniques in perpetrator treatment, additional focus and support is given to specific offender issues, as well as placing appropriate responsibility on the offender.

CHAPTER V

OUTCOME RESEARCH

There is a lack of research in the field of child sexual abuse (Wagner, 1987). Much of the available literature is more descriptive in nature than research-based (Meiselman, 1979). Clinical beliefs and treatment in this area have little empirical support (Conte, 1984; DePanfilis, 1986). Studies in the area of sexual abuse and incest tend to describe some individual characteristics and family dynamics that may be present, but are not supported through research. The area of treatment effectiveness is also seldom addressed.

When working with incest families, some unique concerns are present which may affect research. The current use of primarily clinical and case studies makes little use of theory (Parker & Parker, 1986). Withholding treatment from a control group creates an ethical problem (Sgroi, 1982). Use of self-report may be tainted by offender fear of consequences and the cultural view of incest (Mayer, 1988; Parker & Parker, 1986; Renvoize, 1982). Observational research has also been used, which may allow the observer to perceive and experience the change process in the clients, although observer bias and influences may occur (Mayer,

1988). Finally, study results are often generalized beyond the scope of the research, resulting in inaccurate interpretations of data (Laing, 1988).

Research in the area of family therapy has developed over the last thirty to forty years. A focus on important variables, such as Guerney's (1985) addressing pre-existing, process and outcome variables shows the early progress in this area. Similar to other therapy research, there are many methodological concerns, such as working with interactions, validity concerns, small samples, bias, and incorrect definition of the problems addressed. Use of two coders' agreement to define interactions has been used, but this may still be problematic. Interpretation of findings must also be done carefully (Nelson, 1983). Although family therapy has been used with incestuous families, Cross (1985) reported many mixed results regarding outcome, neither supporting not negating the effectiveness of family therapy.

Many methodological limitations are present in much of the research on sexual abuse or incest which has taken place up to this time. This includes such problems as: variance of the incest definition (DePanfilis, 1986; Meiselman, 1979; Sgroi, 1982), small samples (Alter-Reid et al., 1986; Conte, 1986; Meiselman, 1979; Parker & Parker, 1986; Vander Mey & Neff, 1982), lack of representativeness of samples (Conte, 1986; DePanfilis, 1986; Vander Mey & Neff, 1982), lack of random and probability sampling (Parker & Parker, 1986;

Vander Mey & Neff, 1982), lack of experimental controls (DePanfilis, 1986; Meiselman, 1979; Sgroi, 1982), and a failure to use comparison groups (Meiselman, 1979), objective measures, and statistical analysis of data (Alter-Reid et al., 1986). Systematic measurement of antecedents and effects (Vander Mey & Neff, 1982) and objective measures for individual and systemic assessment and therapeutic change are also needed (Sgroi, 1982; Trepper & Barrett, 1986). Lack of rigorous methodology and specifying to allow for replication has been problematic throughout the literature (Conte, 1984; Vander Mey & Neff, 1982). However, Cross (1985) reports that there has been progress in clarifying techniques and increasing individualization of therapy research, such as "...what treatment with what therapist with which clients under what conditions" (Cross, 1985).

Various findings are reported regarding the benefit of treatment for the offender. Many programs report that it is still too early to have outcome results (Taylor, 1986). One aspect that is often discussed in the literature is offender recidivism. Recidivism is often assessed through self-report and through the court system as an ongoing aspect of therapy (Groth, 1982) and is one of the few manners in which progress is reported.

Recidivism of sex offenders was reviewed in a study by Furby, Weinrott, and Blackshaw (1989). Although there were

numerous differences across studies which made comparisons quite difficult, the authors found several patterns from reviewing the literature in this area. First, they were unable to find support that clinical treatment reduces the rate of sex offenses or that it may be more effective for one type of offender than another. Second, there appeared to be a correlation between a longer follow-up period and a greater percentage of offenders committing another crime. Finally, some evidence may be present indicating that recidivism rates differ for different types of offenders. Issues such as working with different populations, different research designs and different manners of measurement made a more complete summary of the studies impossible.

The issue of treatability is discussed often in literature on working with offenders (DePanfilis, 1986; Fowler, Burns & Roehl, 1983; Groth, 1982; Kempe & Kempe, 1984; Mayer, 1988; Renvoize, 1982). A more positive prognosis is seen when a person takes responsibility for his actions, did not use physical force, has no psychopathology or criminal record, has positive social and occupational skills and has strong supports (O'Leary, 1990). If the offender accepts court-supervised treatment, a more positive prognosis may also be seen (Kempe & Kempe, 1984). However, prognosis in treatment often tends to be subjective, with no reliable outcome data. Poor measures of success or failure and short follow-up times are problems in

this area (Herman, 1981).

Although offender recidivism is often the criterion for success, Herman (1981) also suggests measurement of positive well-being for other family members. As well as the offender's acceptance of responsibility (Kempe & Kempe, 1984; O'Leary, 1990), the non-offending parent needs to accept appropriate reponsibility for her role in incest occurrence and understand the role as a protective agent in the family system to avoid reoccurence (DePanfilis, 1986; Kempe & Kempe, 1984). The child also needs the opportunity to address and understand what has occured while voicing any concerns (DePanfilis, 1986; Kempe & Kempe, 1984). Proper treatment given to the entire family is seen as a positive prognosis, although this is not necessarily true for the multi-problem family (Renvoize, 1982).

No empirical studies have been found to clarify the success of different treatment modalities (e.g. individual, group, marriage/couple, family therapy) (Wagner, 1987). However, there is some agreement in the field that traditional once-weekly non-directive or insight-oriented therapy is not effective with this population (MacFarlane & Bulkey, 1982 cited in Wagner, 1987). Although counseling and self-help groups have been reported as aiding in the treatment of incest families and stopping the continuation of incest behavior, none have been evaluated through the experimental process with control groups and random

assignment (Vander Mey & Neff, 1982).

There is also a lack of longitudinal, methodologically sound studies regarding effective treatment modalities (Mayer, 1988). Literature on systemic work does not generally include critical analysis of treatment, with the exception of Herman and Hirscman (1977) stating that psychoanalytic therapy should not be used because of the focus of guilt on the victim (cited in Vander Mey & Neff, 1982). Vander Mey and Neff (1982) report findings of the Giarretto's Child Sexual Abuse Treatment Program (Giarretto et al., 1978), that of over 600 families treated for over 10 years, incest has not reoccurred with those that completed the entire formal treatment plan. Although counseling is consistently reported to aid in treatment and prevention of incest, no evaluation has occured regarding education or self-help counseling (Vander Mey & Neff, 1982).

In summary, research in the area of treatment of the incest offender and family is still in a relatively new state. Increased attention to methodology, specific definition, and experimental design can be helpful in beginning to establish more comprehensive research in this area. More complete research may also be developed by "...determining which therapeutic approaches are most effiacious given various client characteristics and conditions of treatment" (Becker & Hunter, 1992, p. 89). To look further into the area of research, both systemic and

behavioral research will be discussed.

Systemic Findings

The current view of research in the area of systems therapy is that conceptual frameworks must be clarified and based on empirical findings. Research on treatment effectiveness has been lacking. Rohrbaugh and Eron (1982) also stated the need to demonstrate effectiveness of the strategic systems therapies as well as how they compare to other treatments. Some positive empirical support has been shown for structural family therapy in several areas (e.g. anorexia, asthma, psychosomatic symptoms, adult drug addictions) (Gurman & Kniskern, 1981b cited in Cross, 1985).

Conte (1986) reviewed the literature on the family systems approach to sexual abuse. He reported that father-daughter incest is a very small number of reported cases, while representing the bulk of literature. There is an assumption that incest is different from other types of child victimization, although this has not been supported by initial evidence. As systems theory is not causal, one must be careful not to assume relationships that have not been proven through research. Many of the characteristics that are used to describe incest families have not been demonstrated to be related or even present in some families. Conte advocated for an individual view of each family where all factors are taken into account to begin to establish relationships or interactions as supported by research.

Conte emphasized that the benefit of the family systems approach may only be found by working to establish empirical findings to support this work.

Although systemic research is quite recent (Parker & Parker, 1986), there is currently some work to address research in this area. Present research is being designed to work with and be useful for clinical treatment (Meredith, 1986). Longitudinal studies regarding treatment effectiveness and prevention planning are seen as productive (Kempe & Kempe, 1984; Parker & Parker, 1986). Time designs, such as multiple baselines, may increase information as an option to true experimental design (Conte, 1988). Single-case research may also be used, using clinical experiences to empirically build knowledge of the effectiveness of interventions, with reliability seen through independent agreement of coders (Nelson, 1983). This could be integrated into systemic therapy by making use of team members to observe and code behavior. Using all systems available (e.g. family, subsystems, larger systems) may help in gaining additional information and toward identification of change.

A review of family interaction research is described by Eisler, Dare, and Szmukler (1988). The authors note the lack of research in this area. They suggest a new approach to research in the family, looking at research "...as a process of hypothesis formation and testing, [which] is

quite consistent with a systems point of view" (Eisler, Dare & Szmukler, 1988, p. 56). By looking for a different way to formulate and test hypotheses, they look at possible ways to assess whether different kinds of observational data are able to be generalized. They suggest that one clinician's description and hypthesis of family interactions may be confirmed or falsified by another observer. Their study showed that complex clinical hypotheses can be verified through research. Several recent studies that have combined aspects of both research and clinical models of observation are discussed, suggesting further work to satisfy research criteria while focusing on issues of clinical importance.

There are several newer ways of approaching research to look at therapeutic change from a wider range. There are two types of research: the rational approach, that gets information directly from a source or family, drawing conclusions from inferences, and the empirical approach, used by observing actual interactions and family dynamics in session (Nichols, 1987). Using a combination of these two types may help to gain the most information when working with a family, to go beyond an individual focus with a relational vacuum (Sider, 1986). Specific social contexts may also be viewed as the focus of research to see if any specific context may increase risk of a particular problem, with the social context then being the focus of change (Clarkin & Haasm, 1986). Both individual and systemic

issues must be considered to sufficiently address target issues. There is some evidence that family treatment affects change beyond the targeted focus, which may support the strategic use of other family members to work toward change. As the context in which a technique is used is believed to be important to its effectiveness, e.g. individual vs. dyad or family, this is an area for future focus.

Although there is much literature on systemic theory, there is a noted lack of research in this area. Research addressing specific aspects of treatment and treatment effectiveness are a specific need. Finally, although there is much literature present describing the dynamics of the incest family and treatment recommendations, there are not studies available describing treatment effectiveness in this area.

Behavioral Findings

Behavior therapy has shown numerous studies to address different areas of research and treatment effectiveness. As behavior therapy integrates research and accountability as primary aspects of the theory, this is not surprising. A variety of studies describe the effectiveness of different behavioral techniques with incest or other sex offenders. A summary of the behavioral research will be described.

Empirical findings support positive results with assertiveness training. Rimm and Masters (1974) report

findings of two studies showing an increase in positive heterosexual relations after assertiveness training and above 50% maintenance in a one-year follow-up. Olfactory aversion has mixed research findings, with some reports of only short-term effectiveness (Renvoize, 1982), and others reporting effectiveness (Marshall et al., 1983). Bancroft and Marks (1968) used aversion therapy with four pedophiles with one showing lasting improvement. Quinsey, Bergerson and Steinman (1973) also used aversion therapy, showing increases in sex preference for adults (cited in O'Leary, 1990). Satiation therapy is reported as especially useful in bringing about rapid interest loss in inappropriate sexual stimuli (Salter, 1988). Positive results were found with use of covert sensitization in eliminating deviant behaviors and thought impulses (Quinsey & Marshall, 1983 cited in Marshall et al., 1983) and in working with situational molesters (Lanyon, 1986). Little empirical backing was found for masturbatory retraining (Mayer, 1988). Marshall and Eccles (1991) report that outcome evaluations show positive, although not conclusive, support for treatment, with cognitive-behavioral programs have the clearest empirical support.

Marshall and Barbaree (1988) described the outcome of outpatient treatment for child molesters (cited in Becker & Hunter, 1992). Techniques used to eliminate deviant thoughts included electrical aversive conditioning,

satiation therapy, and use of smelling salts. Education and practice in socialization and sexual knowledge were an additional part of treatment. Marshall and Barbaree (1988) also report results from follow-up from 9 to 117 months after treatment, showing 14% recidivism with treated and 32% recidivism with the untreated group.

Becker and Hunter (1992) reviewed studies that evaluate treatment outcome for adult perpetrators of child sexual abuse. They report that a variety of behavioral techniques were described in the literature, such as covert sensitization, aversion therapy, aversive behavioral rehearsal, arousal conditioning, masturbatory satiation, social skills training, and cognitive restructuring. Behavioral studies reviewed include: Kelly, 1982; Enright, 1989; Alford, Morin, Atkins & Schoen, 1987; Earls & Castonguay, 1989; Maletzky, 1980; Abel, Mittelman, Becker, Rathner & Rouleau, 1988; Marshall & Barbaree, 1988; and Rice, Quinsey & Harris, 1991 (cited in Becker and Hunter, 1992). Relatively low recidivism rates were found in all but one study, and a positive evaluation of treatment outcomes was given. Methodolological problems were still present, but a generally positive view of effectiveness of behavioral techniques was given.

A review of the literature shows more research in the are of behavioral treatment for sex offenders. This is to be expected as behavioral treatment and techniques are

generally research based. However, there are still problems in defining the effectiveness of specific behavioral techniques on the population of incest perpetrators, as most studies include a variety of techniques being used within the therapeutic study. Secondly, different groups are included in the definition of sex offenders for different studies. The focus of a study may range from including incest offenders, rapists, or child molesters, as well as reporting a wide range of potential violence of the offenders. All of these aspects need to be better clarified to increase the benefit of research for behavioral techniques in this area.

Future Research

Many topics have been suggested for future research. Conte (1984) described the need for studies in all areas regarding child sexual abuse, as the field is at the point where outcome studies can be generated. There needs to be a focus first on diagnostic studies, innovative treatment, and documentation of what is currently being used to get as much information as possible (Kempe & Kempe, 1984). Longitudinal studies are recommended to do future planning (Kempe & Kempe, 1984).

Several basic methodological issues need to be addressed in future empirical research in this area. This includes clearly defining the population and sexual offense (DePanfilis, 1986; Seng, 1986), establishing controls,

comparison groups, and clearly defining samples (Alter-Reid et al., 1986; DePanfilis, 1986). Studies should also be desgined with large enough samples to be able to gather more complete data.

All incest research should include use of as many assessment resources as possible. Comprehensive clinical assessment is of primary importance (Babins-Wagner, 1991). Therapeutic tools such as psychological testing or objective personality tests (e.g. Minnesota Multiphasic Personality Inventory or MMPI) may be more helpful, as structured, objective testing aids in unbiased reporting of knowledge (Meiselman, 1979). Numerous studies investigate the possible value or problems associated with using the MMPI for assessment and monitoring of offender treatment (Chaffin, 1992; Hall, Shepherd & Mudrak, 1992; Langevin & Watson, 1991; Langevin, Wright & Handy, 1990; Murphy & Peters, 1992). Assessment tools are also helpful in gaining information as they are researched with expected error of measurement identified and quantified (Laing, 1988). These provide additional information and may be used successfully within behavioral and systemic aspects of therapy. It is important to assure standardization of assessment procedures (Becker & Hunter, 1992). As many skills are part of evaluation for treatment success (Mayer, 1988; Taylor, 1986), viewing progress in these areas may give additional information regarding progress. Assessment and treatment

plans must address the individual needs of each family system.

Conte (1986) summarized several areas in which family therapy research should be focused in the area of sexual abuse. First, he suggests using a family perspective with all cases of sexual abuse, whether inside or outside the family system to begin to clarify similarities and differences for these situations. Second, research should be expanded to focus on the interaction between individual and larger systems, to begin to understand how these may affect vulnerability to incest and treatment effectiveness. Third, he suggested more of a focus on identifying processes that may affect sexual abuse development and/or maintenance. There should be continued research efforts including descriptive studies of characteristics that separate incest studies from others. Finally, an emphasis must be maintained on treatment research, clarifying treatment effectiveness and problem areas (Conte, 1986).

A variety of suggestions for future research are given throughout the literature (Alter-Reid et al., 1986; Conte, 1984). A few areas that deserve attention in this work include work with the incest perpetrator. Much of what has been written in the literature describes the effects of sexual abuse or incest on the victim (Browne & Finkelhor, 1986) rather than addressing offender treatment. As some offenders report sexual abuse as part of their history,

exploring the relationship between being the victim and then, later, the offender, may positively influence the direction of treatment. The effect of the larger systems, such as social services and court, should be viewed in conjunction with systemic therapy in moving toward positive change (Conte, 1984). Finally, research in the area of systemic work with the incest offender and family system needs to be addressed. This must be dealt with prior to research in the combination of behavioral interventions in the systemic treatment of the incest perpetrator.

By reviewing the literature, it may be seen that there is little conclusive research in the areas of child sexual abuse and systemic therapy. Although there is more research addressing different behavioral techniques with sex offenders, much of this work needs additional attention to specific methodological issues prior to being able to draw conclusions regarding the benefits of specific types of treatment effectiveness with this particular population. Increased information in these areas would be needed as a primary basis to begin research on the effectiveness of treatment for incest offenders that combines systemic therapy and behavioral techniques.

CHAPTER VI

SUMMARY

The majority of literature in the area of child sexual abuse supports the conclusion that the entire family system is involved in the functioning of incest behavior. It is also quite challenging to address this behavior in a positive and comprehensive manner. As treatment with the perpetrator has not been a primary focus in the literature up to this time, this was determined to be an area where attention is needed. This work has described the integration of behavioral techniques in systemic work to challenge and address the needs and issues of the incest perpetrator. Both the benefits and potential problems with this approach will be discussed.

The family systems approach is the primary approach mentioned in the literature when working with the treatment of incestuous sexual abuse. Systemic theory is used because of its ability to address the circular interaction of individuals involved in the family system that create and maintain the system which supports incest behavior. Behaviors and cognitions of the individual can also be viewed within the systemic view. Change must occur within the system to support individual behavior change. Incest

has been addressed in much of the systemic literature, with specific conceptualization and treatment ideas being addressed particularly within structural-strategic work. Many techniques have been developed in structural-strategic therapy that work well in addressing the incestuous family system, such as the variety of techniques used to address denial. The many writings on incest in the structural-strategic approach make a strong basis for individual work with the offender.

Many aspects of behavioral treatment are also seen as effective in changing the behavior of the incest offender. This is important, as many specific behavior changes must occur for the offender to assure that he will not continue to abuse sexually. Through use of specific behavioral and cognitive-behavioral techniques, effective change may occur to help the offender learn and practice new cognitions and establish new patterns of behavior. Although systemic issues that allow incest behavior to occur are to be kept in mind, many individual offender issues must be addressed through direct behavioral techniques to stop the incest behavior.

There are several specific behavioral concepts that are particularly appropriate for work with the incest perpetrator. First, the incest behavior must be stopped. Second, the behavioral approach emphasizes the offender's responsibility for his behavior rather than placing blame on

other parts of the family system. Also, there are many behavioral techniques that allow a clear focus on many offender issues, such as addressing inappropriate cognitions, increasing positive socialization, changing inappropriate sexual behavior, and increasing sexual knowledge. Finally, behavioral work focuses more on measurements of specific behavior and has more research available than systemic therapy to support treatment effectiveness.

There are several benefits in combining systemic and individual perspectives. First, by looking at a situation systemically, normative information is provided regarding family functioning. This normative information can be used as a framework to integrate therapeutic alternatives (Sider, 1986). Absence of the individual perspective may result in missing some individual aspects or motivations that affect the family system. Similarly, when systemic variables are ignored, information may be missed regarding complementary roles or interactions, including the systemic benefits of certain interactional patterns or individual behaviors (Boszormenyi-Nagy, 1986). The family system is often the context for finding the function or meaning of a behavior and is an additional source of information. Instead of approaching the treatment of incest with a rigid therapeutic framework that mirrors the rigid responding of the incest family, use of both systemic and individual variables is

proposed in order to work with each family system in an individualized manner.

There are several points of discussion in reviewing this work. There are a variety of areas that are addressed in offender treatment that include the goal of lessening or stopping the frequency of specified behaviors while increasing more positive behaviors. Both behavioral and systemic approaches address change in the present and have specified techniques to learn new skills to work toward change in behaviors and interactions. The combination of specific behavioral techniques in systemic work with the perpetrator supports the idea of maintaining the systemic concept even while working individually with the perpetrator. The two approaches support each other in working toward the goals of change for the perpetrator.

One area to be addressed involves the division of father-daughter incest from other types of incest in much of the literature and treatment considerations. This separation of work with incest perpetrators from other perpetrators of sexual abuse has not yet been supported through any literature. Some sources stated that this group is sometimes over-represented in reported cases of sexual abuse and literature (DePanfilis, 1986; Parker & Parker, 1986). Conte (1986) has suggested applying the family systems approach to all sexual abuse cases until research is found to support or negate any differences from dynamics or

treatment issues in father-daughter incest from other types of incest. As this separation does not appear to be grounded in any research base, it should be disregarded until clarified through research.

A review of the literature also emphasizes a primary need for research. Much of the current literature is descriptive in nature rather than being research-based. An additional challenge arises to incorporate more research in work with the incestuous family system without returning to the linear style of other studies, defeating the systemic theory. As systemic and family approaches have seldom been addressed or supported in research, this is a critical need to further treatment. The behavioral techniques which have more empirical support are to aid in research support with this population. Behavioral research must also continue to increase information regarding specific sex offenses under more controlled situations to establish or to strengthen this research base. By integrating the two approaches, there are more possible ways to address research toward the goal of establishing measurements of treatment effectiveness.

An additional reason to address treatment effectiveness is the cost benefit of offender treatment in comparison to incarceration (Becker & Hunter, 1992). There is a realistic concern in American society of balancing the possible need for treatment or incarceration of the offender with the

questions of appropriateness and of cost of care. Offender treatment is quite cost effective in comparison to incarceration. Since offender treatment tends to be more of a continuum of care rather than a "solution", the emphasis should be moved to offender treatment whenever possible rather than incarceration.

In summary, this approach organizes two primary theories and treatment modalities which have addressed incest or sexual abuse treatment in previous studies. The combination of structural-strategic and behavioral theory supports individual treatment issues of the child sexual abuse offender through use of behavioral techniques within the established systemic approach. The integration of the individual behavioral techniques with systemic work also supports the therapist in addressing different issues about the incest with the appropriate parts of the system, such as work with the individual, subsystems, or the family system. This also reinforces offender responsibility for the abuse. The tools of behavior change that have been specified in previous behavioral work can be used to support issues unique to the offender and provide a basis for research. The conceptual basis described here may also be supportive for work with other aspects of the incestuous family system. This work offers a positive approach to treatment of the incest offender by using a strong theoretical basis to conceptualize incest treatment in a

more managable and specific way.

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The thesis is, therefore, accepted in partial fulfillment of the requirements for the degree of Master of Arts.

April 13, 1994 — Date

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