

## INTEGRATING MARITAL AND INDIVIDUAL THERAPY FOR INCEST SURVIVORS: A CASE STUDY

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*This article focuses on the integration of individual and marital therapy modalities in the treatment of an adult incest survivor who was experiencing marital distress. A case study is presented that illustrates a particular approach to the treatment of marital disorders with an incest survivor and her spouse and a particular form of integration.*

The current climate in the marital and family field is one that fosters an integrative approach across treatment approaches and, more recently, across modalities. This impetus has arisen from the need to match the diversity and complexity of the phenomenon the therapist is trying to change with powerful, relevant, and flexible treatment strategies (Lebow, 1984). Various approaches to integration have been advocated in this field (Johnson & Greenberg, 1987b), the two most viable being a theoretical and clinical synthesis of two or more complementary approaches or the matching of specific interventions from different approaches to particular problems as they arise in therapy. The issue of how and when to integrate individual intrapsychic and interpersonal systemic change strategies seems to be particularly pertinent at the present time (Nichols, 1987).

This article presents a case study of therapeutic change in an adult incest survivor requesting marital therapy for relationship problems in which experiential individual therapy was integrated with emotionally focused marital therapy (EFT), an experiential systemic approach to restructuring the marital bond (Johnson & Greenberg, 1987a). The

case is then presented as both a general illustration of the integration of marital and individual therapy and as a specific example of the use of these integrated modalities to address this kind of presenting problem.

### **Incest as a Determinant of Relational Problems in Adulthood**

There is substantial evidence that incest experiences in childhood are associated with long-term disruptions in normal adult living, particularly problems in forming and maintaining intimate sexual relationships (Buskirk & Cole, 1983; Gelinas, 1983; Meiselman, 1978; de Young, 1982). It is difficult to specify direct causal links between incest experiences and later problems since the disordered family structures conducive to incest tend to be damaging in themselves and the disclosure of incest may also create family disruption or even disintegration. Incest is also a multifaceted phenomenon in which sexual exploitation of a child by a trusted family member is only one aspect. The isolation and deprivation resulting from the secrecy surrounding the incest may be as ultimately damaging as the incest itself, particularly as it often occurs at a critical time when the child is learning how to relate to others. Many factors play a part in how traumatic and damaging incestuous experiences may be. It has been suggested, for example, that father-daughter incest is more damaging to the victim than sibling incest; however, in at least one study of long-term effects, sisters involved in incest were found to be just as disturbed as daughters (Meiselman, 1978). Other factors may also play a role in determining the severity of long-term effects (Finkelhor, 1979). These factors include the age of the child when the incest occurs (evidence suggests that the younger the child the more long-term negative effects), the duration of the incestuous relationship, and the family's response upon disclosure as well as the amount of force and coercion used. Specifically,

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the effects of incest have been summarized by various authors as depression, low self-esteem, suicidal behavior, and psychosomatic disturbances (Deighton & McPeck, 1985; Tsai & Wagner, 1979). Victims also tend to take unassertive roles in adult relationships and are seemingly unable to terminate or avoid abuse. This may be related to the fact that women victims tend to have had passive, submissive mothers as models when growing up and to have a low sense of self-efficacy especially in relation to members of the opposite sex. Such women have had little experience of how to balance taking care of others and caring for themselves.

The most prevalent and pervasive effect of childhood incest, however, appears to be an inability to trust others. This, then, results in extreme ambivalence concerning intimacy, minimal self-disclosure, and a sense of worthlessness which in turn creates self-defeating relationship patterns with the opposite sex (Tsai & Wagner, 1978). This is hardly surprising considering that incest is sexual abuse that occurs in the context of a dependent relationship in which a child expects and requires nurturance and protection and then experiences profound abandonment and betrayal. These women tend then to experience themselves as vulnerable and defenseless and to have negative expectations about how much control they have over life events and relationships in particular (Buskirk & Cole, 1983). All of the above tend to foster rigid coping defenses which then create problems in adult relationships.

The second most pervasive effect of incest appears to be sexual dysfunction. The incestuous experience seems in many cases to pervade adult sexual relationships resulting in orgasmic dysfunction and a general lack of sexual responsiveness. Sexuality has become associated with pain, fear, and guilt, and some victims choose to avoid sexual relationships altogether or turn to homosexual relationships. Intimacy and sexuality are then predominantly viewed in a context of paralyzing fear and evoke memories of a time when the victim was overwhelmed by negative emotion and betrayed by a trusted protector. Gelineas (1983) relates the phenomenon mentioned above to post-traumatic stress syndrome and suggests that adult victims' response to the incest trauma can be viewed as chronic traumatic neurosis resulting in repression and dissociative numbing to stimuli associated with the original abuse. However, such numbing is never totally effective, and repetitive intrusions

occur often in the form of vivid flashbacks that create a heightened sense of vulnerability and a desire to seek treatment. Nevertheless treatment is most usually sought for issues such as relational problems, and the incest is often not disclosed to the therapist. This disguised presentation where the history of incest remains hidden, and negative affects are therefore not available for treatment, is exceedingly common.

Treatment for incest survivors has often been delivered within a group format and the focus has been on issues such as learning to trust, letting go of shame and guilt, accepting the self as worthwhile and lovable, and confronting the powerless stance that survivors often assume in present relationships (Blake-White & Kline, 1985; Wooley & Vigilanti, 1984). From the nature of these issues it is also apparent that a natural arena in which these problems arise and may be dealt with is in present adult intimate relations. The self is defined in relation to the present other and the relationship with this significant other is where the issues arising from the incest can be worked through. An alternative to group treatment of incest victims is the combination of individual and marital therapy. Emotional reactivity and blocks arising from the past incestuous experience exhibit themselves most powerfully in present intimate interactions and in this context become explicit and accessible to change. The issues of separateness and connectedness, differentiation of self, and dependence on others can be worked through in relation to the family of origin (Deighton & McPeck, 1985) or in relation to the survivor's current marital relationship.

In the context of couples requesting marital therapy it seems especially important for therapists to inquire as to possible childhood sexual abuse since the effect of such abuse can be a primary determinant of current relationship problems which then need to be addressed on an intrapsychic as well as an interpersonal level.

### **The Integration of Marital and Individual Modalities**

Until recently the main concern in terms of integration in the psychotherapy field in general, and in marital therapy in particular, has been integrating interventions across various approaches, for example, behavioral and dynamic change strategies in marital therapy (Segraves, 1982). More recently, however, there is a recognition of the need to provide flexible treatment packages that

include more than one modality and perhaps combine individual, marital, and/or family interventions. Specifically, there has been a growing concern in the field as to how best to integrate interventions that focus on the experiencing individual with interventions that focus on the interpersonal context (Nicols, 1987).

Until now, approaches have been relatively modality specific. For example, systemic interventions, while implying that marital dysfunction is the basic structural problem in dysfunctional families, have focused mostly on resolving triangulation using family therapy. Dysfunctional patterns involving three or more members of a system have been addressed rather than applying systemic interventions to the couple relationship *per se*, and individual motivation and change processes have largely been discounted. On the other hand, problems that have been defined in individual terms such as depression have begun to be viewed more and more in terms of interpersonal context, but interventions have remained within the modality of individual therapy and have not included couple or marital treatment (Klerman et al., 1984).

If the psychotherapy field is now at a point of integrating not only across various approaches and change strategies but across modalities, then many of the same issues that are relevant to integrating across approaches may apply (Johnson & Greenberg, 1987b). If integration is to be viewed as more than simply the expansion of permissible strategies, it is necessary to find or create theoretical and clinical continuity between the differing approaches or modalities to be integrated. It would be difficult, for example, to integrate behavioral marital therapy with experiential individual sessions. Two basic models for integration have been proposed. One consists of a synthesis of two models that address intrapsychic and interpersonal dimensions. The second advocates focusing on the total patient system including individual, marital, and family aspects. Specific different approaches and modalities might be used at various points in therapy. In this second model, the therapist is constantly involved in a process diagnosis of the determinants of the presenting problem and choosing the appropriate approach and modality for that problem. A therapist might then suspend structural family therapy and refer a client for analytic individual therapy for a time (Pinsof, 1983). This article focuses on the first model where two approaches or modalities form a coherent synthesis. Such a synthesis should then allow for

an easy flow between individual and marital sessions and intrapsychic and interpersonal interventions.

One approach to integrating self and system is then to synthesize an interpersonal systemic perspective with a complementary and compatible intrapsychic perspective. Two possibilities here appear to be object relations theory (Finkelstein, 1987), which suggests that present interactional behaviors are a projection of intrapsychic schema created in past intimate relationships, and Kohut's (1977) self-psychology, which focuses on the individual's need for security and a sense of self-worth and how these needs can be achieved through relationships with others. Here the integration of self and the creation of mature, nurturing, intimate relationships with others is viewed as different sides of the same coin. Using this kind of perspective, a marital therapist might then focus on various elements of self and how they are played out in a personal relationship; that is, the therapist may take an intrapsychic focus at various times in the couple session or schedule individual sessions to create insight into intrapsychic needs. It is not completely clear at the present time how insight into individual schema concerning the self in relation to others then translates into the creation of new relationship events and new interactional patterns, which is the main concern of a modality such as marital therapy.

A third theoretical perspective that facilitates the integration of individual and interpersonal modalities is an experiential gestalt approach (Kaplan & Kaplan, 1982, 1987; Lesonsky et al., 1986), which views the experiential organization of the individual as creating the field in which that individual operates and the field as maintaining each individual's dominant organization of experience. The aspects of self that arise in any given situation are then constantly constructed from the intrapsychic processing of experience and the interpersonal rules, or what experience is supported in a particular context. Therapy based on this model attempts to facilitate a more inclusive and flexible way of processing experience and thus a wider range of interactions; aspects of self previously disowned can then be integrated into self and system. This process can occur between therapist and client as in individual therapy or between clients as in marital or family therapy. The way the gestalt experiential and systems perspectives fit together in terms of their view of human functioning, pathology, and the process of change is

discussed more fully elsewhere (Greenberg & Johnson, 1988). In both perspectives, change may be seen as essentially a process of amplifying deviations in interpersonal patterns and intrapsychic processing. The gestalt perspective, however, does not refer to circular causality but to the process of mutual influence and the reciprocal determination of inner and outer realities. It provides a kind of metatheory that includes interpersonal and intrapsychic elements.

One approach to marital therapy that lends itself to the integration of individual and couple interventions is EFT (Johnson & Greenberg, 1987a). This approach is a synthesis of experiential, gestalt, and systemic interventions that allows for great flexibility of focus and easily accommodates the use of individual experiential sessions interspersed with conjoint couple sessions. EFT focuses on the present processing of experience and the creation and enactment of that experience in relationships. In conjoint sessions, the focus shifts between intrapsychic and interpersonal realities; individual sessions are an extension of this change process rather than a new direction or the inclusion of an alien element.

Presented below is an example of a treatment program for an adult incest survivor experiencing marital distress, a presenting problem that particularly lends itself to the integration of individual and marital modalities. The therapist in such a case has to modify rigid perceptual schema and emotional responses arising from distrust of others and rigid interactional patterns that reflect these responses and schemas and also maintain them.

### Case Illustration

Mary, a 35-year-old government employee, came into therapy because she had become involved in an extramarital affair and wished to extricate herself from this relationship and talk about her confused feelings concerning her marriage. This marriage was Mary's second; the first had been very short and occurred when Mary was very young. Mary had been married to her present husband, Paul, an engineer, for ten years and had two daughters under five. After terminating the extramarital affair, Mary and her spouse began marital therapy. The couple presented an extremely rigid interactional pattern of pursue-withdraw during therapy, with the husband pursuing for emotional contact, sharing, and sexuality and Mary resenting his intrusiveness and withdrawing. Paul suggested (wrongly) that Mary's sexual detachment was a result of her being molested by her father, which Mary denied. In an individual session, however, which is part of the routine assessment procedure in EFT, the issue of incest was discussed. In the session, with the therapist's support, Mary was able to share that from the time she was eight until the time she was twelve, she was constantly molested by her oldest brother (who was seven years older). This brother was the mother's favorite, very

talented, and always in poor health; for the last years of his life he had cancer and the sexual abuse ended when he died at the age of 18. Mary was clear that to tell the therapist this secret was to betray her brother who was very much alive for her and her family. The mother, who apparently knew nothing of the abuse of her daughter, still talked of the oldest son constantly and visited his grave frequently. Mary's siblings, her sister (2 years older) and her younger brother (3 years younger) respected the family belief that the older brother was "perfect." Mary's father seemed to occupy a peripheral and passive role in this family. The older brother's illness in this case exacerbated Mary's guilt: "How could I hate him? He was sick, he was dying, so what I felt didn't seem to be important." The only safe place for Mary during the years from 8 to 12 was an uncle and aunt's house which she was occasionally allowed to visit on weekends and holidays. She would threaten to tell her mother about her brother's behavior but did not, because she was afraid of his anger and also because she was unsure of her mother's response. She experienced her mother as rejecting and uncaring. In therapy, she minimized her experience, had difficulty showing any anger toward her brother, and felt guilty revealing this secret to the therapist. With the support of the therapist, she then told her husband about both her recent affair and the past sexual abuse.

### Intervention Procedures

Individual and couple modalities were integrated. The goals for the individual sessions with Mary were to alleviate guilt and shame and explore issues of basic trust, control, and self-worth. These issues were explored using experiential techniques and techniques particularly suited for working with affect (Greenberg & Safron, 1986). The sessions focused on the client's experiences, such as her fear when she heard her husband's footsteps on the stairs, or her sense of violation during sex, and the interpersonal consequences of her experience, such as her withdrawal from her husband and her occasional bursts of hostility toward him. The client was encouraged to reprocess problematic situations and techniques such as repetition, and the use of concrete metaphors were used to heighten and expand her experience in the present. For example, the client spoke of shutting her husband out and so protecting the "little girl," the vulnerable part of herself, from him. She summarized her tendency to dissociate herself from her experience: "When there is nothing but fear, the only way out is to disappear." She then began to explore her tendency to "disappear" in various problematic situations such as during foreplay or when emotional closeness was offered to her. At one point a gestalt two-chair intervention was used to allow Mary to express and explore feelings for her brother such as her fear, rage, and sadness at his betrayal. This allowed her to place responsibility for the incest on the perpetrator and access her need for

security and caring. The dissociative process, splitting or blocking, which protects such clients from the terror and pain associated with the incest experience (Blake-White & Kline, 1985), can be effectively addressed using gestalt experiential techniques. The client at various points was able to speak from polarized aspects of her experience. For example, one aspect was examined as, "You are not important—and if no one was there for you it is because you are dirty, not worth loving, and so have no right to be angry; maybe you are lying or crazy." The second aspect was expressed as pain and rage at being betrayed and helplessness and terror at feeling so vulnerable and so alone. Each aspect was elaborated on and experienced so that the first could be challenged and an integration of both aspects could take place. The therapist used techniques to promote the full experiencing of these positions rather than insight-oriented interventions. These aspects of self also emerged in a vivid manner in couple sessions and were explored on an interpersonal level. For example, Mary was unable to accept signs of caring from her spouse and would reject his gifts or affection. Once she was able to accept his comfort she then accessed grief at her previous deprivation and great fear of the loss of her newfound security. The concurrent processes of intrapsychic exploration and relationship redefinition reciprocally influenced and reinforced each other.

In the individual sessions with the husband, which were not as frequent as with Mary, the goals were to help Paul deal with his own response to his wife's behavior, and support him to be present in the relationship in a way that facilitated her opening up to him. This necessitated working on his own frustrations and anxieties which were implicit in his interpersonal style. This style in the beginning of therapy was rather aggressive, demanding, and intrusive. He was insecure and anxious that he could not get his wife to respond to him. He also needed support to deal with the extreme emotions his wife was experiencing.

In the couple sessions, the goal was to alleviate the marital distress maintained by the couple's severe pursue-withdraw interactional pattern by modifying the cycle so that both partners could be more flexible in their relationship positions and more accessible and responsive to each other. It was necessary to create a climate in the relationship in which Mary's basic struggles and blocks concerning trust and safety could be addressed and resolved.

The use of individual and couple sessions was planned to a certain extent but also evolved as the requirements of therapy became apparent. Therapy started with four individual sessions, with Mary focusing on her brief affair. This led to a series of twelve marital sessions where the couple's relationship was assessed and treated and the issue of Mary's sexual abuse became explicit. The therapist then proposed a format where Mary was seen for a number of sessions alone (ten sessions) to deal with some of her blocks in the relationship with Paul which seemed to arise from her incestuous experience. After five months, the focus of therapy shifted again and sessions became mostly marital sessions, interspersed with occasional individual sessions for Mary and sessions on request for Paul. This easy flow across modalities was possible because the individual and couple interventions were compatible and complementary both on a theoretical and clinical level. The process also reflected the particular presenting problem in that sessions were often two weeks apart, whereas the therapist normally preferred a weekly format and decisions concerning modality shifts were made with the couple's, especially Mary's, input and participation. These kinds of accommodations were necessary to keep the pace and intensity of therapy at an acceptable level for this couple, particularly Mary, and to give her a sense of control over the process.

The pace of the therapy process was also lessened by the alliance issues that arose. The potential issue of the husband feeling excluded or threatened by the alliance between the therapist and Mary did not arise but was monitored by the therapist and addressed in individual sessions with him. The alliance between Mary and the therapist, however, reflected the mistrust that incest victims normally feel not only for the perpetrator but also for other family members, such as the mother, who are experienced by the victim as betraying and depriving. In this case, Mary had never told anyone of her abuse and had felt totally isolated and uncared for in her family. The therapist also became, at times, the one who had somehow forced her to betray her brother to whom she had a fierce loyalty. The client tended to be somewhat reticent in the therapy process and to see the therapist as an aggressor and potential violator, at least until the last months of therapy. The alliance between the therapist and client was a recurring issue in therapy.

The process of therapy in terms of main themes,

issues, and progress is described below.

The first set of conjoint sessions after the couple assessment focused on Mary sharing her past experience and helping Paul to deal with her revelations. The pursue-withdraw cycle was also explicated and the feelings underlying this cycle expanded on. The couple's problem was then redefined (step 4 of the EFT treatment process) in terms of Paul's anxiety in the face of his wife's distancing and his response, which was to demand and push for physical and emotional closeness, and Mary's fear of contact, inability to trust, and need to protect herself from men, which resulted in her staying in her shell or resentfully accommodating to his needs. Paul experienced himself as powerless and rejected in the relationship, while Mary experienced herself as coerced and terrified. Mary's intrapsychic issues concerning guilt, control, and fear of closeness were clearly enacted in the interaction with her spouse. At first the most prominent issue was resentment of his perceived attempts to control her. The therapist facilitated her owning of her position of "I'll shut you out." The couple then moved into step five of EFT which involves owning and exploring underlying feelings. Paul was able to explore his fear of being abandoned and desire to push for a response rather than to ask from a position of vulnerability. Mary was able to explore her need to be taken care of "as a child," and to feel safe with Paul. They then went on to access their needs and listen to the needs of the other. At this point in therapy, Mary began to refuse sex, and Paul was able to accept this. The relationship between them had improved considerably and the negative cycle was less rigid and automatic. As the couple became closer and the relationship safer, Mary became aware of various times or trigger points when her alarm at "almost trusting" Paul would increase. As she put it, she nearly let go of her shield. She also became clear that at these points it was her abusive brother she was relating to, not Paul himself.

The focus of therapy then shifted to individual sessions. Paul needed some sessions (three in all) to support him in his desire to help his wife and to allow him to control his reactions to her distancing. Issues such as his sense of failure in the face of his inability to make Mary feel loved were dealt with. In the individual sessions with Mary, she began to work more intensely on her fear of being abused and controlled. The typical issues for incest survivors arose here, such as her inability

to have faith in the love and caring of others and her view of herself as unworthy and unlovable. Mary explored her feelings toward her brother and became more and more aware of how flashbacks to that experience determined her sexual and emotional responses to her husband. Using techniques such as the two-chair technique Mary was able to confront her ambivalent feelings of rage and love for her brother. Grief was also involved in that allowing herself to become angry at him meant losing the main attachment figure of her childhood. As Mary attended to her experience and resynthesized her emotional responses, core self-schema concerning the essential unworthiness of self and a sense of abandonment by the whole family were uncovered and confronted. Specific points at which fear would arise in her relationship with her spouse were explored, but specific memories were still obscure. The confusion between past and present here was acknowledged, as when Mary stated, "I don't know who raped me, my husband or my brother," or when she felt driven to respond to her husband's needs and deny her own, thus reflecting her past compassion and loyalty for her dying brother, or when she felt her fear of taking control and saying no, thereby incurring his (her brother's/her spouse's) anger and rejection. The sensation of being trapped, squeezed, and intruded on, wanting to scream for help and knowing no one would come, was the most immediate emotional reality of sexual contact for Mary. She was able to acknowledge that she punished her spouse as if he were her brother and began to share herself much more openly with him. After these individual sessions, the treatment format then shifted again to a synthesis of individual (mostly with Mary) and couple sessions.

At this point, the couple sessions involved Mary asking for more time to gradually begin to trust and allow Paul close and Paul dealing with his anxiety concerning this process. She was able to share her fear of opening up and "paralysis" with him and asked to be cared for "like a little girl" and he was then able to respond. She was then able to make love to her husband "for the first time," and differentiate between her dead brother and her spouse. She was also able to accept and respond to her husband's need for reassurance without feeling totally responsible and compelled to take care of him at her own expense. In the conjoint sessions, Mary was gradually able to withdraw less and to test out and enact her doubts

as to the reality of her husband's love for her and the safety of letting him come close. Outside the sessions, she was able to share with him when flashbacks occurred and to allow him to comfort her. At this point, she was also able to experience orgasm for the first time during lovemaking.

After one year of therapy (approximately 30 sessions) the couple were reporting significant differences in their relationship and interacting very differently in therapy sessions. Mary seemed to have resolved many of the issues arising from her incest experiences. She was able to differentiate responses that reflected past rather than present experiences, for example, resenting her husband when he expressed a need for physical care such as when he was sick, stating in the session, "I don't care if you die," and realizing that the target of this response was her brother rather than her husband. The couple then entered the termination phases of treatment and attended a number of monthly sessions to ensure that changes made were integrated into the relationship. At the suggestion of the therapist, Mary also enrolled in an incest survivors group to support her as she continued to grow and change.

## Summary

The successful resolution of this case seemed to be a function of the use of intrapsychic and interpersonal interventions which reflected on and modified one another. In terms of the question of how best to integrate individual and marital modalities this article suggests that to facilitate a complementary flow between individual and marital or family modalities, a theoretical and clinical synthesis of individual and interpersonal models is necessary. These models should then be compatible in terms of clinical focus, change strategies, and concepts of human functioning. One possibility is an experiential information-processing approach that lends itself to a focus on the process of how the self is construed and thus constructs interactional patterns and how these patterns then reflect and create the self as experienced. EFT, a synthesis of intrapsychic and interpersonal approaches, easily accommodates the inclusion of individual sessions.

The determination of when to switch to specific modalities becomes, as Pinsof (1983) suggests, a function of determining blocks to future progress and how best to address such blocks. It may be possible, for example, for some incest victims to

deal with their issues simply in the interpersonal arena of marital therapy without engaging in individual sessions. This kind of integration across modalities requires a constant process diagnosis and a continual decision by the therapist as to which modality creates the most leverage for change.

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