

Reclaiming the Mother–daughter Relationship after Sexual Abuse

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This paper seeks to provide direction to therapists working with mothers and daughters after a disclosure of father–daughter sexual abuse. The importance of the mother's belief in and support for the child's recovery is highlighted, as are some of the cultural assumptions about mothers and daughters which negatively impact on the relationship. Despite paying lip service to offender responsibility, there continues to be a culture of mother blaming in the child sexual abuse and family therapy literature on incest. Current research findings challenge some of the prevalent myths about mothers' responses to their children's disclosures. Few clinical sources have addressed this issue, and therapists who reject the mother blaming literature are therefore left with little guidance as to how to work more effectively with mothers and daughters. Consequently they may unwittingly further undermine the relationship. Work with mothers and daughters as they recover from intrafamilial sexual abuse is discussed, and key therapeutic themes and guidelines for practice presented. We explore the significant theme of the rebuilding of trust between mothers and daughters and facilitate a process whereby the woman is able to bear witness to and acknowledge the trauma experienced by her daughter.

INTRODUCTION

This article documents a practice model which has arisen out of our struggle to make sense of the experiences of young women and their mothers, as they attempt to reclaim their relationship after the ravages of sexual abuse.¹ Having rejected the mother-blaming practices we found in the clinical literature, we discovered few sources which could give us guidance in working respectfully and effectively with mothers and daughters.² In seeking new directions we have drawn on a range of theories, including Feminism and Social Constructionism, but have found that no single theory is adequate to explain and deal with the complexities of families, relationships and sexual abuse. Our practice is informed by the theoretical considerations outlined in this paper, and by the knowledge gained through our clinical practice, with theory and practice continually informing and critiquing each other.

THE CULTURAL CONTEXT OF THE MOTHER–DAUGHTER RELATIONSHIP

*'A son is a son 'til he takes him a wife;
a daughter's a daughter for the rest of her life'
(folk saying)*

It is impossible to think about working with mothers and daughters after incest without understanding the

cultural context in which this relationship occurs. Accorded a unique and special place in our culture, the mother–daughter relationship remains central to women's lives, and yet painfully vexed. Walters sums it up in the following way: 'if mother is the cornerstone of family life, the mother–daughter relationship is the bricks and mortar that holds it together' (Walters, 1988: 34).

Accordingly much has been written about mothers and daughters, in both the popular press and academic literature (Friday, 1977; Rich, 1986; Abramson, 1987; Firman and Firman, 1989; Edelman, 1994; Debold, Wilson and Malave, 1994; Walters, 1992). For all the differences between these works, and there are many, a common thread is the complex ambiguity of the relationship between mothers and daughters. As Rich says, '... The materials are here for the deepest mutuality and the most painful estrangement' (Rich, 1986: 226).

This polarisation of the mother–daughter bond between a deeply satisfying and mutually enriching relationship on the one hand and an aching divide with the capacity for terrifying destruction on the other has its roots in the way in which we have represented mothers in our culture. As Parker (1995) explains, 'the mother' has been either idealised or denigrated. Writers have either extolled her virtues and in doing so created a kind of goddess, the 'perfect mother'; or alternatively portrayed her as the 'monster mother' who has been held culpable for all the ills of her children. This split creates and reinforces what Caplan (1989) calls 'Mother–Daughter Barriers', which are represented by the 'perfect-mother' or 'bad-mother myths'. She argues that these myths ensure that mothers and daughters

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remain divided, and blame themselves and each other for the barriers between them. She summarises:

... in the daughter's eyes, the Perfect Mother myths make all mothers' good efforts seem inadequate because they're imperfect, and the Bad Mother myths highlight mothers' failings and even make some of their strengths or neutral points seem harmful (Caplan, 1989: 69).

The contradictions of the Perfect mother or Bad mother myths have particular relevance to mothers and daughters after incest, leaving both in a bind. Both parties internalise these unattainable ideals: the images shape daughters' expectations of their mothers, and mothers' own expectations of themselves. Furthermore when the cultural expectation that the mother-daughter relationship will be totally satisfying and fulfilling is not met, both feel cheated. As Walters asks,

How is it possible for daughters to escape blaming their mothers for whatever goes wrong in their lives when this view is supported by popular cultural images, and codified by social and psychological theorists (Walters, 1988 40).

The Table extends Caplan's ideas to those we consider to be particularly powerful after a disclosure of incest. Through the mother myths listed by Caplan, women's ordinary faults or limitations become failings as mothers. 'Bad mothers' exist in the shadow cast by the 'perfect mother', for by definition they are everything that 'perfect mothers' are not.

These myths exist for all mothers, but after a disclosure of incest, become particularly constraining. They highlight the dilemmas which women face as they attempt to respond to the changing expectations of family life. Men are meant to be less 'absent' in their families, and women are expected to assist this process by stepping aside and allowing partners to develop new ways of being fathers to their children. This conflicts with the expectation that women will also act as protectors and oversee the family relationships; for how can fathers independently develop appropriately close and intimate relationships with their children, if mothers are

always to mediate? If one looks closely at the myths outlined above, the woman's dilemmas become clear. The difference in her achieving the label of 'good' versus 'bad' mother may depend entirely on the actions of her husband. A woman can behave in exactly the same way—for example allowing or encouraging a close relationship between her husband and daughter—with the judgement as to whether this constitutes 'good' or 'bad' mothering depending on whether or not he chooses to abuse her trust.

Mothers by definition are not women; they are mothers first and foremost (Walters, 1988). Concern for herself or her marriage is in conflict with the requirements of the perfect mother, yet faced with the disclosure of incest, a woman feels paralysed and in deep shock. Her world is suddenly in turmoil, and at that precise moment, when her resources may be most stretched, she is expected to be a capable, protective parent putting the needs of the abused child above all others (Dwyer and Miller, 1996). Women struggle with what to do and how to juggle the contradictory demands made upon them, torn between the needs of the abused child and those of other children in the family, and between their own needs and others'. The myths which encourage them and their daughters to believe that mothers will always know what is best, and will know how to respond in a selfless and assured way, leave no room for the reality of the abuse and its impact on the mother-daughter relationship.

Against the background of the perfect mother or bad mother myths, understandable responses to crisis are interpreted as further evidence of the failure of the mother, and of her relationship with her daughter. In this way both mother and daughter fail, by not achieving the mythical perfection of the mother-daughter bond. As therapists we are faced daily with the reality of mother-daughter relationships which may be under enormous stress, and bear little resemblance to the fantasy of the unbreakable bond; and yet the ache of a daughter for her mother's support and nurturance, and

Table 1:

'Perfect mother' Myths	'Bad mother' myths
Perfect mothers are all-knowing and all-seeing*	Bad mothers refuse to know the truth
Perfect mothers know what's best	Bad mothering causes lasting harm to children
Perfect mothers have a uniquely close and loving relationship with their daughters	Bad mothers let others come between themselves and their children
Perfect mothers put mothering first	Bad mothers put their own needs first
Perfect mothers facilitate a close relationship between children and fathers	Bad mothers allow fathers to abuse their children
Perfect mothers treat all their children equally	Bad mothers ignore the abused child's needs

*Humphreys (1990) has discussed in detail the implications of the belief in mothers as all knowing and all seeing.

our acknowledgment of the centrality of that connection in our culture, requires us to find creative and respectful ways of assisting them toward recovery.

THE IMPORTANCE OF THE MOTHER TO THE CHILD'S RECOVERY

The longlasting and negative impact which abuse may have on survivors is now well documented and accepted, confirming the experience of clinicians who daily see the self destructive impact of the abuse on the bodies, souls and minds of their clients (Mullen, Martin, Anderson, Romans and Henderson, 1993). Less recognised is the negative impact on the mothers of the children abused, yet there is substantial evidence that mothers may warrant being viewed as 'secondary victims' (Byerly, 1985; Deblinger, Hathaway, Lippman and Steer, 1993). Maternal suicide attempts have been reported, as has ongoing psychological distress (De Jong, 1986; Goodwin, 1981; Kelly, 1990). Issues of grief and loss are profound for both mother and child, emotionally, practically, and economically (Dwyer and Miller, 1996).

Despite the severe impact which abuse may have on both the woman and her child, there is strong evidence that the path to recovery for a victim is enhanced by strong support from the non-offending parent, in this case the mother (Adams-Tucker, 1982; Conte and Schurman, 1987; Everson, Hunter, Runyon, Edelson and Coulter, 1989). In addition, mothers are often viewed as important to effective intervention, with a significant relationship between low maternal support and psychological disturbance in victims (Kemp and Kemp, 1978; Herman and Hirschman, 1981; Merrick, Allen and Crase, 1984; Lawson and Chaffin, 1992; Wyatt and Mickey, 1988). Finklehor (1984) noted that child victims whose relationship with their mother was emotionally distant may be at greater risk for the development of mental health difficulties, while Gilgun (1990) found that the presence of confidants and supportive persons in a child's life were more important in affecting outcome than were aspects of the abuse. Berliner (cited in Schonberg, 1992) interviewing child victims, reported that the key to regaining emotional health for children was not counselling, but support from their mothers.

Given the evidence regarding the importance of the mother's belief and support in her child's recovery from sexual abuse, it can be seen as good common sense to make extensive efforts to engage and support women whose children have been abused, and this course may well turn out to be cost effective in the long term. However the history of mother-blaming is long and remains entrenched in practice. The conceptualisation of the mother in the literature has traditionally been of little assistance to those wishing to engage with women; adopting the attitudes found there would severely constrain a therapist's ability to engage with a woman and support her in helping her child.

MOTHER-BLAMING LITERATURE AND ITS IMPACT ON WORKERS' ATTITUDES

The clinical literature on incest has looked at mothers and daughters from various angles, but until recently was interested in the mother's culpability—that is, it was an exercise in mother-blaming. The focus was on the extent to which she was responsible for the occurrence and/or continuation of the abuse (Kaufman, Peck and Tagiuri 1954; Lukianowicz, 1972; Justice and Justice, 1979). With scant evidence and questionable research, authors concluded that mothers were collusive, weak, and ineffectual (Gutheil and Avery, 1977; Zuelzer and Reposa, 1983; Lustig, Dresser, Spellman and Murray, 1966). It has been claimed that mothers frequently respond to their daughter's disclosure of incest with disbelief, and/or rejection. The conclusion drawn was that incest was in part caused by a poor mother-daughter relationship; that mothers sacrificed their daughters sexually to their fathers; that the daughter's failure to disclose the abuse was further evidence of their poor relationship; and that the mother and daughter were competitors for the man's affections.

The feminist critiques of this literature changed the parameters of debate by highlighting the role of gender, and the power differential between women and men (McIntyre, 1981; Carter et al., 1986; James and MacKinnon, 1990; Dominelli, 1989). These critiques exposed the sexist values and attitudes which underpinned the conclusions drawn in existing literature. Wattenberg concluded:

.. recent appraisals have pointed out that a substantial portion of the literature on father-daughter incest is replete with logical fallacies, built-in biases, and occasional sheer nonsense. That fragmented observations based on skewed clinical samples were accepted as doctrine that shaped practice is a serious charge against scholars in the field who purport to provide research-based knowledge as a base for practice (Wattenberg, 1985: 205).

Despite the existence of convincing refutations of these works, and of the values which underpin them, they remain a powerful influence on beliefs and practices. Current authors continue to cite them without mentioning their limitations, or fail to cite more recent research which negates their conclusions (Tinling, 1990; Levang, 1989; Engel, 1991). The values and attitudes such works espouse have become rooted in the field with a permanence which defies logic, and the power of their ideas to influence practitioner attitudes has been amply demonstrated. Dietz and Craft (1980) studied the attitudes of 200 protective workers, particularly on the role of the mother in incest. They found that workers' attitudes paralleled those attitudes found in the literature, with the strongest relationship being between reading the literature and the belief that the mother was equally responsible for the abuse. A decade later, Kelley (1990) found similar attitudes. She surveyed over 200 police, child protection workers and nurses in the USA, and asked subjects to attribute responsibility based on a range of scenarios of sexual abuse. She found

that 88% did not hold the offender entirely responsible for the abuse; 84% attributed some responsibility to the mother—whether or not the offender was in the family; and that 20% attributed some responsibility to the child. In the Australian context, in 1990 Breckenridge (cited in Breckenridge and Berreen, 1992) found in her New South Wales survey of child protection staff, that while workers were not as blaming of mothers in the occurrence of abuse, 71% maintained the belief that mothers knew to some extent about the abuse prior to the disclosure.

Finding a helpful position to take vis-a-vis the mother and daughter relationship, has therefore remained a complex issue. Therapists are familiar with the hurt and bitterness with which many survivors view their mothers, and it is not unusual to find greater anger directed toward them than toward offending fathers. With victims frequently describing alienated relationships between themselves and their mothers, and the apparent inability of their mothers to protect them, it can be easy for therapists to see no other possible explanations. Herman and Hirschman (1977), working from a feminist position of victim advocacy, made the following observation of mothers' powerlessness, but in doing so accepted the view of collusion:

The message that these mothers transmitted over and over to their daughters was: your father first, you second. It is dangerous to fight back, for if I lose him I lose everything. For my own survival I must leave you to your own devices. I cannot defend you, and if necessary I will sacrifice you to your father (Herman and Hirschman, 1977: 746).

The clinical responses to these kinds of views has been at best confused. In an attempt to rebuild a closer mother-daughter relationship and to help ensure future protection, mothers have been required to apologise to their daughters for failing to protect them (Trepper and Barrett, 1989; Giaretto, 1982). Giaretto was the most blatant in his attempt to have mothers share responsibility and to apologise:

By termination 50% of the program sample [of mothers] admit that they were very much responsible, compared to not at all claiming responsibility at intake. This change of attitude comes from learning that a failing marriage is invariably one of the precursors to incest (Giaretto, 1982: 54).

This 'Humanistic Treatment' response of mothers and fathers together admitting responsibility to their daughters was supported by Herman and Hirschman (1977: 753). It is not surprising that this position still holds currency, particularly for therapists who work primarily with victims and daily face the grief and suffering of their clients. As Wattenberg so eloquently summarised,

Information about mothers is frequently screened through the perceptions of betrayal in remembered pain by daughters; the typically complicated relationships of mothers and daughters are made almost impenetrable by the secrets of father-daughter incest ... (Wattenberg, 1985: 207).

It is our contention that the first step for therapists

seeking to work respectfully with mothers and daughters is to familiarise themselves with the abundant research which provides for different and more sensitive ways of understanding the position of mothers, and which gives clues to issues to which therapists may need to attend. A number of researchers who have been informed by the feminist critiques of the mother-blaming literature have looked at women's responses to the crisis of disclosure, particularly around the issues of belief and protection (Knudson, 1981; Johnson, 1985; Pierce and Pierce, 1985; Everson et al., 1989; Hubbard, 1989; Sirles and Franke, 1989; Sirles and Lofberg, 1990; Humphreys, 1990; Hooper, 1989; Carter, 1993; Krane, 1994). It has been concluded that most women do believe their children after a disclosure of incest; for example Pierce and Pierce (1985) found that 84% of mothers were believing and protective toward their children following disclosure. Similarly, Sirles and Lofberg (1990) found that 78% of their sample believed the disclosure, findings also supported by Conte and Berliner (1988). No competent studies have determined that women usually knew of the abuse prior to disclosure, or usually attempted to cover it up. Rather it has been found that when women did learn of the abuse, they tended to notify someone outside the family. It has also been demonstrated that not believing, or fluctuating in belief, is not a function of maternal pathology, but a *normal* response to profound crisis. *Many* women go through a process of coming to belief, including fluctuating between belief and disbelief, or even holding both positions simultaneously (Humphreys, 1990). It is also important not to make assumptions about the certainty of a poor mother-child relationship. Mothers and daughters are often close, and failure to disclose to one's mother may be about protecting her, or about fear of the father rather than representing collusion on the part of the mother (Knudson, 1981).

Though much attention has been focused on women, the research underlines the importance of ensuring that the perpetrator and his behaviours and attitudes do not become invisible. A range of complex factors have been shown to influence a woman's belief and support, and central to these is her relationship with the abuser (Humphreys, 1990; Sirles and Franke, 1989; Faller, 1989; Everson et al., 1989). The relationship between the mother and child cannot be seen independently from the relationship with the abuser, and his response to disclosure (Faller, 1986; Lipovsky et al., 1996). Other authors have concluded that distance between mother and child is a result of the abuse, and of the man's capacity to enforce this distance in order to access his victim, rather than a cause of the abuse (Jenkins, 1990; Laing and Kamsler 1990).

In the light of this evidence we generally reject the practice of mothers apologising for the abuse. We believe the practice confuses the issue of responsibility, undermines the mother-daughter relationship, and is simply a more subtle form of mother-blaming. Of course in the minority of cases where mothers have known about the abuse and failed to take action to protect their

child, or have actively participated in the abuse, then they must accept their share of responsibility for the harm to their daughter. However even a perception that a woman has 'failed to take action' needs to be examined with caution, since fear of violence may be a constraining factor, or her belief that she *has* taken protective action, however unsuccessful that action was eventually found to be. As with offending fathers, if the daughter wishes to hear her mother apologise in these circumstances it would be entirely appropriate. However it must be emphasised that these are not the typical presentations, as has been highlighted in the research evidence, and should not form the basis for a general approach to therapy with mothers and daughters.

The consequence of abuse, as demonstrated by the research, is a mother who may at first, or over time, appear to be unsupportive or unbelieving. If we take this research seriously it is our responsibility as therapists to work not only with the already so called 'supportive' or 'protective' mothers and their daughters, but to assist those whose relationships have been most damaged by the abuse. It is therefore imperative that the therapist normalise the disbelief and not exclude the mother too early from the therapeutic process. Rather than a therapist viewing a women's disbelief as collusion or psychopathology, an understanding of the normal processes of grief and crisis is more useful and respectful (Dwyer and Miller, 1996).

IDEAS FOR CLINICAL PRACTICE

Before looking at the specifics of our clinical practice, we will outline some of the general principles informing our work. It is of major importance that all work with family members be coordinated and that close communication be maintained if more than one therapist is involved. In the Sexual Abuse Team at the Bouverie Centre, we frequently have two or more therapists seeing different parts of the family, though we do not consider this essential to mother-daughter work. A single therapist is perfectly adequate (and in some circumstances may be preferable), as long as she is able to engage both parties, and to maintain both relationships. Whoever conducts the therapy, we believe there are basic principles which should underpin all work. These include attention to the process of therapy, understanding recovery, and the developing nature of the particular mother-daughter relationship.

We aim to facilitate a process where young women and their mothers can learn to trust themselves and each other. To do this we need to engage the mother in providing a believing and supportive response to her daughter; and for the daughter to allow herself to be nurtured by her mother. We have learned the importance of hastening slowly and not rejecting the mother from the therapeutic process if she does not initially 'believe and support' her daughter. We also believe that young women can and do recover from abuse and that they need not be permanently 'damaged'. This is not to minimise the experience, but rather to maintain a sense

of hope. With both the young woman and her mother, understanding the depths of their crises will allow a therapist to remain empathic and understanding, but should not blind her to possibilities for them to develop new strength and personal agency. The spirit of the therapeutic journey should be one of hope and empowerment. One young woman shows the defiance present in daring to hope, in the words of a poem she wrote during a group session:

First they slaughtered our
dove of purity.
Then they killed our
dove of trust.
But we still have our
dove of hope.

Being hopeful does not signify a 'Pollyanna' approach. Rather it requires the therapist to enter deeply into the darkness of the victim's and her family's experience; to be creative, and have a willingness to be exquisitely attuned to the experiences of both parties. From the outset of therapy it is vital to convey a strong sense of belief and acknowledgment of the survivor's account of her experience. However despite the dark and serious nature of the issues dealt with, as with any good therapy, there is space for humour, playfulness and personal warmth. We place great emphasis on establishing a safe environment where all feelings are normal including the gross, crazy and destructive ones, in the context of the abnormal trauma the young woman and her mother have been forced to endure. The therapist needs to sit with despair, fear and grief of enormous magnitude, which is often beyond our knowing and which sometimes defies their attempts to express in language. That which is beyond language challenges family therapists to search more deeply for meaningful and helpful responses. For this reason, the establishment of rituals which mark important milestones and celebrate and affirm successes can have great impact, and therapy itself can become one of those rituals.

It is naive to focus on the mother-daughter relationship as if it exists in isolation from other influences such as the complex broader systems of courts, police, protective agencies, other therapists, residential agencies and to ignore the primary importance of siblings, extended family, community and friendship networks. It is important therefore that the therapist take an holistic, systemic approach. Between the mother and her daughter, there is clearly a recursive process in action, as the position of each is shaped and influenced by the other's behaviour and response to her. The two women are also greatly influenced in turn by the position the offender takes. His denial or minimisation, continuance of violent or threatening behaviour, attempts at self destructive behaviour, removal from the home, continued attempts to rationalise and blame everyone else for the abuse or, alternatively his acknowledgment of and remorse for his actions, have dramatic impact on the mothers and daughters with whom we work.

This paper focuses on working conjointly with the

mothers and daughters, but we also place great importance on individual and group work. This may act as a preparation for the conjoint work, or where that does not become possible, it can assist in resolving grief and lingering pain over the damaged relationship. In some circumstances a young woman may wish to distance herself from her mother, for example if the latter chooses to continue living with the perpetrator. This can be extremely painful for both mother and daughter, and the therapist may need to provide increased levels of support and to engage other supportive friends or relatives at those times.

As family therapists we work with other family members over the course of therapy, and view family sessions with siblings and significant others as potentially playing a vital part in the healing process. Work with one part of the family informs work with other members. For example, we use the information gained from offenders to assist mothers and daughters make sense of how the abuser came between them. Similarly, information from victims enables us to confront offenders with the impact of their abusive behaviour. Guiding all our work is the interests and needs of the victim, and the importance of the mother–daughter relationship. It is to this relationship that we now turn. The following four guidelines outline our approach in more detail.

1. Share information with mothers and daughters regarding the dynamics of the abuse and the process of recovery

Families generally lack information about abuse and feel incredibly disempowered and vulnerable when they first approach the therapy process. They need a variety of information to help them make sense of the behaviour of the victim, the offender, and of their own responses. Mothers are perplexed as to why their children left their disclosure so long, and informing them about the latest research can be very empowering. For example, information regarding the ‘Child Sexual Abuse Accommodation Syndrome’ (Summit, 1983) is generally very useful, as are the findings by Salter (1992) who, after an exhaustive survey of the research, found that consistently *not* disclosing appears to be normative for child sexual abuse. She concluded ‘... there are no studies which have found a majority of children disclose child sexual abuse in childhood, much less immediately after the abuse’ (Salter, 1992: 174). It may also be important to discuss, with both the daughter and her mother, the meaning of post traumatic stress disorder and other sequelae of abuse. Families have given us strong feedback about the helpfulness of therapists normalising the often frightening behaviour of their daughters, in the context of the trauma they have experienced.

In working with women and their daughters, therapists need to take two positions simultaneously. We need to sit beside them in their crises, at the same time as we offer leadership, direction and advice. In recognising the profound crisis of confidence and self-esteem for women in terms of their mothering and relationship

competence, we normalise their see-saw experience as they struggle to believe their daughter’s disclosure. However we also do not hesitate in being directive if there are current issues of risk, particularly if the perpetrator is still living in the family home. Mothers are often looking for direction, and a clear message from the therapist that the most helpful thing they can do at this point is to ask their partner to leave for a time, can be a welcome relief.³ It is our experience that where a mother is still aligned with the perpetrator, she is able to hear this and not respond defensively, provided that services and a respectful response are also offered to her partner. These processes can take time and therapists may need to offer sessions more frequently in the initial stages, both individually and conjointly.

As therapy progresses, it is important to pre-empt the therapeutic journey and to emphasise the circular, layered nature of healing. This avoids disappointment and a sense of failure when recovery does not progress in a linear fashion. It can decrease families’ anxieties to know that for most people in their situation the recovery process can feel at times like ‘one step forward, two steps back’, and that issues may need to be worked and reworked, and finally understood at a deeper level. From our clinical practice, it is quite common for daughters to re-experience symptoms and re-engage in self destructive behaviours at significant times of transition. Crises can be triggered by birthdays, Christmas, Father’s Days; by having contact with the perpetrator or by her mother’s resuming contact with him; or even by her mother’s initiating divorce proceedings. Rather than waiting for crises to happen, it is good practice to plan ahead for these significant events and where appropriate, increase family and individual support. The transition points often provide therapeutic opportunities to empower the mother to more effectively support her daughter and challenge the daughter’s old patterns of protection of her mother and avoidance of intimacy.

2. Respect the family’s pace and timing

It is much wiser to privilege the daughter’s, rather than the mother’s, need for distance or closeness, particularly in the early stages of therapy. It is unwise to insist on family or mother–daughter sessions when the daughter is clearly unable to cope with them, and may be at risk. This does not mean however that one cannot continue working systemically. In individual sessions with the daughter, the constraints to her willingness to see her mother can be explored and understood whilst the therapist also needs to support and honour the mother in her own struggle. Simultaneously in individual sessions with the mother, her experience can be explored and validated whilst promoting an understanding of her daughter’s position.

If the daughter experiences rage towards her mother, therapists are often invited to take a polarised position. That is, to join with the daughter and blame the mother for the abuse, seeing her as a destructive influence; or conversely, to try to convince the daughter of her

mother's blameless position and the evil ways of her father. Either position may result in therapy becoming stuck. The therapist must align strongly and patiently with the daughter's experience, as her rage towards, and rejection of, her mother usually flow out of deep trauma and a sense of abandonment by her mother. The therapist may find herself engaged in a dance where she acknowledges and explores the daughter's rage, affirming it as natural, given her childhood experience—whilst at the same time seizing any opportunity to extend the daughter's view and explore the other side. That is, her ambivalent attachment and often desperate ache for connection to her mother; and the circumstances which may have made it difficult for her mother to be there at the time of the abuse. For example, one daughter seen in therapy used to state repeatedly that her mother 'should' have known and struggled to grasp how she could not have known about the abuse. For the first two months of therapy, she refused to have conjoint sessions, but eventually consented to have contact by fax machine. It was useful in therapy to explore what might have made it possible for her mother to not know of the abuse. Eventually the daughter articulated her father's secretive methods and her own ways of hiding any evidence. From a young age she would always shower herself, would attribute any blood stains on sheets or pyjamas, to a blood nose, and would always put her own dirty clothes and linen straight into the washing machine. Only over time and after having the opportunity to explore and vent her rage, could this daughter begin to consider these and other ways in which the secret was kept from her mother.

Some mothers, unaware of the abuse or constrained by their own crisis at disclosure, may respond in ways which further undermine and threaten the relationship with their daughters, for example by not believing aspects of the abuse or not meeting their daughter's needs. In these circumstances, the therapist needs to join the woman in exploring the constraints on her belief and support. However she must also be led to consider the impact of her response, and the work she needs to do in order to regain, in her daughter's eyes, her 'right to mother'. When the woman is engaged with the therapist and willing to embark on the process of healing her relationship with her daughter, she can be coached in what she needs to do to 'earn her stripes' in her child's view. This may include doing specific things the child requests, for example, only talking about the abuse issues in sessions.

3. Facilitate an ongoing process where the mother can acknowledge and bear witness to the suffering and degradation experienced by her daughter

This is the central tenet of our work—the recognition that a ritual needs to exist to acknowledge the daughter's experience of pain and abandonment. This should not be confused with issues of offender responsibility by having the woman apologise. Rather than

expecting mothers to apologise for the occurrence of the abuse, our clinical experience suggests that it is much more healing for women to express their deep sorrow and grief at what their daughters have experienced. This is a subtle yet profound shift in clinical practice. When the timing is right for both the daughter and mother, it can be extremely healing for the therapist to facilitate a process whereby the daughter is able to share with her mother the feelings she experienced when the abuse was occurring. Feelings such as confusion, pain, terror, abandonment, anger, rage, shame, sadness, numbness or even feeling special are common states for children enduring ongoing abuse. If the daughter can express these to her mother in a non-blaming, yet direct way as being part of her childhood experience, it signifies a major step towards trusting her mother to be able to tolerate her pain and towards breaking out of the old established pattern of protecting her mother from her abuse experience.

The therapist can facilitate a process where the mother deeply acknowledges how awful it was for her child and bears witness to the betrayal and suffering inflicted by the father. It is also very moving for the daughter to hear her mother validate her sense of confusion and abandonment when the abuse happened, or her rage that her mother did not know. Where mothers have not felt blamed and therefore have not felt the need to respond defensively, we have witnessed very moving sessions where the daughter is able to share her memories and be responded to and nurtured by her mother in a way she ached for as a child and adolescent. Women frequently seize the opportunity to mother their daughters in a way which was denied them at the time of the abuse, but timing, attention to detail and careful preparation are required for these sessions to have a successful outcome. The process may be more realistically carried out over many sessions as the mother's response frees the daughter to trust and share more at a deeper level, as time goes on.

4. Acknowledge the difficult process of rebuilding trust and actively work towards a supportive mother–daughter relationship

Many young victims of abuse have spent most of their lives protecting their mothers from the knowledge of the abuse. They may have been told by the perpetrator that telling would kill their mother or split up the family. They may also fear the consequences for themselves of speaking out. Anna Salter (1994) described important distinctions between the experiences of young women who have been abused by sadistic and non-sadistic offenders. Our clinical experience certainly supports this consideration. If the abuse involved repeated and escalating acts of sadism, the therapist is wise to hasten slowly. Where the abuse has been sadistic and involved physical torture, therapy which requires her to expose herself and trust her mother may feel terrifying and totally unsafe. The young woman will require enormous amounts of reassurance and will feel safer if the thera-

pist has a respectful, collaborative approach, which places her in a position of having control over the process. The delicate balance between respecting the young woman's pace and yet gently challenging and encouraging her to try new ways of being and relating, is surely the art and soul of the therapeutic relationship. It is particularly so in the work with mothers and daughters.

Just as we need to encourage mothers to take up the opportunities which arise to nurture their daughters, daughters also need to be encouraged to allow themselves the experience of being 'mothered'. Old patterns are hard to break and they will frequently avoid sharing current problems with their mothers, as well as the abuse experience. Therapists will need to creatively work with current issues which will inevitably arise, so that both parties can experience a more trusting and supportive relationship and daughters don't become isolated in their pain. It is often helpful for daughters to hear many times, in different ways, why their mothers do believe them. The therapist can play a role in facilitating the mother's detailed verbal, and perhaps written, expression of her reasons for believing and supporting her daughter. Young women have given us important feedback as to the impact this work has on their recovery. As one young woman wrote:

Telling my mum was the hardest thing I've ever done. I didn't realise what a strong woman she is, and how much she cared for me. I always pretended I was adopted. I've learnt to trust my mum and we are really getting to know one another. It's weird, even though once I disclosed she believed me, I was too scared to tell her how bad I felt and how much I hated her then. It's taken time but I think we're getting there—it feels so much better. I don't have to worry about my mum falling apart now.

There is a strong invitation in this work for the therapist, particularly if she is a woman, to become the 'perfect mother'. Whilst in the initial stages of therapy and at crisis points, the therapist may play a central role and be quite directive, as the recovery process progresses, one must be mindful of relinquishing this position. Because of the strong rapport built up over time between the therapist and the daughter, the latter may become very attached to and dependent on the relationship. It can be useful to set explicit goals where eventually the young woman uses the support available from her mother and significant others, and negotiates crises in a more autonomous way. Mothers also need to be encouraged to believe in their daughter's, and their own, competence and desire to heal. At times this involves empowering mothers to set appropriate limits and consequences for their younger daughters and not to put every difficulty down to the abuse. They are also empowered by not seeing the recovery process as centred on the therapist, and by regaining confidence in their own common sense and parenting skills.

CONCLUSION

This paper highlights the significant theme of mother-blaming in the literature and joins more recent critiques

in challenging this view. Research acknowledges the importance of the mother's ongoing belief and support in recovery of the young person from intrafamilial child sexual abuse. We highlight the social context of the mother-daughter relationship, and the role abuse plays in undermining it, and explore four major themes in offering a sensitive clinical response. We emphasise the importance of the mother being able to bear witness to her daughter's suffering and to express her sorrow as a major theme in our clinical practice. We offer these ideas as an alternative to those practices reported in the literature, which maintain mother-blaming, and which further undermine the mother-daughter relationship.

Notes

¹This article is a companion to one previously published in this journal, dealing with issues of disenfranchised grief for mothers and daughters after incest (Dwyer and Miller, 1996).

²Laing and Kamsler (1990) provide one of the few exceptions.

³Our position is always to attempt to engage the man in taking responsibility for the decision to leave the home (Jenkins, 1990), but alongside this, or where it does not succeed, we attempt to assist the woman in making decisions in favour of protection.

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*I will arise now, and go to Innisfree,
And a small cabin build there, of clay and wattles made:
Nine bean-rows will I have there, a hive for the honeybee,
And live alone in the bee-loud glade.*

William Butler Yeats, (1893). 'The Lake Isle of Innisfree'.

Living alone in the 'bee-loud glade' will be enriched by the regular arrival of your copy of the *ANZJFT*. Remember to inform Blackwell of your changed address. See inside front cover for details

