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# Family Practice Grand Rounds

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## Family Dynamics: A Case of Incest

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San Antonio and Temple, Texas

DR. JANET P. REALINI (*Assistant Professor of Family Practice*): Welcome to the Family Dynamics Teaching Conference. We hold these conferences once a month to present and discuss a family that has been of particular interest or concern in the Family Health Center.<sup>1</sup> Our goals are to gain insight into the dynamics of the family, how illness affects the family members, and how the family affects the illness. With our new understanding, our next goal is to help the family practice resident in his or her management of the family; we make specific suggestions and help the resident formulate a plan for follow-up. Although family therapy is not our primary goal in this conference, we often see that the interview process itself is of therapeutic value to the family.

The resident will present some background information on the family and their problems. The audience of medical students and residents may have questions about the family or suggestions for areas where further information is needed. The group can thus help the resident focus and plan his interview. After the resident interviews the family, the conference participants will discuss the family and the interview and help the resident formulate a plan for the family's management.

DR. GLEN R. COUCHMAN (*Third-year resi-*

*dent in Family Practice*): I am presenting the Nash family\* (Figure 1) because I recently became aware that they have a problem with father-daughter incest. I have treated Rose, Jenny's mother, for over two years for rheumatoid arthritis, with Felty's syndrome and pulmonary involvement. She was recently hospitalized for progressive hypertension, congestive heart failure, and acute renal failure.

Danny, Jenny's father, whom I have never met, is a blue-collar worker who has had problems with alcohol. He is free on bond after being arrested for charges of incest brought by Rose and Jenny.

There has been a recent split in the family: Rose's divorce from Danny became final about seven months ago. Rose, Jenny, and Joe currently live together in government-subsidized housing. The three older boys—Robert, Jim, and Howard—work in the oil fields and support their father financially and emotionally. The older daughter, Ruth, who also had an incestuous relationship with her father, "sides" with Danny and the older boys. They argue that the incest is a problem to be settled within the family and not taken to the courts.

The incest apparently began with Ruth. Jenny became involved at the age of 8 years. Her father forced her to have intercourse with him regularly until she was 17 years old. Jenny told her mother about it when she was 14 years old. At about that time, her friends at school found out; she began missing school and eventually dropped out. Danny brought her to the Family Health Center for a therapeutic abortion when she was 16 years old. The identity of the father of the pregnancy was never clear. Jenny ran away from home shortly after the abortion and stayed several months with a friend.

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\*The names of the family and its members used here are not the actual names of the patients presented.

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Danny did not approve of Jenny's boyfriends and forbade her to see them. Last year, Jenny became involved with a boy her own age who was killed in an automobile accident. Jenny told me that Danny's response was one of disappointment that he didn't get to kill the boyfriend himself. This occurred about the time of Rose and Danny's separation and the reporting of the incest.

The separation and divorce were apparently precipitated by Danny's becoming violent, destructive, and physically abusive to Rose. Rose also implied that he may have made sexual overtures to Joe, the youngest son.

**RESIDENT:** What charges is Jenny bringing against her father?

**DR. COUCHMAN:** Actually, since the charges being brought against Danny are criminal ones—statutory rape and incest—Jenny does not have to press charges at all. However, since Ruth refuses to testify, Jenny's testimony is the foundation for the district attorney's case. If she testifies, the district attorney has a case that he can prosecute. If she refuses, he does not.

**ELIA ORTIZ** (*Family Health Center social worker*): Danny is trying to convince Jenny not to testify against him. He uses the money the older boys give him to buy her presents and books. He has promised to finance her education. With all this attention, Jenny is unsure what she wants to do.

**DR. REALINI:** What is your role with this family?

**DR. COUCHMAN:** Until recently I was unaware of the incest. I had been seeing Rose and Jenny for their medical problems, and Ruth for her current pregnancy. In the last several months, through inquiries about the divorce, the issues of the impending trial became apparent. Since that time, I have been seeing Jenny for supportive counseling.

Rose and Jenny are the only family members who could come for the conference today. Ruth, who was present for the preparatory home visit that Ms. Ortiz and I made, could not be here today.

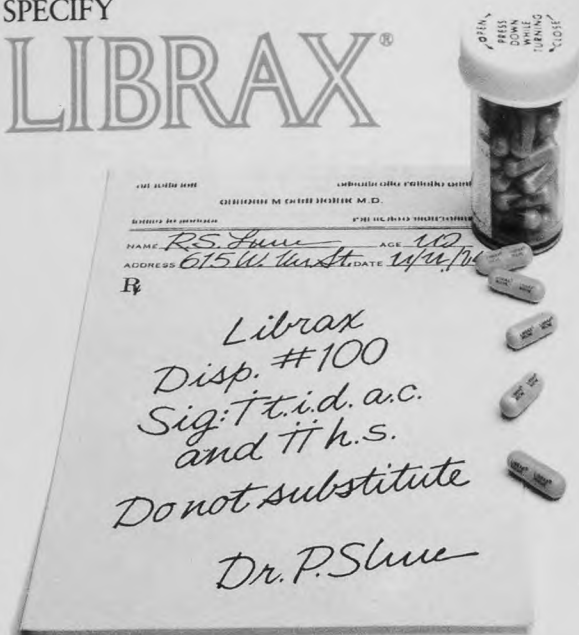
### The Interview

**DR. COUCHMAN:** Rose and Jenny, these are some of the other physicians from the Family Health Center. I think it's normal to be a little nervous in front of so many people. Perhaps we

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SPECIFY

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**Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows: "Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis. Final classification of the less-than-effective indications requires further investigation.

**Contraindications:** Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies.

Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur. **Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.



Roche Products Inc.  
Manati, Puerto Rico 00701

## NITRO-BID® Ointment (nitroglycerin 2%) BRIEF SUMMARY

FAMILY DYNAMICS

**INDICATIONS:** This drug product has been conditionally approved by the FDA for the prevention and treatment of angina pectoris due to coronary artery disease. The conditional approval reflects a determination that the drug may be marketed while further investigation of its effectiveness is undertaken. A final evaluation of the effectiveness of the product will be announced by the FDA.

**CONTRAINDICATIONS:** In patients known to be intolerant of the organic nitrate drugs.

**WARNINGS:** In acute myocardial infarction or congestive heart failure, nitroglycerin ointment should be used under careful clinical and/or hemodynamic monitoring.

**PRECAUTIONS:** Symptoms of hypotension, particularly when suddenly arising from the recumbent position, are signs of overdosage. When they occur, the dosage should be reduced.

**ADVERSE REACTIONS:** Transient headaches are the most common side effect, especially at higher dosages. Headaches should be treated with mild analgesics, and nitroglycerin ointment continued. Only with untreatable headaches should the dosage be reduced. Although uncommon, hypotension, an increase in heart rate, faintness, flushing, dizziness, and nausea may occur. These all are attributable to the pharmacologic effects of nitroglycerin on the cardiovascular system, but are symptoms of overdosage. When they occur and persist, the dosage should be reduced. Occasionally, contact dermatitis has been reported with continuous use of topical nitroglycerin. Such incidence may be reduced by changing the site of application or by using topical corticosteroids.

**DOSAGE AND ADMINISTRATION:** When applying the ointment, place the specially designed Dose Measuring Applicator supplied with the package printed side down and squeeze the necessary amount of ointment from the tube or pouch onto the applicator. Then place the applicator with the ointment side down onto the desired area of skin, usually the chest (although other areas can be used). Spread the ointment over a 6x6-inch (150x150-mm) area in a thin, uniform layer using the applicator. Cover the area with plastic wrap which can be held in place by adhesive tape. The applicator allows the patient to measure the necessary amount of ointment and to spread it without its being absorbed through the fingers while applying it to the skin surface.

The usual therapeutic dose is 2 inches (50 mm) applied every eight hours, although some patients may require as much as 4 to 5 inches (100 to 125 mm) and/or application every four hours.

**TUBE:** Start at ½ inch (12.5 mm) every eight hours and increase the dose by ½ inch (12.5 mm) with each successive application to achieve the desired clinical effects. The optimal dosage should be selected based upon the clinical response, side effects, and the effects of therapy upon blood pressure. The greatest attainable decrease in resting blood pressure which is not associated with clinical symptoms of hypotension, especially during orthostasis, indicates the optimal dosage. To decrease adverse reactions, the dose and frequency of application should be tailored to the individual patient's needs.

Keep the tube tightly closed and store at room temperature 59° to 86°F (15° to 30°C).

**FOIL POUCH:** The 1-gram foil pouch is approximately equivalent to one inch as squeezed from a tube and is designed to be used in increments of one inch. Apply the ointment by squeezing the contents of the pouch onto a specially designed Dose Measuring Applicator supplied with the package printed side down.

**PATIENT INSTRUCTIONS FOR APPLICATION:** Information furnished with Dose Measuring Applicators.

**HOW SUPPLIED:** NITRO-BID® Ointment is available in 20-gram and 60-gram UNI-Rx® Paks (six tubes per pack); in individual 20-gram, 60-gram, and 100-gram tubes; and in Unit Dose Identification Paks of 100 1-gram foil pouches.

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could start by your telling us a little bit about your family.

ROSE: I was married for 24 years and divorced seven months ago. I have six children.

DR. COUCHMAN: How have your health problems affected your family?

ROSE: My ex-husband was never able to cope with my being handicapped, especially during the time when I couldn't take care of myself or the children. It was a barrier between us.

JENNY: My sister and brothers couldn't cope with it either, except for Joe. Daddy couldn't cope with it. I have accepted it. She couldn't wait on us, and the other kids didn't like that. Dad didn't help much.

DR. COUCHMAN: Who kept things going?

JENNY: Financially, Daddy did. But as for raising us, he left that up to us ourselves. The only thing he did was to make sure there was money to put food on the table.

ROSE: Before I was stricken so badly, I was the one who took them to school, attended PTA meetings, baked them things, all of that. When I was stricken with the arthritis, I was in so much pain, I could hardly move. I wasn't able to watch the children, especially if they would run away from me. Sometimes they even went hungry because I couldn't cook or wash. Jenny sometimes helped after she was 10 years old or so. Occasionally, my husband or my mother-in-law would help out. My church wanted to send somebody over to help, but my husband would not allow any church people in our house. Later on, I could wheel up to the stove and cook a little.

DR. COUCHMAN: How has the divorce affected the members of your family?

ROSE: I don't know. Ruth, my oldest daughter, hit bottom and got into some trouble. I know she resents me being away. Now she seems to be doing okay. Howard hasn't changed; he resents the divorce. Jim is an enigma to me. I don't know how he feels. Sometimes he fakes a smile for me; sometimes he is very loving. He has a very high IQ and a violent temper. Joe is quiet. He is not saying anything. Robert is pushing me to go back to Danny.

DR. COUCHMAN: Tell us about your relationship with Danny.

ROSE: Well, lately it's weird. I don't under-

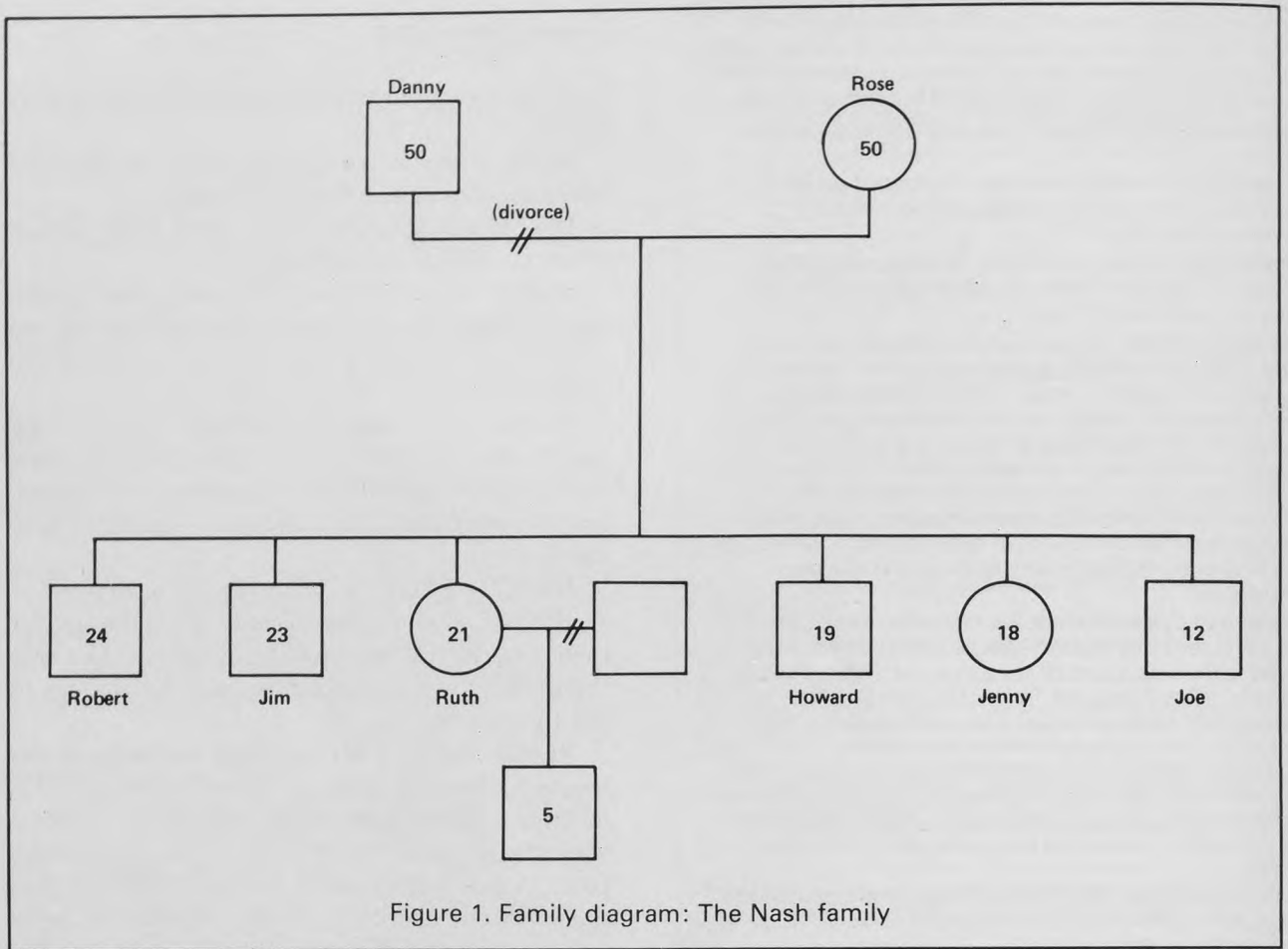


Figure 1. Family diagram: The Nash family

stand it, but when I think of my husband, I think of my father. I always put my husband on that same pedestal with my father, but that was a mistake. Danny is not that kind of man. He has never lived up to being on that pedestal. He is domineering and overbearing, very opinionated, and very jealous. He is smart, too; he can convince you of anything. For example, he nearly convinced me that he didn't mess up the kids—that it was my fault! He is so convincing, he can make you forget your own line of thought. He hates my church, too. He hates all religions.

DR. COUCHMAN: What was your relationship with Danny like ten years ago?

ROSE: Even then, it was going down the drain. I used to think he could do no wrong. But he kept doing things that tore that image down. Now I feel sorry for him.

A lot of times I think that it partly *is* my fault. If I hadn't let him take over—if I had stood on my

own two feet—it might not have been this way.

DR. COUCHMAN: Jenny, how was your dad as a father?

JENNY: He was always concerned about who my friends were—who I hung out with, what I did, where I went, and what time I'd get in. About my boyfriends he would tell me, "Don't date him, he's bad for you," or "Don't date him, he's looking for only one thing." I was confused. I would ask myself, "Well, what are *you* out for, Daddy?" I didn't know what was right. He was a good father, though, in a lot of ways. He was always there when I needed him. He would always be there to bail me out of something.

My sister is loyal to our father. She was never sure of herself; she has always been jealous of me. I would ask Daddy for something, and she would get angry with me. When I was a baby, she would

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push me away from him and say, "My daddy, my daddy! He's not your daddy!" But I knew better. What really tore her apart was that what was happening to her was also happening to me.

DR. JAMES M. TURNBULL (*Associate Professor of Family Practice and Psychiatry*): Did you know about what was happening to her?

JENNY: It was "our little secret." "If you tell, I'll tell Daddy that you told, and you'll get in trouble." I was scared to death of my dad, so I didn't tell. Daddy told me, "Don't tell Mommy, because Mommy's sick, and she can't take it." When I was about 14 years old, I realized that it wasn't right—that I had to tell my mother about it. My brothers knew what was happening. My brothers and everybody are scared of my father. They have reason to be: he is the monster of all monsters. I have always thought of him that way. It's weird, though. Right now I feel like I am closer to my father than I ever was in my whole life. We talk about what happened. He tells me he was wrong. He even wants to go to counseling with me. There's a program that takes the fathers and daughters, the other children, and the mothers into counseling.

ROSE: He didn't want to go at first. I couldn't believe it when he said he would. I really feel bad for him; he has lost everything.

DR. COUCHMAN: What has he lost?

ROSE: His home, me, liberty. He has told me over and over that he did love me—that he still does. He says it was just that I never showed love when he wanted it. I don't know if that's true or not. I just don't know. He would like to live with Joe—he loves Joe. He's the baby, of course. I don't know. I have suspicions. Is he putting on an act because the trial is coming? I am not going to give him a good conduct medal yet. But I am *not* going back. He was violent these last two years, and it was awful. I was scared to turn around.

DR. COUCHMAN: What has the effect of this upcoming trial been on your family?

ROSE: They are torn between me and him. They don't want me to do this. Ruth, particularly, is going to be very hurt. She only married to get away from Danny. I don't know what I am going to do about her being hurt.

JENNY: I get a lot of pressure from my brothers and sister. Ruth, especially, tells me that

if I win and Dad goes to jail, she will never talk to me, she will kill me. I haven't gotten any pressure from Dad, though. It's weird. We can talk, yet we'll be going into a courtroom against each other very soon.

ROSE: He's not worried. He has the best lawyer in town.

JENNY: They told me he could get 15 to 20 years.

ROSE: Everybody thinks he won't go to jail.

JENNY: In a way, I hope he does get off. I am not thrilled to death about sending my own father to prison. I am not thrilled about losing my brothers and sister, either. It will be painful to walk into the courtroom. I know what people will think of me.

At least, now he knows that I am not fooling around. I used to tell him a lot, while he was doing it, "Someday I'll see you in a courtroom, and we'll get this straight, I promise." All I want to do is show him he can't do this to me anymore. All I want to do is walk into that courtroom and make it clear to him that he can't just walk away from what he did. It went on for nine years; nine years is not something you can easily forget. I will always remember.

I thought that the first time I saw him after he got out of jail, he would jump out of the car and wring my neck and stomp all over me. But he didn't. He said, "Do you really want to take me to court?" I told him no, but I have to. I tell him every time I see him that this is something that is going to happen, and we can't turn back. He wants me to go out of town. He says it is only going to hurt us, and then he threatens that his lawyer is going to "get ugly." He told me he would bring up degrading and shocking things about my life. But that won't stop me because nothing shocks me. Nothing could be as degrading as what happened to me.

ROSE: And he said that it was my fault! They threaten to tell stories about me and my father.

DR. COUCHMAN: We talked about that. It may be that he is trying to frighten you away from the courtroom.

DR. TURNBULL: Jenny, what are you going to be doing in the future?

JENNY: Well, in a week I take my high school equivalency examination. After that, I want to go

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This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dose so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be re-evaluated as conditions in each patient warrant.

**INDICATIONS AND USAGE:** MINIZIDE (prazosin hydrochloride/polythiazide) is indicated in the treatment of hypertension. (See box warning.)

**CONTRAINDICATIONS:** RENEESE (polythiazide) is contraindicated in patients with anuria, and in patients known to be sensitive to thiazides or to other sulfonamide derivatives.

**WARNINGS:** MINIPRESS (prazosin hydrochloride), like most antihypertensive drugs, may cause syncope with sudden loss of consciousness. In most cases this is believed to be due to an excessive postural hypotensive effect, although occasionally the syncope episode has been preceded by a bout of severe tachycardia with heart rates of 120-160 beats per minute. Syncope episodes have usually occurred within 30 to 90 minutes of the initial dose of the drug, occasionally they have been reported in association with rapid dosage increases or the introduction of another antihypertensive drug into the regimen of a patient taking high doses of MINIPRESS. The incidence of syncope episodes is approximately 1% in patients given an initial dose of 2 mg or greater. Clinical trials conducted during the investigational phase of this drug suggest that syncope episodes can be minimized by limiting the initial dose of the drug to 1 mg, by subsequently increasing the dosage slowly, and by introducing any additional antihypertensive drugs into the patient's regimen with caution (see DOSAGE AND ADMINISTRATION). Hypotension may develop in patients given MINIPRESS who are also receiving a beta-blocker such as propranolol.

If syncope occurs, the patient should be placed in the recumbent position and treated supportively as necessary. This adverse effect is self-limiting and in most cases does not recur after the initial period of therapy or during subsequent dose titration.

Patients should always be started on the 1-mg capsules of MINIPRESS. The 2-mg and 5-mg capsules are not indicated for initial therapy. More common than loss of consciousness are the symptoms often associated with lowering of the blood pressure, namely, dizziness and lightheadedness. The patient should be cautioned about these possible adverse effects and advised what measures to take should they develop. The patient should also be cautioned to avoid situations where injury could result should syncope occur during the initiation of MINIPRESS therapy.

**RENESE:** RENEESE should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects of the drug may develop in patients with impaired renal function.

Thiazides should be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma. The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

Thiazides may be additive or potentiative of the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic blocking drugs.

Periodic determinations of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance, namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medications such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are: dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop with thiazides as with any potent diuretic, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Digitalis therapy may exaggerate the metabolic effects of hypokalemia, especially with reference to myocardial activity.

Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in hepatic or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be either increased, decreased, or unchanged. Latent diabetes mellitus may become manifest during thiazide administration.

Thiazide drugs may increase responsiveness to tubocurarine. The antihypertensive effects of the drug may be enhanced in the post-sympathectomy patient.

Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

If progressive renal impairment becomes evident, as indicated by a rising nonprotein nitrogen or blood urea nitrogen, a careful reappraisal of therapy is necessary with consideration given to withholding or discontinuing diuretic therapy.

Thiazides may decrease serum protein-bound iodine levels without signs of thyroid disturbance.

**PRECAUTIONS: Carcinogenesis, Mutagenesis, Impairment of Fertility:** No carcinogenic or mutagenic studies have been conducted with MINIZIDE (prazosin hydrochloride/polythiazide). However, no carcinogenic potential was demonstrated in 18-month studies in rats with either MINIPRESS (prazosin hydrochloride) or RENEESE (polythiazide) at dose levels more than 100 times the usual maximum human doses. MINIPRESS was not mutagenic in *in vivo* genetic toxicology studies.

MINIPRESS produced no impairment of fertility in male or female rats at 50 and 25 mg/kg/day of MINIPRESS and RENEESE respectively. In chronic studies (one year or more) of MINIPRESS in rats and dogs, testicular changes consisting of atrophy and necrosis occurred at 25 mg/kg/day (60 times the usual maximum recommended human dose). No testicular changes were seen in rats or dogs at 10 mg/kg/day (24 times the usual maximum recommended human dose). In view of the testicular changes observed in animals, 105 patients on long-term MINIPRESS therapy were monitored for 17-ketosteroid excretion and no changes indicating a drug effect were observed. In addition, 27 males on MINIPRESS alone for up to 51 months did not have changes in sperm morphology suggestive of drug effect.

**Use in Pregnancy:** Pregnancy Category C. MINIZIDE was not teratogenic in either rats or rabbits when administered in oral doses more than 100 times the usual maximum human dose. Studies in rats indicated that the combination of RENEESE (40 times the usual maximum recommended human dose) and MINIPRESS (8 times the usual maximum recommended human dose) caused a greater number of stillbirths, a more prolonged gestation, and a decreased survival of pups to weaning than that caused by MINIPRESS alone. There are no adequate and well-controlled studies in pregnant women. Therefore, MINIZIDE (prazosin hydrochloride/polythiazide) should be used in pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers:** It is not known whether MINIPRESS (prazosin hydrochloride) or RENEESE (polythiazide) are excreted in human milk. Thiazides appear in breast milk. Thus, if use of the drug is deemed essential the patient should stop nursing.

**Pediatric Use:** Safety and effectiveness in children has not been established.

**ADVERSE REACTIONS: MINIPRESS:** The most common reactions associated with MINIPRESS therapy are: dizziness 10.3%, headache 7.6%, tachycardia 7.6%, lightheadedness 6.5%, palpitations 5.3%, and nausea 4.9%. In most instances side effects have disappeared with continued therapy or have been tolerated with no decrease in dose of drug.

The following reactions have been associated with MINIPRESS, some of them rarely. (In some instances exact causal relationships have not been established.)

Gastrointestinal: vomiting, diarrhea, constipation, abdominal discomfort and/or pain.  
 Cardiovascular: edema, dyspnea, syncope, tachycardia.  
 Central Nervous System: nervousness, vertigo, depression, paresthesia.  
 Dermatologic: rash, pruritus, alopecia, lichen planus.  
 Genitourinary: urinary frequency, incontinence, impotence, priapism.  
 EENT: blurred vision, reddened sclera, epistaxis, linitis, dry mouth, nasal congestion.  
 Other: diaphoresis.

Single reports of pigmentary mottling and serous retinopathy, and a few reports of cataract development or disappearance have been reported. In these instances, the exact causal relationship has not been established because the baseline observations were frequently inadequate.

**RENESE:** Should overdosage with RENEESE occur, electrolyte balance and adequate hydration should be maintained. Gastric lavage is recommended, followed by supportive treatment. Where necessary, this may include intravenous dextrose and saline with potassium and other electrolyte therapy, administered with caution as indicated by laboratory testing at appropriate intervals.

**DOSAGE AND ADMINISTRATION: MINIZIDE (prazosin hydrochloride/polythiazide):** Dosage: as determined by individual titration of MINIPRESS (prazosin hydrochloride) and RENEESE (polythiazide). (See box warning.)

Usual MINIZIDE dosage is one capsule two or three times daily, the strength depending upon individual requirement following titration. The following is a general guide to the administration of the individual components of MINIZIDE.

**MINIPRESS: Initial Dose:** 1 mg two or three times a day. (See Warnings.)

**Maintenance Dose:** Dosage may be slowly increased to a total daily dose of 20 mg given in divided doses. The therapeutic dosages most commonly employed have ranged from 6 mg to 15 mg daily given in divided doses. Doses higher than 20 mg usually do not increase efficacy, however, a few patients may benefit from further increases up to a daily dose of 40 mg given in divided doses. After initial titration some patients can be maintained adequately on a twice-daily dosage regimen.

**Use With Other Drugs:** When adding a diuretic or other antihypertensive agent, the dose of MINIPRESS should be reduced to 1 mg or 2 mg three times a day and retitration then carried out.

**RENESE:** The usual dose of RENEESE for antihypertensive therapy is 2 to 4 mg daily.

**HOW SUPPLIED:**

STRENGTH	COMPONENTS	COLOR	CAPSULE CODE	PKG. SIZE
MINIZIDE 1	1 mg prazosin + 0.5 mg polythiazide	Blue-Green	430	100's
MINIZIDE 2	2 mg prazosin + 0.5 mg polythiazide	Blue-Green/Pink	432	100's
MINIZIDE 5	5 mg prazosin + 0.5 mg polythiazide	Blue-Green/Blue	436	100's



FAMILY DYNAMICS

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to college and study to be an x-ray technician.

**RESIDENT:** Why did you drop out of school?

**JENNY:** Too many kids in the neighborhood were aware of what was going on. My sister told her friends, and it got all over the school. They would tease me, and I just couldn't cope.

**DR. COUCHMAN:** That's about all the time we have. We want you both to know how much we appreciate your coming to this conference.

Discussion

**DR. COUCHMAN:** Jenny seemed quite mature here at this conference. Yet at the home visit, she seemed very childish.

**DR. TURNBULL:** This is typical, in my experience, of adolescents in her situation. They are often described as pseudosophisticated or pseudo-mature.<sup>2</sup> This may be because they are forced into an adult's role of surrogate mother and wife or because of their unusual closeness to an adult. They can also be quite seductive, and you saw a little of this in Jenny today.

**DR. REALINI:** I was struck by how strong and maternal Jenny seems. She even touched her mother's hair as if *she* were the mother and Rose the child. I wonder if this is a manifestation of Jenny's "assuming" the maternal role.

**DR. TURNBULL:** There are a number of features of this family that have been typically described in such families. This is a good demonstration of the dynamics of the conflict between the two sisters. It is typical that the older one becomes jealous at the time the father becomes interested in the younger sister. Jenny brought out this competition very clearly. Jenny's ambivalence about her relationship with her father is also typical.<sup>3</sup> She tells us he is a good father on the one hand, but that she wants to get even with him on the other. She does not want him to go to jail, but she does want him to suffer.

**MS. ORTIZ:** Do you think she is angry at him because of the way he responded to her boyfriend's death?

**DR. TURNBULL:** I don't have enough information from today's interview to understand why she is so much more angry than her sister. I am concerned that she will suffer from guilt if her father goes to prison.

DR. REALINI: It seemed to be a relief to her that everyone thought he would not go to jail. If he is not convicted, then she will have satisfied her need to take him to court without having to send him to prison.

RESIDENT: Can an incestuous relationship like this happen in normal families?

DR. REALINI: I don't think so. Incest is a reflection of significant pathology.<sup>4,6</sup> At the very least, the parents' marital relationship is usually disturbed.<sup>4</sup>

DR. TURNBULL: Well, there are three things that are known to be associated with incestuous relationships in families. The first is isolation of the family from the community. We may see this to some degree in this family. For example, the father excluded his wife's church members and perhaps other visitors from visiting the household. The second association is with alcohol, and Danny has a history of problems with alcohol. The third factor that may lead to incest in a family is a physical, emotional, or sexual disability or illness on the part of a spouse that makes that spouse unavailable to the other. The daughter assumes certain traditionally maternal functions and the sexual role of the mother as well.<sup>4</sup> This role reversal is perhaps the most prominent predisposing factor that this family displays. Clearly, Mrs. Nash's medical problems have caused her to be unable to function as a mother or as a wife, at times.

DR. COUCHMAN: Should I encourage Jenny to testify against her father or not to testify against him?

DR. TURNBULL: From studies of families with incest, it appears that the most constructive thing to do is to keep the family together. The incest must be stopped, of course, and this is ordinarily done by getting its existence "out in the open." In this way, with counseling, the family can be kept together, and the incest can be stopped.

RESIDENT: I would have trouble dealing with this family. I am so furious with the father, I think he should be put away.

DR. REALINI: Many of us have similar feelings. We have to be careful that such feelings don't interfere with our taking the best possible care of such a family. The family physician should remain calm and professional and, if possible, interview all family members.<sup>4</sup> Talking to the father and developing a working relationship with him is impor-

tant in caring for a family with incest.

DR. TURNBULL: I would be totally impartial with respect to Jenny's testifying or not. She has to resolve this ambivalence herself. Besides, I don't feel that I know enough about why meeting her father in court is so important to her.

DR. PAUL C. WEINBERG (*Professor of Family Practice, Psychiatry, and Obstetrics-Gynecology*): Certainly, I would be supportive of the family's going to counseling.

MS. ORTIZ: Jenny is going to need support from us, no matter what she decides to do.

DR. COUCHMAN: So will Rose. She needs to cope with all the guilt feelings that she is having.

DR. TURNBULL: I would like to reinforce one point. Dr. Couchman knew nothing about the incest in this family, although he knew the family for two years, and the incest had been going on for about ten years. There are some clues that an incestuous family may present. The adolescent may be isolated and not attend school activities. The father may be very protective, and not allow her to take part in social activities after school.

DR. WEINBERG: Runaway behavior on the part of the adolescent is frequently the first sign of trouble.<sup>4</sup> There is often a crisis point in the family in father-daughter incest cases when the daughter begins to get socially involved with boys.

DR. REALINI: Much incest that goes on never comes to our attention as professionals. It is important that we maintain a high index of suspicion of incest, or we will miss the diagnosis. When we see a teenager who runs away, or acts out, or is isolated, we should "think dirty" and wonder if incest is involved.

Thank you, Dr. Couchman, for presenting this interesting family. I hope this conference will be helpful to you in their management.

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