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Breaking Secrecy

Adult Survivors Disclose to their Families

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With families in which incest has occurred, secrecy is the organizing principle of all family relationships. Both the testimony of survivors[2,5] and the clinical literature[9,11] emphasize the central role of the incest secret. Children who have been sexually abused by adults outside the family also frequently keep this secret as a result of intimidation or shame.[7,17,18] Secrecy compounds the trauma of the sexual abuse itself by isolating the victim from others, so that her perceptions can not be validated.[16,19] Often the victim comes to doubt her own experience of reality, which is at odds with the family's version of the truth. Many, if not most, victims of child sexual abuse reach adult life still preserving the rule of secrecy.

Disclosure of the secret has been described as an important step in the process of recovery.[11] However, few authors have described this process in detail. Brief discussions of disclosure to the family of origin may be found in recent works by Bass[3] and Courtois,[6] and a somewhat more extensive description is provided by MacFarlane and Korbin.[15] These authors all emphasize the powerful impact of disclosure both upon the victim and her family, an impact that can either be therapeutic or destructive. All advise caution and careful preparation in order to minimize the potential for negative outcomes and maximize the therapeutic benefit of disclosure.

In this article, we will define some of the parameters that we believe determine a successful disclosure. Our impressions are based upon ten cases in which one of the authors (ES) assisted the patient in the preparation and conducted the family meetings in which disclosure took place, 20 cases in which the same author consulted to other therapists to assist in the preparation for a family disclosure, and 50 cases in which patients in group treatment with one or both of the authors utilized the group support to prepare and carry out a disclo-

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sure. A fuller description of the group treatment model may be found elsewhere.[13]

RATIONALE FOR DISCLOSURE

Disclosure of the secret to the family of origin is an important part of the process of recovery from child sexual abuse. It provides the opportunity for the adult patient to speak the truth that as a child she was obliged to conceal. Many adult patients have for years cooperated with what they perceive to be a family rule of silence regarding the abuse. In preserving the family secret, they carry the weight of a burden that does not belong to them. Unburdening is a powerful step toward giving up the shame, guilt, and sense of responsibility for the abuse that so many survivors feel.

Disclosure also encourages freer communication within the family and frequently prompts other family members to come forward with suppressed information. This not only provides the patient with new insights about her family, but also potentially aids other family members who have been carrying a burden of secrecy. Disclosure also decreases the danger to any other children known to the family who may still be at risk from the same offender.

Disclosure may also be a step toward renegotiating relationships within the family from the position of an adult with choice and power. The experience of child victims of sexual abuse is one of powerlessness and forced compliance. Often the adult survivor continues to relate to her family in much the same way as she did as a child, perceiving the wishes of her parents and other family members as compulsory rules that must be obeyed. Disclosure represents a voluntary departure from perceived family rules.

Finally, disclosure often provides an opportunity to heal the mother–daughter bond. In many incestuous families, the perpetrator actively undermines the relationship between mother and daughter in order to establish his sexual domination of the child. The mother is rendered powerless and unable to protect her daughter.[10,11] Many survivors feel betrayed and abandoned by their mothers. In the absence of direct communication, they usually believe that their mothers knowingly or willingly sacrificed them. Survivors often feel contempt for their mothers' powerlessness. They may by extension regard all women (including themselves) as undeserving of respect or trust. The disclosure session represents the beginning of free communication between mother and daughter and may provide the opportunity to begin the restoration of their badly eroded relationship. We believe that reestablishing the connection between mothers and daughters, when this can be achieved, is highly therapeutic and empowering for both parties. For many survivors, forgiveness for their mothers is inextricably linked to forgiveness for themselves.

We also place special emphasis on breaking secrecy between mothers and daughters, because we have found that mothers are more

likely than offenders to be receptive to disclosures, to take responsibility for their role (usually a passive one) in perpetuating the abusive situation and to take some action to make amends. They are also more easily enlisted as guardians of the next generation and tend to take active steps to protect other children (younger siblings or grandchildren) who are still at risk from the offender even if they do not ostensibly admit that they believe their daughters' disclosures.

Disclosure can be an empowering experience regardless of the family's response. Because power resides in the truth-telling itself, a well-prepared disclosure cannot fail. The purpose of the disclosure is for the patient to speak the truth as she knows it, without need for confirmation from others and without fear of the consequences. How the family reacts to this information is not the patient's responsibility. Clearly, a validating and sympathetic response is extremely gratifying when it occurs, but the patient's belief in the validity of her experience should not depend upon family acceptance. A disclosure session may be quite successful even if met by hostile denial. In this case, the patient is encouraged to observe the family pressure for silence, and to enlarge her understanding of the dynamics of the family. She is empowered by her ability to maintain her own point of view despite intense pressure to recant.

When questions of disclosure or confrontation are under consideration, the therapist will often find that his or her own feelings about the patient's family of origin are strongly aroused. For example, the therapist may see a family member as hopeless and incorrigible and may encourage a rupture of what appears to be a completely unrewarding or destructive relationship, without regard for the patient's loyalty and attachment.[8] Overly protective feelings for the patient may lead the therapist to discourage initiative and risk for which the patient is in fact prepared or to intervene in an attempt to "rescue" the patient from the family. Conversely, anger and impatience may lead the therapist to push a patient prematurely into a confrontation. The therapist must constantly examine his or her own emotional responses in order to avoid pressuring the patient into actions that reflect the therapist's rather than the patient's agenda.

TIMING AND PREPARATION

Proper timing is the single most important determinant of a successful disclosure. The therapist must know when to stand firm in the face of urgent pressure from the patient to proceed immediately, as well as when to encourage the patient who believes she could never openly discuss the abuse with any family member. Patients often attempt a disclosure prior to entering treatment or very early in the course of treatment. This premature disclosure is almost invariably a disappointment to the patient, who rarely has a clear understanding of her own motivations and proceeds on the basis of impulsive anger or unrealistic expectations. The family rarely responds as the patient

wishes, and the patient has not yet learned that her well-being is not contingent on her family's response. Feelings of failure and self-doubt are common following a poorly timed disclosure. Fortunately, an early unsatisfactory experience does not preclude the possibility of later attempts, with better preparation and much better results.

The work of disclosure properly belongs in the later stages of treatment and recovery. Prior to contemplating a family disclosure, the patient should have stabilized her own self-care and self-protection and should have established a good working alliance in therapy. She should have reasonable access to her own memories of abuse, though her memory need not be complete. She should be able to relate the details of the abuse in the safety of her own therapy and should be able to bear the associated affect without flight into dissociative symptoms or self-destructive behavior. She should be clear in her own mind that the responsibility for the abuse lies with the perpetrator. She should have some understanding of the psychological harm caused by the abuse, and should have had the opportunity in treatment to mourn the losses of her childhood. She should feel compassionate toward her child/victim self, and should have some experience of the power of righteous anger as opposed to the destructiveness of helpless rage. In short, she should have achieved a degree of self knowledge and self-integration that will be able to withstand active denial, blaming, and rejection that may be provoked by confrontation with the family.

The preparation period for a family disclosure may range from 6 months to 2 years. In early stages of treatment, when patients are not yet ready for disclosure, the focus may be on taking some degree of initiative and control in the ongoing contact with other family members. The established pattern of holiday rituals, visits, letters, and phone contacts should be carefully explored. The patient may initially need help in negotiating simple appropriate boundaries and setting limits on family contacts that are destructive to her. As the patient is recovering painful memories in the course of treatment, she may initially wish to reduce phone contacts or visits or even suspend them completely for a time. She may wish to use visits to observe her family dynamics or to gather information that would shed light on the abuse history. Each small departure from established patterns of relating to the family may feel very threatening both to the patient and to the family; explicit preparation is necessary to help the patient assert herself without feeling the need for elaborate explanations or angry outbursts that would result in full disclosure. At this point in preparation, the deliberate decision *not* to engage the subject with the family may be empowering to the patient.

Example 1

During her childhood, Alice had made many unsuccessful attempts to gain protection from her brother's sadistic sexual abuse. Her indirect complaints had been minimized or ignored, because her brother was so highly valued in the family. Her brother had since died. His memory was celebrated prominently at all family holidays and gatherings. Alice

felt obliged to endure the glorification of her brother in silence as the price of inclusion in the family holidays. An important early step in her preparation for disclosure was her decision to leave a Thanksgiving dinner when home movies of her brother were shown, without calling attention to her departure or offering an explanation.

The patient invariably begins the process of preparing a disclosure hoping that it will lead to validation from the family. The patient initially hopes that the perpetrator will accept responsibility for the abuse, apologize for the hurt and pain he inflicted, and do something to make amends. She hopes that the nonoffending parent (or parents) will believe her story and apologize for failing to protect her. The patient also initially fears (and, of course, also wishes) that the disclosure will have a catastrophic effect on the family. She may fantasize that her father will have a heart attack or stroke during the session, that her mother will have a nervous breakdown, that her parents will divorce following the disclosure, or, if the offender was not a part of the immediate family, that both her parents will become enraged and kill him. The patient may also fear catastrophic retaliation from the offender, who may have threatened such retaliation in the past.

Though the patient usually fantazies that disclosure will have a tremendous impact, in reality most families respond to disclosure with denial or minimization and tend, after a short period of time, to carry on as though nothing had happened. Some family members may in fact harden their denial in response to disclosure. One task of the therapist in preparation for disclosure is helping the patient bring her expectations into the realm of reality. By the time she enters the disclosure session, the patient may still hope for a dramatic response to her words, but she must be ready for disappointment. The therapist should pay special attention to helping the patient imagine all the responses that might possibly occur and anticipate her own reactions in detail. A list of questions the patient might ask herself in anticipation of disclosure may be found in a recent self-help manual for survivors.[3]

In the initial stages of preparation, the patient may also regard disclosure as an all-or-nothing event in which the secret is dramatically revealed to all family members at once. The family is often perceived as a monolith, with unitary and undifferentiated responses. This assumption should be questioned at the outset. The patient should be encouraged to consider carefully which family member might best be chosen for an initial disclosure. It is useful to review systematically a list of family members and even friends of the family, in order to locate someone who might be supportive and validating or who might offer additional information. The patient should be encouraged to make an initial approach to the person most likely to be receptive. Often the patient is able to identify a relative who may be considered "different" or "eccentric" or may have been scapegoated or excluded from the family. Such partial outsiders may be receptive to a disclosure and may offer new insights or perspectives on the family. This information is then incorporated into the planning for the next step in family disclosure.

With each disclosure to a family member, the patient obtains more information about the family, integrates this information, and is more able realistically to identify sources of support and opposition. She may then move on to the next step in the disclosure process, building from the most to the least receptive family members. Siblings often turn out to have independent knowledge of the abuse or to have been victimized also. Disclosure to a sibling may result in the formation of a new alliance for understanding the dynamics of the family and validating the patient's experience.

In cases of sibling incest, patients are often confused about whom to hold accountable for the abuse. The offender is almost always an older brother who in childhood appeared very powerful to the patient. However, the patient also frequently feels great empathy for the offender, recognizing that he too was a child at the time. Because sibling incest frequently occurs in a neglectful or oversexualized family environment,[1] the patient may recall the incest initially as an attempt on the part of both siblings to find comfort and nurturance that was otherwise unavailable. For this reason, full resolution is rarely achieved by disclosures or confrontations among siblings alone. Involvement of the parents at some point in the disclosure process is usually necessary.

In cases of father–daughter incest, the patient may decide initially to disclose to a sibling or to her mother without confronting the father directly. However, these disclosures often put the mother and siblings in a position of divided loyalty, in which they feel challenged to take the patient's side against the father.[4] They may respond with anger at the patient who has refused to maintain the status quo in the family and has placed them in such a difficult situation. In order to avoid scapegoating and retaliation, the patient must be prepared to make it clear to mother or siblings that she is simply asking them to listen, not necessarily to take any particular action or to choose sides in a family conflict.

Some incest victims will not be interested in confronting their fathers at all but will wish to confront their mothers. They may initially feel more anger toward their mothers, who they perceive as having neglected and abandoned them, than toward their fathers, who at least paid some attention to them.[11] In these cases, preparation for the disclosure session must include a clarification of the fact that responsibility for the sexual abuse lies only with the father. The patient is encouraged to express her anger at her mother's failure to protect her but also to develop a more realistic view of the limitations of her mother's power and resources. The active role of the father in undermining the mother–child relationship is carefully explored. The patient may for the first time entertain the idea that her mother might have been kept away from her rather than actively rejecting her. An attempt is made to reconstruct the economic, social, and psychological circumstances in the mother's life during the patient's childhood. In this process, questions often arise that can be posed during the disclosure session, thus involving the mother in the reconstruction of the family history.

Example 2

Beverly's mother had endured years of marriage to an alcoholic and violent man who sexually abused all four of their children. Beverly believed that her mother willingly tolerated the abuse and felt embittered and alienated from her. After careful planning, Beverly invited her mother to meet with herself and her therapist. In response to her disclosure, her mother expressed regret, took responsibility for her failure to protect the children, and acknowledged that she had been overwhelmed, intimidated, and unable to cope with the situation as she would have wished. Beverly assessed the impact of these meetings as follows: "Even though our relationship still has many ups and downs, I think I learned better how to appreciate my mom's situation in this world and she learned better to appreciate mine. I was surprised and pleased to discover that we didn't occupy such alien worlds after all."

Other patients may wish to proceed with a direct confrontation with the offender. In these instances it is especially important that the patient be prepared to face active denial, blaming, and attempted retaliation. If the offender is her father, she must also be prepared for his attempts to recruit other family members to discredit and scapegoat her. Occasionally, if the father has a high potential for violence, physical safety will have to be considered as well.[15] Even acknowledgments and apologies may be couched in such minimizing and evasive language as to negate their value to the patient (a verbatim example of such an "apology" may be found in an article by Trepper[20]). In general, we recommend that the confrontation with the offender be deferred until after alliances have been built with other family members, especially in cases of incest. The more disclosure work that has been done prior to confronting the offender, the greater the possibility that the family will support the patient and contain the aggression of the offender.

As the patient prepares for a disclosure session, there may be vacillations and setbacks that interfere with her readiness. A fixed timetable should be avoided, and the patient should resist either internal or external pressures to set a date based on matters such as family convenience, holidays, or major events in others' lives. The purpose of the disclosure is the empowerment of the patient; therefore, matters such as the scheduling of the session should be as far as possible at the patient's convenience and under the patient's control. The patient should be prepared to negotiate not only the request for the disclosure session, but also such matters as the date, time, and location of the session and the question of payment for the session if it is conducted in the presence of a therapist. The patient should also anticipate and plan her contact with family members in the period immediately preceding and following the session.

Example 3

Carla's mother did not drive and habitually relied upon Carla for rides. When Carla's mother accepted an invitation to meet with Carla and her therapist, both mother and daughter initially assumed that

Carla would drive her mother to and from the session. As the time approached, Carla recognized that this prospect greatly increased her anxiety. She therefore arranged taxi transportation for her mother.

The patient should be considered ready to proceed when she has a clear and detailed agenda for the disclosure session, feels capable of taking charge of the agenda within the session, has anticipated as far as possible all the possible outcomes of the disclosure and feels ready to accept whatever the outcome may be. She is fully prepared when she understands that the true purpose of the session is for her to break the rule of silence and tell her experience aloud.

THE DISCLOSURE SESSION

The role of the therapist in the disclosure session is to create an atmosphere of safety and calm, to facilitate the meeting, to validate the patient's reality, and to bear witness to the patient's story. Although the therapist takes the position that the whole family can benefit from the session and is prepared to offer consultation and support to all family members, it should be clarified that the session is being conducted at the initiative of the patient and for the benefit of her recovery. It is a family meeting, but not a family therapy session, as the family has not requested treatment. Following the disclosure, some members of the family may wish to enter therapy for themselves, either separately or together, but this is a matter separate from the disclosure session.

The disclosure session may be conducted by a patient's individual therapist or by an outside consultant. An outside consultant may be called upon for several reasons. The individual therapist who has no training in family therapy may not feel comfortable with the task of facilitating a potentially difficult family meeting and may request a consultant experienced in working with families. The family may feel less defensive with an outside consultant than with the patients's primary therapist. The patient may feel protective of her relationship with her individual therapist and may be reluctant to compromise this relationship by permitting her family to intrude upon it. An outside consultant is generally freer than the patient's primary therapist to offer support to other family members without compromising the alliance with the patient. If an outside consultant is brought in, he or she will need to work closely with the primary therapist.

The therapist's role in the session is to empower the patient to carry out her prepared agenda. After initial introductions and explanations of the purpose of the meeting, the therapist provides structure in such matters as timekeeping, focusing the attention of all participants, and reminding the patient of her agenda. As far as possible, however, the conduct of the session is turned over to the patient. Patients may wish to speak from notes or to bring in other prepared materials.

The patient may wish to begin by setting out her guidelines or

rules for the session. It is usually necessary to make explicit rules, for example, that there be no physical contact or no interruptions when one person is speaking. The initial guidelines may focus on apparently trivial matters; in fact they create an environment of safety and empowerment for the patient. It is often a completely novel experience for patients to imagine that they can be the maker of rules. Many patients use the guidelines to pre-empt likely responses that they would find intolerable.

Example 4

Denise wished to disclose to her mother. She anticipated that her mother would respond by launching into long, rambling, digressive stories deflecting attention away from the secret of sexual abuse. In the guidelines for the session, she told her mother that if anyone got off the main point she would interrupt and return the focus to the matter at hand.

Example 5

Elizabeth instructed her father, the offender, that explanations or additional information were welcome responses but that denials would not be heard during the disclosure session. She stated a rule that he could choose to remain silent or to leave, but not to challenge her statement of facts.

After the initial guidelines have been stated, the patient then tells the family members present what happened to her, including specific details of the sexual abuse. Vague or general statements are usually insufficient, because they allow for avoidant or minimizing responses. Patients may resist sharing details of the experience because they feel this is an additional invasion of their privacy. With adequate preparation, however, they come to understand that their privacy was destroyed long ago and that only the privacy of the offender is protected by secrecy.

Example 6

Frances read the following narrative to a family meeting at which her father, mother, brother, and sister were present: "When I was 7 years old, daddy came to my bedroom for the first time. He told me that I was old enough for a special secret game. He sat down on the bed and held down my shoulders with one hand. Then he put his other hand under the covers and penetrated my vagina with his fingers, breathing heavily, and whispering that I was really going to like this. When he was finished he warned me that I would be sent away from home if I ever told anyone about this."

Patients may or may not wish to tell their story with feeling in the disclosure session. Some patients may fear breaking down and crying or giving in to angry outbursts; conversely, some patients may fear that they will become numb and dissociated in the session and simply "go through the motions." It is not possible to predict ahead of time what the patient will feel; however, the patient can plan ahead of time for

the therapist to intervene if she is responding in a manner that threatens to disorganize her in the session. It is also important to give permission ahead of time for whatever feelings may emerge during the telling of the story, so that the patient does not feel obliged to live up to a preconceived "right way" of doing it.

Following the recitation of the facts, the patient then describes the impact that the abuse has had on her life. She may wish to give a chronology of her development, leading up to a description of the long-term effects upon her adult life. The patient who has had amnesia for the experience for part of her life may wish to describe the process of recovering memories.[14] As in the narrative of the abuse experience, it is important for the patient to be as clear and explicit as possible; however, she may also wish to preserve some boundaries. For example, she may wish to state that her capacity for intimate relationships has been seriously impaired without describing the details of her sexual dysfunction.

The patient may also at this time wish to describe the effects that the abuse has had on her relationships with the people in the room. Here, again, concreteness and attention to detail are most effective in communicating the reality of the problem to the family. Family members often tend to minimize the impact of the abuse and to urge the patient to "put it in the past," and "get on with life." Explanation of the long-term effects of the abuse elucidates the ways in which disturbed family dynamics continue in the present, long after the sexual abuse has ended.

Example 7

Gail told her mother: "It wasn't safe to visit you with my children. I was afraid to let Dad babysit or let the children sleep in a separate room. Until I was ready to tell you what happened I couldn't explain."

Example 8

Harriet told her father: "Every time I come home to visit you try to get me alone and ask me how's my love life. You find ways to brush up against my body and touch me. It makes me sick to my stomach, and I hate it."

Following this disclosure the patient should be prepared to tell family members exactly what response she would like to hear from them in the session and what concrete actions, if any, she would like from them in the future. Patients should feel free to ask for the responses they most admire, as long as they are prepared for disappointment. Some families, in fact, may be able to respond appropriately but have no idea of what is wanted. The patient may be so unused to stating her wishes and the family so unused to considering them, that no reciprocity has been possible up to this point. Some patients may complain that having their wishes granted will be meaningless if they have to state them explicitly and that only a spontaneous empathetic response would be acceptable. However, in families ruled by secrecy, empathy has been almost by definition destroyed, so that a clear state-

ment of wishes is necessary to reestablish any sort of positive relationship.

Example 9

Irene, the oldest of seven children, had been repeatedly abused by her father. During Irene's early years, her father had been extremely violent and had beaten her mother repeatedly. Her mother had fled several times, taking the younger children with her, but leaving Irene and two brothers alone with her father. In preparing to disclose the sexual abuse to her mother, the patient determined that she wanted to ask for an explanation of why she had been left with her father when other children were protected.

During the disclosure session, the mother stated that she was saddened but not surprised to learn of the abuse. She described a situation in which she had many small children and no money or skills, and was dependent on unsympathetic relatives for refuge. She stated that her relatives would take in no more than four children, and that she left Irene and her brothers reluctantly, believing she had no other options. She stated that she had felt very guilty for abandoning Irene and her brothers but had hoped that they would be old enough to protect each other.

Example 10

In the course of a disclosure session, Joanna stated that she wished to hear her mother say that she loved her. Her mother replied, "Of course I do." The therapist interceded, reminding the mother that the patient had asked to hear the words "I love you." With great embarrassment the mother repeated these words, after which both mother and daughter cried and embraced.

The patient's statements about her wishes following the session are usually brief, because the patient will need time to digest what has occurred in the session before deciding what further contact, if any, to pursue. The patient may request that a family member keep the session confidential, allowing the patient to disclose to others in the family at her own pace. She may request that future contacts take place in a certain manner, or that no further contact take place until she is ready to initiate it. More long-range wishes may include requests for redressive action. The patient may ask family members to take action to ensure that the perpetrator no longer has access to other children in the family. When the perpetrator is confronted, the patients may wish to request that he pay for some part of the cost of her treatment or that he seek treatment for himself.

THE AFTERMATH OF DISCLOSURE

A successful disclosure is almost always followed by exhilaration and disappointment. The patient feels surprised at her own courage and daring. She has broken the secret and survived; no great catas-

trophe has befallen her or her family. Comments like "I didn't know my own strength" are common. She no longer feels intimidated by her family or compelled to participate in destructive family relationships.

Where the possibility of restoring some family relationships has been opened up, the patient may feel excited and even euphoric; soon, however, the patient must face the reality that rebuilding a damaged relationship, even with the best of intentions, is a slow and tedious process. Where the response of the family has been hostile and invalidating, the patient must give up the hopes for the fantasized reconciliation. A period of active grieving usually follows a disclosure session; however, in its aftermath, the patient usually feels less entangled in the demands and rules of the family and freer to pursue more rewarding relationships with adult peers. In the words of one patient:

"Initially I felt a sense of success, completion, incredible relief! I was so glad it was finally over with. Then, I began to feel very sad, deep grief. It was extremely painful and I had no words for what I was feeling. I found myself crying and crying and not knowing exactly why. This hardly ever happens to me; I am usually able to have some kind of verbal description to accompany or explain my feelings. This was just raw feeling. Loss, grief, mourning. As if they had died. I felt no hope, no expectations from them; I felt the clear experience of their limitations and I knew there was nothing that was unspoken on my part. In other words, I didn't feel, 'Oh, if only I had said this or that.' I had said everything I wanted to say in the way I wanted to say it. I felt very complete about it and was very grateful for the lengthy planning, rehearsals, strategizing, etc. It allowed for maximum clarity and maximum safety for me, and minimized the possibility that I would be violated.

"Since then I have felt free . . . I feel HOPE! I feel like I have a future! I feel grounded, not like I'm manicky or high. When I'm sad, I'm sad; when I'm angry, I'm angry. I feel realistic about the bad times and difficulties I will face, but I know I have myself. It's very different. And it's nothing I ever could imagine, not at all. I always wanted this freedom and I was always fighting to get it. Now it's no longer a battle—there's no one to fight—it's simply mine."

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