Family Practice Grand Rounds

The Dynamics of Incest: Presentation of One Family in Acute Crisis

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DR. JIM WILSON (*Family Physician, Assistant Professor, Department of Family Practice*): The discussion for Grand Rounds today deals with the problem of incest. Mr. Lammer will begin by presenting background medical and social information obtained when he interviewed this family as an assignment for an undergraduate course in family practice. His interview occurred prior to the recognition of the present problem. Dr. Pease, who is a third-year family practice resident, will describe the crisis event which brought the situation to our attention. Dr. Clements, who is a marriage and family counsellor, Dr. Cadoret, a psychiatrist, and I will have some general comments about incest and family dynamics following the presentation of the family medical and social profile.

MR. ED LAMMER (*Second Year Medical Student*): The family is presently composed of four members living at home; the father, J. K., the mother, L. K., and the two daughters, A. K. and B. K., who are children from the mother's previous marriage.

J. K. has a long history of psychiatric and medical problems. He was hospitalized once for depression and once due to a medication overdose. Eventually, the diagnosis of bipolar affective disorder was made, but one of the psychiatrists treating him felt that there was little clinical evidence for that diagnosis. The patient never had episodes which could be considered hypermanic. However, lithium was begun, and his depression improved remarkably. J. K. had a history of heavy alcohol consumption until a few years ago. Significant medical problems include chronic obstructive pulmonary disease aggravated by smoking two to three packages of cigarettes a day for many years. He stopped working four years ago, complaining that shortness of breath severely limited his activity.

L. K. has been in relatively good health. She underwent a cholecystectomy several years ago. The daughters have no serious or chronic medical problems, but more will be said about that by Dr. Pease later.

The family has experienced severe economic hardships due to the father's inability to work. Initially, the father was self-employed. His wife assisted in the business, and their income was sufficient to keep the family at a satisfactory economic level. The business folded at the time of his hospitalization for depression. Following this, the family subsisted on unemployment and Social Security benefits. Later, the mother was able to supplement this income by working part time as a waitress. Health care costs have added to the economic burden, but the family has been assisted by Medicaid.

When I interviewed the family, there seemed to be no major problems in their relationships with

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each other. I was not made aware of the previous marriage of L. K., and I did not know that the girls were stepdaughters of J. K. Dr. Pease will present more information about some of the family's medical problems that have been dealt with in the Family Practice Center.

DR. JAMES PEASE (*Third Year Family Practice Resident*): Before I talk about the crisis event I would like to review some of our office records of the family. During the four years that we have cared for the family, many visits to the office have been made by the family members. The mother, who is in her mid 30s, has been to the office for 36 visits. The following problems have been recorded on her problem list: gynecological problems, anxiety, depression, marital and sexual problems, and various minor dermatological problems. The husband in his early 40s has been seen 38 times and his problems are listed as: chronic obstructive pulmonary disease, chronic prostatitis, rectal bleeding, hypertension, and depression.

A. K., the older daughter, has been seen 16 times with problems including menstrual disorder, vaginal discharge, school difficulty, and minor illnesses. B. K., the younger daughter, has been seen ten times in the office with problems including anxiety, breast discomfort, and minor illnesses.

The incest problem was divulged when B. K. and her mother presented together to the Family Practice Center with a note which had been written by B. K. to her mother. In the note B. K. described the relationship she and her stepfather had maintained and stated that they had been having intercourse over the past several years. B. K. was extremely frightened to relate this to anybody because she felt her stepfather would harm her if she did so. During the interview it was learned that the older daughter had also experienced a similar relationship with the stepfather.

Initially, the mother was very angry and initiated legal action against the father. Eventually, however, this action was dropped and the stepfather was hospitalized in a psychiatric hospital for a period of time before being discharged on medication. Plans were made for the family to begin treatment with a family counsellor. It has been a very emotional experience for me dealing with this family through this crisis. I have felt somewhat inadequate because of my lack of experience treating families in which incest has occurred.

DR. WILSON: Incest, according to *Dorland's Medical Dictionary*, is sexual intercourse between persons too closely related to contract a legal marriage. State laws regarding incest generally prohibit persons with a degree of consanguinity in which marriage is void from having sexual intercourse with each other. Many state laws specifically include adopted or stepchildren in this definition.

The incest taboo has existed to some extent in most societies and cultures that have been studied. The nature and rigidity of the taboo have been found to vary from culture to culture. Only the mother-son incest seems to be universally prohibited in every culture.[1]

Notable exceptions to the incest taboo have been known throughout history. In ancient Egypt, pharaohs were permitted to marry a sibling of the same father but were prohibited from marrying a sibling of the same mother. Incest has been tolerated in some European royal families and has been permitted in some primitive tribes during religious ceremonies.

Sociologists have tried to relate certain forms of sexual deviance, including incest, to the social role of women. The degree of matriarchy or patriarchy that exists in a culture has been hypothesized to be the crucial factor.[2] In matriarchal societies a more permissive attitude toward sex exists. In such a society, incest is the sexual behavior most feared and condemned, while homosexuality is tolerated. Patriarchal societies are characterized by more restrictive attitudes toward sex in general. Homosexuality is the deviance most feared, while incest causes less concern.

One entire chapter of Leviticus in the Bible discusses sexual relationships in the family. The Greek civilization was also concerned with incest, and many of the terms we associate with incest were derived from them. Oedipus complex refers to mother-son relationships; Electra complex is a term applied to father-daughter relationships; and the Phaedra complex is the term applied to incestuous relationships between children and stepparents.

Anthropologists and sociologists have developed many theories to explain the existence of the incest taboo.[1] The anthropological viewpoint postulates that incest was rare and sporadic among primitive societies because it was socially isolating and destructive. As with the Egyptian pharaohs,

incest could be institutionalized when it seemed to benefit the society. From the biological viewpoint, incest was thought to be detrimental to the race. Primitive man saw a connection between incest and human abnormalities and therefore established rules against inbreeding. In *Totem and Taboo* Freud postulated that the incest taboo arose to eliminate disruptive and competitive forces within the family. Specifically, he thought the incest taboo was set up to prevent fathers and sons from competing for the females in the family.[3]

Valid statistics on the incidence of incest in our society are difficult to obtain. Part of this comes from the differences in reporting from state to state because of differing definitions in state laws. Also, it seems likely that a bias in reporting episodes of incest may exist, tending to favor reporting it when it occurs in families of lower socioeconomic classes and covering it up when it occurs in higher social classes.

Weinberg's study of incest in 203 families reported an incidence of 1.2 cases per million population in 1910, 1.9 cases per million population in 1920, and 1.1 cases per million population in 1930.[4] Seventy-eight percent of those were father-daughter incest, 18 percent were brother-sister incest, three percent involved multiple incestuous relationships in the family, and there was only one percent reported as mother-son incest. In all of the mother-son relationships, either one or both of the participants was psychotic.

Father-daughter incest is the most common type, and the type we are dealing with here. The fathers in such relationships have been described as coming from chaotic families with poor economic backgrounds, and families in which there was little affection expressed between the family members.[5] It has also been noted that such men, more often than not, had a disturbed relationship with their own fathers. Fathers in a father-daughter incestuous relationship tend to have a poor education, are frequently immature in their sexual orientation, and have a poor sexual adjustment. In one study of father-daughter incest, 19 of 26 fathers were described as psychopaths, and 4 of the 26 were alcoholics.[6] In such cases there is usually a history of criminal behavior in the father. In families with more than one daughter, the incestuous activity frequently begins with the older daughter and involves each daughter in turn as she grows older.[7] Upon discovery of the relationship, the father frequently offers many reasons to rationalize his behavior. Such fathers have been noted to experience little personal guilt, except as a reaction to the shame and disgrace that the relationship has brought onto the family.[5]

The wife and mother is central to understanding family dynamics. She plays a central role in promoting the development of the relationship between the daughter and father. The mother-wife in this situation is frequently described as hostile, unloving, and frigid.[8] The mother-wife has also been described as passive, submissive, and overly dependent upon her own mother.[5] Frequently the mother-wife has subtly or unconsciously encouraged the relationship between her husband and daughter, but she denies the relationship until it has been discovered in some other manner. Usually the mother-wife denies guilt and is unwilling to accept any responsibility for the relationship or her contribution to it.

Many father-daughter incestuous relationships endure over many years. This may imply that the daughter passively encourages the continuation of the relationship. In some reported cases, the daughter has actually initiated the incestuous relationship. There is little written about the personality of daughters because they are frequently protected by the courts so that indepth study has been difficult. Daughters from incestuous relationships have been found to suffer from depression, fatigue, loss of appetite, generalized pains, sleep disturbances, and in many cases have become sexually promiscuous after termination of the incestuous relationship.[5] A disturbed relationship with her own mother has also been common.

Dr. Clements will add some comments on the family dynamics in incestuous families.

DR. WILLIAM CLEMENTS (*Assistant Professor, Marriage and Family Counselor, Department of Family Practice*): The acknowledgement of incest is sometimes as traumatic to the family as the actual incest itself. Discovery often brings a host of strong emotions such as fear, anger, humiliation, and guilt out into the open. In addition, the family frequently has to cope with the additional stress secondary to court proceedings, hospitalization, and the removal of family members from the home. Thus, a descriptive analysis of those family dynamics found in cases of incest refers to the situation before discovery took place,

while treatment occurs ex post facto after everything is more or less out in the open.

Let's talk about three patterns of father-daughter incest. First, there is the pattern of indiscriminate promiscuity in which incest between the father and daughter is just one component of the total pattern. Another pattern of incest is pedophilia where the father has a sexual interest in young girls, including his own daughter. Another pattern of incest is familial incest in which the sexual contact of the father is restricted solely to members of the family.

With the latter pattern of incest, which I think describes the family discussed today, the family maintains a facade of a happy family. However, there is noted almost always a disturbance in the sexual relationship between the parents. In addition, the mother tends to divest herself of maternal responsibilities in the home and promotes the daughter into a role of nurturing or taking care of the family. This type of behavior represents a massive denial on the part of the mother. Leading up to the discovery and at the point of discovery itself, extreme guilt and anxiety are often experienced by the daughter. This guilt is not so much because of the existence of the sexual relationship, but because of the daughter's fears of harming the family and causing it ridicule and humiliation.

In light of these characteristics, the treatment from a counseling viewpoint would consist of: (1) marriage counseling for the parents to restore their relationship; (2) therapy for the father in an attempt to condition him not to be attracted to his daughter; (3) counseling for the daughter to allow her to ventilate whatever feelings she might have in regard to the incident(s) and the relationship with her father; and (4) a meeting(s) of the entire family together to talk about the family relationships. In summary, the family ideally has the need to get involved in four different types of counseling, which might take place concurrently.

DR. REMI CADORET (*Professor, Departments of Family Practice and Psychiatry*): Briefly, I would like to comment on a pattern that may point to a high-risk family, which I think is present in this situation. If one is aware of the high risk of certain patterns, one can be a little more sensitive in picking it up. In a recent study from Northern Ireland representing a fairly large sample of the population, four percent of women and girls in the sample referred for psychiatric care gave a history of incest. A number of interesting features from these families were followed up, and it was discovered that 14 of the 26 fathers in the sample were described as inadequate-psychopath.[6] Inadequate-psychopaths are people who have difficulty responding to life stresses. Other people in the study were described as aggressive psychopaths, a type of personality that usually ends up in jail. Four of the men in the study were alcoholics. The father in this family certainly had severe personality problems, including alcoholism. About half of the fathers in this study had served jail sentences for various crimes.

In another recent review in a psychiatric journal in which 14 cases of incest were studied, it was reported that the father or stepfather was usually violent, alcoholic, or both.[9] In that study, the mothers were described as chronically depressed. Depression in mothers was not discussed in the Northern Ireland study, but it was mentioned that ten of the mothers were fully aware of what was going on and chose to remain quiet about it. Both studies stressed the patterns of the daughter assuming many of the mother's responsibilities. Of course, every family that exhibits this pattern of behavior is not necessarily an incestuous family.

We ought to be concerned about outcome for individual family members and the family as a whole. In the American study, 12 out of 14 marriages ended in divorce or separation. In the Irish study 2 out of 26 marriages were ended, and in both the divorce occurred after the father was prosecuted and jailed. There seems to be some difference in outcome depending on the way the situation is handled. In terms of treatment, it is important to consider the family unit. Will it be broken up? Who is the patient under these circumstances? How will the news be broken to the rest of the family? I suspect that the way the physician responds to these questions may determine how the family will react. Will it be taken to court or will the family members seek counseling?

What happens to the daughters after this type of experience? One of the problems in dealing with incest is our lack of knowledge concerning long-term outcome. We don't know whether the outcome is better for the girls if they stay with their families or whether divorce and separation is better because they are away from the influence. In

the Irish study, 11 of the 26 girls seemed to develop character disorders, mainly sexual promiscuity. Four of them became prostitutes. All of those who developed character disorders came from very disturbed homes with alcoholic, psychopathic fathers and promiscuous mothers. Therefore, I don't think it can be said that the daughters' problems were caused by the incestuous relationship with their father. Five girls developed frigidity and aversion to sexual relations after they were married. Three of them showed symptoms of hysterical personality, and frigidity and aversion to sexual relations are classical symptoms of hysterical personality. Therefore, I suspect many of them may have had hysterical personalities all along. In six girls, there was no apparent long-term effect at all.

DR. ROBERT RAKEL (*Family physician, Professor and Head, Department of Family Practice*): Did they deal with the relationship happening again?

DR. CADORET: No, they didn't deal with recidivism, which is quite high and which I think demonstrates the need for treatment for the fathers and the mothers.

DR. RICHARD COOK (*Third Year Family Practice Resident*): It seems to me that the legal classification of this problem is crucial to the treatment. Is this really child abuse or is it a criminal sexual offense? Which classification is more optimal for the family, and which classification is more optimal for treatment?

DR. CLEMENTS: My response is that it depends on the family. If the daughter experiences a lot of humiliation and degradation and has physical abuse connected with it, that is one thing. However, if the daughter experiences it as a time of closeness, a pleasurable experience, that is, perhaps, something else. Interestingly enough, the studies that I have read report that the daughters who had the least problems were those who were involved at the earlier ages. Those who had the most problems were those who experienced the incest near or during adolescence.[1]

DR. WILSON: Sometimes the mothers are really quite reluctant to press charges, especially if there is a threat that the father will be jailed, since this may possibly leave the family without the bread winner. The mother may prefer to see the daughter leave the home rather than the father.

DR. FORREST DEAN (*Third Year Family Practice Resident*): In retrospect, it is obvious that the family made many visits to the Family Practice Center. Should the diagnosis have been made earlier?

DR. PEASE: All along the way it is very interesting to look at the notes. There were comments like, "We have to watch this family. There is something going on that we don't know about." From my contact with the family, particularly with the girls and the mother, they seemed to be very close, and it has been difficult to get information from them regarding their personal relationships.

DR. CLEMENTS: That is one of the characteristics of this kind of family. There is an implosion with the family energy spent back on the members. By way of contrast, in adolescence one typically observes an explosion with adolescents leaving the home, yet bringing all sorts of friends in. But in this family there is more of an implosion, with the energy directed into the family. No friends are in and out of the home. The family is isolated, and gratification takes place almost solely within the family unit.

DR. WILSON: I would like to thank our presentors and discussants for their participation, and thank you, the audience, for your contributions. I am distributing a list of references used in preparing our discussion and a list of articles suggested for further reading.

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Additional Reading

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