Sexual Abuse

Incest Victims and Their Families

SECOND EDITION

Jean M. Goodwin

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Second Edition

Jean Goodwin
with contributions

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"I was beaten to death," said a girl in [the survivor] group. "I never knew whether I would live tomorrow, but when evening came, I used to stand near the window and imagine the lights of New York. I sat for hours and imagined myself entering the great city . . . I knew that when I entered I would attain solace and be protected."

— Zimrin H: A profile of survival. *Child Abuse Neglect* 10:346, 1986.

"Is it true that a person has only one father and one mother?"

— Semrad E: Personal communication, 1971.

"The more a thing is perfect, the more it feels of pleasure and pain."

— Dante

"I have often thought that the dreams of sad, lonely children come true more frequently than those of happy ones. Because they have remained unfulfilled, their intensity grows as adulthood unfolds . . . . However, it does depend on the ability and determination of the individual to regard his life as one indivisible whole."

— Olgivanna Lloyd Wright

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PREFACE TO THE SECOND EDITION

In 1974 when I began this work, childhood sexual abuse was an obscure area with a compassable bibliography. Kee MacFarlane was in Washington, DC, coordinating the federal grants which funded our New Mexico project, Suzanne Sgroi's project in Connecticut, and a few others. Judy Herman had just started working with groups of incest survivors.

More than a decade has passed. Kee MacFarlane now spends a lot of time testifying in one of the bitterly fought preschool abuse cases. The rest of us, too, are overwhelmed with demands for training, demands that come from other professionals, and the media, as well as from the courts.

The list of contributors attests to the changes that have taken place since the first edition. Half of us are no longer in New Mexico. All of us continue clinical work in this area although none of us any longer works for a child protection agency. Many of the contributors still field my calls for clinical and theoretical advice. Others in my support system include Reina Attias, David Corwin, David Metcalf, David Jones, Brandt Steele, Maria Sauzier, Lenore Terr, Bessel van der Kolk, Richard Kluft, David Spiegel, Bennett Braun, Frank Putnam, Roberta Sachs, and Judy Herman.

I remain grateful to all the people at the National Society for the Prevention of Cruelty to Children who helped me spend 1984 exploring the British system for dealing with sexual abuse. Debra Harris and the other counselors at the Santa Fe Mountain Center facilitated another adventure—taking victims into the wilderness (see chapter 15).

My own changes have taken me into the treatment of adult victims, and into the treatment of their often severe dissociative disorders including Multiple Personality Disorder. The eight new chapters in this edition (1, 3, 7, 9, 15, 16, 18, and 21) reflect this shift.

Also in this edition, I have omitted the chapter on the physical examination because I believe the explosion of information in that area now warrants a book of its own. I continue to emphasize (as I did in the first edition) that expert physical examination is of critical importance to psychological and emotional recovery.

When I try to understand how my own thinking is different today from 7 years ago, I see changes which reflect longer follow-up of a greater number of cases. I focus more heavily now on needs for forensic and psychodynamic interventions because that is where my experience has led me. I am more interested now in long-term effects because I have been in the field long enough to see seemingly resilient child victims later experience their first illegitimate pregnancies, their first suicide attempts, and their first psychiatric admissions. I worry now about a wider range of extreme abuse because I have been fooled so often into thinking I had the whole history only to find there was more. The increased focus on the most severe cases also reflects the inevitable

progression of the expert from being referred the worst cases to being referred the impossible cases—those where incest is complicated by ritual murder, cannibalism, live burial, and so forth. Some of these victims are broken and destroyed beyond my capacity to imagine therapeutic solutions. The psychology of hope has thus become another preoccupation.

In the present climate of reaction against what Roland Summit so aptly termed our reluctant discovery of incest, I am often asked if all this has not been overblown. Surely, my questioners hope, the problem is much less than it seems. Unfortunately, I can only answer no.

Jean Goodwin, MD, MPH

INTRODUCTION

In this book "intrafamilial sexual abuse" and "incest" are used interchangeably to mean the sexual exploitation of a child by an older person in a parental role.

The term "sexual abuse" connects sexual exploitation by parents to "physical abuse" by parents and conveys the recent and revolutionary determination of society to protect children from these parental behaviors. To appreciate the radical nature of this redefinition, one needs only to review Sigmund Freud's 1905 unfinished psychoanalysis of "Dora" (see chapter 2). That work conveys no sense that the teenage patient might require protection from the family friend who was attempting to seduce her, or that her father might be remiss in refusing to believe her complaints, or in continuing to insist that she meet with his friend. Freud shares no worries about the possibility that Dora might contract syphilis or be impregnated should the seduction succeed. Of course, Freud knew that Dora was an unusually tough and stubborn young woman. However, he was also thinking of the situation in terms of "seduction," rather than of "sexual abuse." He, and his society, had not yet defined these behaviors as "abuse."

I have used the word "incest" as well, even though it is an old word with many contradictory, legal, genetic, and psychiatric definitions. "Incest" conveys, in a few syllables, the fact that, in almost all of the cases to be described, the perpetrator was a family member. Another useful attribute of this old-fashioned word is that it connects the families that I treat to a larger body of explanatory, rule-making, and literary attempts to cope with a universal and recurring human problem. People in other times and in other cultures have called these problems "incest"; the families currently in new versions of that crisis because of incest can learn from their experience.

The clinical problems described are those I have encountered in working with over 300 incest victims and their families. Many of these patients have been referred to me by protective service agencies, either because of ongoing sexual abuse of a child in the family or because the mother or father in the abusive family had been previously sexually abused in childhood. Other former and current victims have been referred from psychiatric clinics because of suicide attempts, from prenatal clinics because of ambivalence about a pregnancy, from psychiatric hospitals because of delusions about incest, from general hospital clinics because of somatic symptoms, and from rape counseling centers after a rape subsequent to the incest.

My experience as a psychiatrist and, more specifically, as a consulting psychiatrist to a child protective agency, has shaped my point of view. I see the extreme and the difficult cases, and must rely on friends and colleagues, as well as on certain patients, for an understanding of those incest situations that leave minimal scars. Because I tend to be called in crises—suicide attempts,

pregnancy or venereal disease in victims, runaways, recurrences of the incest—I tend to focus on the recognition, prevention, and treatment of these extremities, rather than on the day-to-day support of the family. An underlying goal in all of my research has been to remoralize the often demoralized social workers, physicians, and therapists with whom I work. Like the incest family, we professionals can become numb to the hurt, fear, and anger in the incest situation unless we are helped to remain hopeful that these feelings can be survived and resolved. In moments of despair after a therapeutic disaster, I will usually ask, "But what can we learn from this?" This question has been the source of much of the work described in this book.

The book's first section guides the reader through the first weeks of talking with a family after an incest accusation has been made. Chapter 1 describes a systematic five-point approach to investigating an allegation of incest. Chapters 2, 3, and 4 give examples of errors that professionals dread in these cases; that is, that one will incorrectly diagnose sexual abuse when the actual diagnosis is something else (childhood neurosis, maternal psychosis—pinworm and dogbite are examples given); or alternatively, that one will be seduced by the family's denial into overlooking actual incest. Chapters 5 and 6 examine direct quotations from family members and drawings done by victimized and nonparticipant children as clinical clues to the family's inner realities. Chapter 7 reviews subtle signs of paranoia found in some incest fathers. Chapter 8 describes how the needs of incest victims vary with the victim's age at the time of the report. Incest victims at a particular developmental stage, and their families, will tend to present with developmentally determined symptoms and will require developmentally appropriate supports.

The middle section of the book focuses on some of the late sequelae of the incest experience. These chapters describe girls and women whose incest experiences usually were not recognized or treated in childhood, but who came to medical attention months or years later with complaints that could be understood as delayed reactions to incest. The chapters are arranged in developmental sequence beginning with those sequelae that appear earliest in childhood. Chapter 9 frames these late sequelae as posttraumatic disorders. Chapter 10 describes a syndrome of simulated neglect that we observed in 9-year-olds who had been physically and sexually abused before age 5. The abused girls recreated in adoptive homes a pattern of denigration and deprivation reminiscent of Cinderella's plight in the faïry tale. Chapter 11 describes a symptom cluster of hysterical seizures, runaways, promiscuity, and suicide attempts in teenage incest victims, and compares clinical observations to Navajo and Anglo-European folk beliefs that connect these symptoms with incest. Chapter 12 examines more closely the occurrence of suicide attempts after incest is revealed. In our sample most attempts occurred in adolescents aged 14 to 16 whose accusations had not been believed by the mother and whose families had not remained intact. Chapter 13 presents a case report of a victim of mother-daughter incest whose temporary

homosexual adjustment in adolescence seemed to be a result of the incest experience. Chapter 14 reviews the genetic hazards of first-degree incestuous matings and describes the clinical problems that develop when teenagers become pregnant by fathers, stepfathers, or uncles. Chapter 15 lists criteria that can be used in adult survivors' groups to recognize those victims of extreme incestuous abuse whose symptoms include severe dissociative disorders such as multiple personality. Chapter 16 expands these criteria so that child-care workers can recognize early in the course of treatment which children are at risk for these disabling syndromes. Chapter 17 describes adult incest victims whose children are now being physically or sexually abused. Chapter 18 describes a severe symptom pattern found in adults who have experienced extreme multimodal incest abuse and have been diagnosed as having borderline personality disorder.

In the last three chapters clinical material is used to explore more general questions. Chapter 19 asks whether or not physicians should report child abuse. We argue that the example of sexual abuse indicates that increased reporting can reduce morbidity for the victim, for her parents, for her siblings, and perhaps for her children. In chapter 20 I ask if my clinical observations of incest victims might be similar to data that tribal leaders and storytellers have used to construct the taboos and legends about incest that exist in all cultures. New versions of medieval folk tales about incest are appended to this chapter and can be helpful in providing metaphors to children who need to talk about sexual abuse. Chapter 21 returns to these folkloric materials asking a different question. Why is it so difficult for us to structure workable societal responses to the incest situation? Why do we fail so often?

Readers tell me it is most useful to approach this book nonsequentially beginning with a chapter of immediate clinical relevance and following the signposts therein to related chapters. Since each chapter is self-contained, this approach works well.

Maintaining confidentiality is an inevitable concern when one is presenting numerous case examples. Names or initials have been invented for some complex cases simply to make the case histories readable. These invented names bear no relationship to the names or initials of real families. When a detailed case history has been required, I have followed a policy of altering one or several nonessential details, such as making an uncle into a second cousin, or a family of four into a family of five. This should foil any attempt to match a particular case history with a real family. My anxieties about confidentiality have diminished as I have seen more and more cases of incest and have come to believe more fully that the patterns are repetitive and compulsive. Former patients who believe they recognize themselves in an example should pause to wonder if there was not another case with a similar pattern, or another dozen cases. The uniqueness of each family's experience will have to wait for expression in the books that the patients themselves will write.

Several chapters have been adapted from some of my previously

published papers. I wish to acknowledge and thank the following journals for their kind permission in allowing my adaptation for this book: *the Bulletin of the American Academy of Psychiatry and the Law* (chapter 2), *Child and Youth Services Review* (chapter 5), *the American Journal of Psychiatry* (chapter 10), *the American Journal of Orthopsychiatry* (chapter 11), *Child Abuse and Neglect* (chapters 12, 13, and 17), *Victimology* (chapter 15), and *Dissociation* (chapter 18).

Several chapters are based on previously published book chapters. Chapter 1 will appear in the Modern Perspectives in Psychiatry series, edited by John Howells, to be published by Brunner-Mazel. Chapter 7 appeared in *Psychiatry: The State of the Art, vol 6,* edited by P. Pichot, P. Berner, R. Wolf, and K. Thaw, published by Plenum Publishing Corp, New York, in 1985. Chapters 3 and 9 first appeared in 1985 in American Psychiatric Association monographs: the former in *Childhood Antecedents of Multiple Personality Disorder,* edited by Richard Kluft, and the latter in *Post-Traumatic Stress Disorders in Children,* edited by Spencer Eth and Robert Pynoos. The final chapter is based on a chapter published in 1988 in *The Lasting Effects of Child Sexual Abuse,* edited by Gail Wyatt and G.J. Powell.

Financial support for much of my clinical work (chapters 4, 5, 6, 10, and 13) with incest victims has come from a sexual abuse demonstration grant from the National Center for Child Abuse and Neglect to the Family Resource Center, Albuquerque, New Mexico.

The list of contributors includes much of my own support system. I would like to thank Wayne Holder of the Child Protection Division of the American Humane Association for getting me into this morass of child abuse. I am also grateful to the faculty and house staff of the University of New Mexico for sharing their patients and their knowledge with me, and to Ellen Stuart and the other staff members of the Department of Psychiatry who have helped me to get all this down on paper. Drs Winslow and Kellner in the chairman's office and Dr Berlin in child psychiatry have been profuse in their material and spiritual support. Dr Anthony Meyer at the Medical College of Wisconsin helped in the preparation of the second edition.

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Evaluation and Treatment for Incest Victims and Their Families: A Problem-Oriented Approach

Jean Goodwin

Surveys indicate that 16% of women in the general population have experienced sexual contact with a relative and 1% to 4% have experienced father-daughter incest[1] (see chapter 17). In psychiatric populations the prevalence is higher with 35% of female psychiatric inpatients reporting incest experiences in childhood with fathers, stepfathers, mothers, grandparents, older brothers, or uncles.[2] Males in the general population are less well studied. There is considerable anecdotal evidence that in the most severely disturbed families all children—both male and female—are sexually and/or otherwise abused, often by multiple family members—both male and female.[3] One survey shows that over half of therapists—psychiatrists, psychologists, and family counselors—have treated at least one child or adult incest victim in the past year.[4]

In the past 10 years certain evaluation and treatment strategies have become routine for child incest victims.[5] In the initial phase this routine includes: (1) a complete *physical examination*, (2) *investigation* to document abuse and to detect *other victims,* (3) *legally mandated reporting* to protective services and in some jurisdictions to law enforcement, (4) interview and evaluation of *the alleged abuser* and other family members, and (5) assessment of the child for *posttraumatic symptoms*. Treatment for child victims tends to be similarly organized around the same five axes: (1) structuring adequate *physical care*, which sometimes requires placement of the child away from the abuser or both parents; (2) individual and group treatment of abused and/or neglected *siblings*; (3) guidance and support for family members as

they progress through various *legal interventions*; (4) individual, group, behavioral, couples', and family therapy to rehabilitate *the sexually abusive parent* and to improve parental and family functioning; and (5) individual and group treatment to decrease posttraumatic and other *symptoms in the victim*.

Even in child victims this ideal model is not always followed, as the following examples illustrate for each of the five problem axes. (1) When confronted by a hypothetical case in which a 9-year-old retracts under pressure a detailed account of long-term oral sex with her father, 75% of pediatricians would recommend that the child be physically examined and screened for gonorrhea and other venereal diseases. Only 50% of psychologists, psychiatrists, and counselors recommended physical examination, although 100% recommended psychological testing for the child. [4] (2) In this same survey, professionals in all categories tended to underestimate the 40% likelihood that if this child were abused, her sibling would have been also.[6] (3) As recently as 1981, 58% of pediatricians surveyed stated that they would not report to protective services a confirmed case of incest.[7] (4) Parents, especially fathers, often flee, avoid, or legally resist evaluation and treatment.[8] (5) Child victims who fail to appear for appointments or who continue to function without major behavior problems may not be referred for treatment or even systematically evaluated.[9]

When an adult victim discloses prior incest, the approach to substantiation is even less systematic. Such disclosures typically occur in the middle phase of a treatment begun because of another chief complaint: Few survivors disclose until trust is established.[10] The therapist may not even conceptualize an investigation phase for the disclosure; a generation ago, some analytically oriented therapists understood such disclosures as "fantasies," a view which focused treatment on internal rather than external realities. [11, 12] However, the importance of ascertaining the realities of the abusive incidents is attested by the high proportion of adult victims who question the authenticity of their own often fragmented or derealized memories and set as a treatment goal either the verification of those memories or some sort of confrontation or acknowledgment of those memories from the abuser or other family members.[13] With the adult victim, the therapist typically does not: (1) require a physical examination, (2) interview siblings, (3) consider possible legal obligations, or (4) evaluate the parents. However, (5) posttraumatic symptoms are targeted here much as they are in a child victim, although the powerful tool of group therapy is less often used.[14]

This review offers clinical examples illustrating how adult as well as child victims benefit from careful attention to the five designated problem areas. The five-problem model will be applied systematically to assessment and treatment planning for children and adults. Particular attention will be paid to the sometimes perplexing issue of "Did sexual abuse take place?" A two-part section describes a brief screening approach for posttraumatic symptoms

in child and adult victims which differentiates severe from less disabling forms of the disorder.

A PROBLEM-ORIENTED APPROACH TO ASSESSMENT

Several studies show that only 6% to 9% of all incest allegations reflect fabrication by child or parent; the majority of these fabrications are produced by adults.[15–19] Despite this relatively low frequency, concern remains that innocent parents will be accused or even convicted. Given the evidence that only 1% of rape events ever result in conviction,[1] this last is statistically unlikely, albeit tragic when it occurs.

The problem-oriented approach offers a systematic way to organize clinical data in those perplexing incest allegations, often arising in custody disputes, when accusations and denials may be mutual, unrelenting, and enraged, and when it is unclear whether the child suffers primarily from sexual abuse or whether the ongoing battles associated with divorce have produced posttraumatic symptoms. Clinicians can be misled in these situations if they place too much weight on the accounts of any single family member or if they neglect evidence from medical examination, witnesses, or other physical evidence such as photographs.[19]

Applying the five-problem model to the substantiation question requires a balanced review of: (1) the *physical findings* on medical examination; (2) *investigatory data* such as the statements of witnesses and physical evidence such as photographs, diaries, and pornographic materials; (3) the potential *victim's statements* and competency to witness in a *legal* setting; (4) data about the suspected *abuser* and the *violence history* in the nuclear and extended family; and (5) data about the victim's *posttraumatic symptoms* and whether these can be linked specifically to details of the traumatic experience described.

The Physical Examination

Physical findings indicative of abuse are present in 50% to 75% of children who have been vaginally or anally penetrated.[20–23] Physical signs may be subtle: Delayed growth or anemia may reflect malnutrition; absent or incomplete inoculations and/or untreated dental problems can indicate medical neglect; bruises or burns can be signs of inappropriate discipline; a toxicology screen may reveal chemical abuse of the child. Undiagnosed or undertreated medical problems may be found in these children; seizure disorders are the most common.[24] Although motile sperm is a rare finding in these chronically sexually abused children, examination of the genital region using magnification (culposcopy) may reveal anal scarring or dilatation, vaginal scarring or dilatation, hymenal stretching or scarring, and microscopic tears, bruises, or abrasions. Syphilis, gonorrhea, herpes, chlamydia, genital

warts, and other venereal infections are virtually diagnostic of sexual abuse, as is pregnancy. [25–28] Review of past pediatric records is always indicated. This can reveal hospitalizations in infancy that were related to unrecognized neglect or abuse. Some abused children develop hysterical conversion symptoms or chronic somatic complaints such as headache or stomach ache[29,30]; these also may have led to prior treatment.

Investigation: Finding Other Victims, Witnesses, and Physical Evidence

Statements from witnesses are sought in child cases in part because of the need to identify other child victims. Intrafamilial sexual abusers were once thought to represent a separate category of offenders, quite different from pedophiles. However, we now recognize that some incestuous offenders sexually abuse many children, experience sexual arousal when fantasizing about children, use coercive strategies identical to those employed by pedophiles, and tend to accept treatment only under legal mandate.[31] Grandfathers who sexually abuse have histories of victimizing numerous grandchildren and often children outside the family as well. They tend also to have victimized their own children, and those who accept treatment describe sexual contacts as adolescents with siblings or other relatives.[32] Several studies indicate that other victims will be found in over 40% of father-daughter incest families in which there are siblings[33]; natural fathers are no less likely to involve multiple victims.[34] Sometimes siblings are found to have been sexually abused by the identified victim or by family members other than the identified abuser. Siblings often have witnessed elements of the sexual abuse; for example, when a 12-year-old incest victim refused her father for the first time, she heard him go into the next bed and sodomize her brother.

School and neighborhood friends of the identified victim may also have been approached sexually by the abuser. Peers are sometimes told about the abuse by the victim, long before adults are consulted. This kind of witness data can be useful especially if the credibility of the victim is in question, due to disclosure of incest during a crisis such as a marital separation or in the midst of a disciplinary dispute involving the victim. Valid disclosures are commonly made in precisely those circumstances in which the victim is least likely to be believed. Evidence that the child has told a peer long before decreases the likelihood that the complaint is an improvised manipulative fabrication. I recall one case in which a second grader told her best school friend about the sexual abuse by her father. Her friend was shocked by this and developed a plan to extricate her from the situation. Their plan was to go to school during the day and camp at night in a tent on the school playground. They would do yard work to make money for food. On the first afternoon, when the two failed to come home on time from school, they were found by frantic parents and punished. The incest problem which had

precipitated the "runaway" was not disclosed to the adult world until 2 years later when the girl contracted gonorrhea. In an even more grim and tragic case, when an adolescent girl disclosed severe physical and sexual abuse to her peers, they arranged for the father's murder.

Assessing the Credibility of the Child's Account

Legal involvement is routine in these cases. Courts or attorneys often ask a psychiatrist or psychologist to assess the credibility of a child's complaint about sexual abuse.[35] Some jurisdictions prohibit expert testimony about credibility on grounds that this determination should be reserved for the trier of fact; however, since clinicians must assess whether a child has been abused as part of making a diagnosis and planning treatment, they will usually have an opinion. In some cases, refusal to reinterview the child is the best response to a request for an expert credibility assessment. For example, consider the case of a child who is 5 years old or under, whose abuse took place more than 3 months ago, and who has been interviewed by more than three evaluators. Children under 5 often have difficulty distinguishing what actually happened from what they thought or wished at the time, and from what has been said about the event.[36] There is some evidence that distortions increase with elapsed time and number of evaluators.[37,38] Investigation and evaluation are best kept separate from treatment.[39] If evaluation is still ongoing 3 months after an allegation, it is likely that is displacing needed treatment.

Before submitting a young child to a repeated reinterview with yet another "expert," the evaluation to date can be reviewed to determine whether the four problem areas other than the child's statement have been carefully pursued. Has a thorough physical examination been completed? Have its results been properly interpreted and integrated? Are there journals, photographs, prior medical records, or witnesses that have not yet been reviewed? Have other family members, including the possible abuser, been interviewed and evaluated? Is there a complete family violence history for all family members? Re-evaluation of the child's account can include interventions other than a reinterview of the child such as: (1) interviews of all individuals that the child has told about the sexual abuse, or (2) observation of investigative video tapes or of one of the child's therapy hours to assess the child's developmental stage, intellectual capacity, communicative style, emotional state, and continued involvement with the sexual abuse complaint. In some difficult cases it becomes apparent that the child himself has never made any complaint about abuse; the entire history of concern may be based on the preoccupations of one of the adults in the family.

When a reinterview is deemed necessary, this interview should be designed to respect the child's developmental capacities and the child's right to freedom from coercion. Children can be coerced by interviewers just as they can by

abusers. Abusers ensure silence and cajole retractions by a process Roland Summit has termed the "accomodation syndrome."[40] I use the mnemonic BLIND as a shorthand for five of the elements involved in the process of traumatizing a child: *b*rainwashing, *l*oss, *i*solation, "*n*ot awake or alert," and *d*eath fears. Abusers brainwash and confuse the child with misinformation or disinformation ("All fathers do this"). They threaten loss of love or loved ones ("It would kill your mother if she knew"). They isolate the child from other sources of information or nurturance ("No one will believe you if you tell"). They initiate or escalate abuse when a child's awareness and concentration are at their lowest (during sleep, during an illness, after a severe punishment). They create an atmosphere of ultimate threat which may be overt ("I'll kill you if you tell"). Covert threat can also be unmistakable to a child.

Coercive evaluations employ subtle variations on the BLIND tactics. The child is not informed about the legal issues at stake. The child's concrete questions like, "Why is there a television camera here?" are not answered. The child is isolated during the evaluation process from sources of nurturance and stability—parents, siblings, extended family, school, neighborhood—and may be threatened with permanent loss of these attachments. Evaluation sessions are prolonged beyond the child's range of attention span or allowed to interfere with eating or sleeping. Death fears can be stimulated by ill-timed, frightening questions (as, immediately after a denial that sexual abuse occurred, "Are you hearing voices now?") or by outright coercion ("That's not what you said on the videotape").

Step-by-step protocols can be helpful in preventing coercive interventions, as can structured and semistructured interviews, structured protocols for use of anatomically correct dolls, and lists of nonleading questions.[41–44] However, any system can be misused if the interviewer loses his or her focus on the child's own reality and endeavors instead to manipulate the child to meet adult needs.

Assessing the Abuser

The evaluator may find that while the 4-year-old in the case has been evaluated repeatedly, the alleged adult abuser has refused interviews with everyone. In England and the United States such refusal is based on rights against self-incrimination. Nevertheless, collateral sources can often be used to document a previous pattern of sexual, physical, and emotional violence. In one case military records revealed a court martial for pedophilia. In another case family members had witnessed the father holding a rifle to the mother's head and threatening to kill the entire family and then himself. Hospital records and police reports may document spousal violence or rape, or previous investigations for child sexual abuse in previous marriages. In some of the complex divorce custody cases, a pattern emerges in which the abuser uses the legal system to intimidate and harass the former spouse. School records

may document paternal overinvolvement with the child, jealous rage reactions, or a pattern of intimidation of teachers by the father. These fathers may appear on the surface as the exemplary, "endogamic," involved fathers described in the older literature on incest.[45, 46] It is only with more detailed history taking that their involvement is understood as rooted in feelings and fantasies of persecution and grandiosity rather than in an adult capacity to parent.[47] (see chapter 7).

Screening for Posttraumatic Symptoms

Various studies report that 20% to 100% of sexually abused children are acutely symptomatic at the time of the allegation.[48–53] Some children present with severe psychosis or characterologic problems that seem to predate the sexual abuse and may reflect constitutional factors or the result of neglect, emotional abuse, or battering that interfered with development in earlier years of life.[54] Some children are completely asymptomatic. The most frequently described syndrome of symptoms includes intrusive memories and feelings about the abuse interspersed by numbing of responsiveness. This syndrome is described in the current *Diagnostic and Statistical Manual* of the American Psychiatric Association as Post-Traumatic Stress Disorder (PTSD).[55, 56]

I have used the mnemonic FEARS to list five basic symptoms of PTSD. These are the five symptoms originally described by Kardiner in his study of "shell-shocked" World War I veterans.[57] They remain the core of present definitions of the syndrome. *F* stands for *f*ears and anxiety. Phobias are found and may encompass all men, or may focus on a particular feature of the abuse, for example, the room where incest occurred. Fears about sexuality are common with 61% to 94% of symptomatic adult incest victims reporting sexual dysfunction.[58, 59] Dysfunction can be pervasive, as avoidance of all kissing in a patient where oral sex had been prominent, or avoidance of all penile contact in victims who maintain the capacity for satisfying sexual experience with females. Sometimes the fears are more circumscribed and can be gotten around by avoiding certain specific sexual practices. Easy startle is characteristic of PTSD and is found in 63% to 76% of adult victims.[60, 61] One incest victim blackened her roommate's eye when approached suddenly. Adolescent and adult victims may take fear for granted when it becomes chronic and may lose sight of the connection between incest-related fears and such coping strategies as alcohol or drug abuse, or keeping the lights on all night. Certain fears are predictable: Female victims will have worried about pregnancy; male victims will have concerns about being homosexual. All victims at some level assume that the abuser's threats about disclosure will "come true" if they break their pledge of secrecy; thus anxiety and fears will increase as disclosures are made in treatment.

E stands for "*e*go constriction," the phrase Kardiner used to describe the "numbing" processes used by the victim to avoid overwhelming anxiety. In young children, the constriction appears as loss of recently acquired

developmental gains, such as exploration or toilet training in a toddler or adaptive school performance in an older child. Parents or teachers may be able to pinpoint a time when the child changed or "faded," which coincides with the onset of sexual abuse. Difficulty in concentrating and learning problems are reported by 23% to 35% of adult victims and 61% describe themselves as emotionally isolated.[60, 62]

A stands for *a*nger dyscontrol. Mildly affected victims often have difficulty expressing anger, masking it with compliance and perfectionism which are nonetheless punctuated by angry outbursts that are usually more terrifying to the victim herself than to her targets. Seventy percent of adult victims say they are still angry about the incest; 65% say they are afraid of their anger; and 64% report displacing anger onto their current sexual partner.[58, 62] Tantrums in young children or "hysterical" outbursts in older children manifest these problems in expression of anger.

R stands for *R*epetition, usually reflected, in mild cases, in repetitive thoughts, feelings, or images of the events. Flashbacks to incest during sexual activity are characteristic. Eighty percent of adult victims report flashbacks.[62] Places, odors, anniversaries may trigger perceptual reliving of traumatic events. Phobias and numbing often reflect strategies for avoiding flashbacks.

S reminds the evaluator of the importance of *s*leep *d*isturbance in PTSD and also stands for sadness. Repetitive, posttraumatic nightmares are an important feature of PTSD; in very young children, frequent night terrors are an indicator of abuse. Posttraumatic nightmares may incorporate specific elements of the sexual abuse experience (the image of a large penis; the sensation of being crushed; the color of the childhood bedclothes) and are accompanied by physiologic arousal or awakening. Of adult incest victims 60% to 82% report trouble sleeping or nightmares.[60–62] Modification and eventual disappearance of posttraumatic dreams is a good indicator of therapeutic success.[63] Incest victims and other victims of PTSD usually have some vegetative signs of depression, such as crying spells, insomnia, appetite disturbance, or morbid self-reproach. Two thirds of incest victims say they are depressed[60]; 84% say they lack self-confidence [62]; 100% report guilt.[61] Antidepressant medication is helpful in some patients with PTSD.[63]

A recent study[64] documents the acute symptoms in 369 children aged 4 to 17 years evaluated within 6 months of a sexual abuse event. Parental ratings on the Child Behavior Profile showed significant differences in symptoms between the sexually abused children and a control group. The eight most common symptoms in the sexually abused children fit the FEARS model: (1) emotional upset, 23% of sexually abused children; (2) withdrawal from activities, 75%, and academic problems, 15%; (3) repressed anger, 19%; (4) fear in presence of abuse stimuli, 31%; and (5) low self-esteem, 33%, nightmares, 20%, and depression, 19%. Percentages of symptomatic victims are higher in the adult samples possibly because of treatment bias leading to exclusion of victims with less severe and long-lasting symptoms.

Screening for severe posttraumatic symptoms In a small percentage of victims, symptoms are quite severe and potentially disabling. Severe symptoms have been associated with (1) presence of a parental perpetrator, (2) long duration of abuse, (3) serious threat of or violence associated with the abuse,[65] and (4) degree of family disruption.[32] A modified FEARS mnemonic describes this severe symptom pattern.

In this syndrome, *F* represents "*f*ugue and other dissociative symptoms." Rather than experiencing anxiety, these victims use fugues, amnesia, depersonalization, and derealization to distance and insulate themselves from the fear-provoking situation. As many as two thirds of victims will have patchy memories for the abuse. Runaways with fuguelike qualities are seen in adolescent victims. Many victims use dissociative strategies in emergency situations, but in the severe cases dissociation has become habitual and uncontrolled. The success of these defenses in combating fears and phobias is illustrated by data from incest victims with Multiple Personality Disorder (MPD).[66, 67] Despite other severe disabilities, only 10% of these victims have orgasmic dysfunction,[68] probably because sexuality often is handled by a specialized alter personality insulated by dissociation from incest-related sexual fears (see chapter 15).

*E*go fragmentation replaces ego constriction in severely affected victims who may fragment completely into multiple personalities or more complexly into the "part-object/part-self" representations found in Borderline Personality Disorder (BPD) (See chapter 18). Ninety-seven percent to 99% of MPD patients report abuse in childhood. Preliminary surveys indicate that 75% of patients with BPD have sexual abuse histories.[69] It is intriguing to try to conceptualize the alternating idealizing and devaluing relationships that characterize the borderline patient as related to difficulties integrating the "public," often "perfect" parent with the secretly abusive parent known only to the child.[70–72]

A in the severe syndrome represents *a*ntisocial acting out. Rather than struggling to repress and control anger, these victims often simply act on angry impulses. Such actions may include paraphiliac sexual activities, prostitution, and repeated family violence in adulthood, such as spousal or child abuse. Burgess et al[73] found that six (10%) of 66 children involved in a pornography ring had been convicted of a crime within 2 years of disclosure. Six became involved in prostitution. The antisocial behaviors were associated with psychodynamic patterns of identification with the aggressor.

R describes the *r*eenactments which occur in these victims in lieu of the predominantly sensory repetitions seen in less severe cases. Repetitive reenactments include experiencing multiple rapes, choosing multiple mates who are physically abusive or multiple mates who incestuously abuse the victim's children (in some cases at exactly the same age that the mother was when she was incestuously victimized). Incest also may be reenacted in a therapeutic relationship in the form of therapist-patient sex. In one sample,

30% of adult incest victims had been abused by a therapist[74]; in another sample 46% had been raped at least once since the original incest.[62]

For the severe syndrome, *S* refers to *s*uicidality and *s*omatization. Patients who present with multiple suicidal attempts or self-mutilations should be screened both for prior incest and the other manifestations of the severe FEARS syndrome, especially dissociative symptoms. Suicidality and somatization tend to appear together in about one quarter of adult incest victims.[61, 62] These severe symptoms are seen in only about 10% of child victims.[64]

Chapter 15 describes a study of 50 women treated in an adult incest victims group; five (10%) had MPD. Each of the five had multiple prior suicide attempts, severe multimodal abuse in their childhoods, and prior psychiatric hospitalization. Three had lost custody of their own children because of abuse and neglect. All had prominent somatic symptoms including two with Briquet's syndrome and one with Munchausen's syndrome.[75] Somatic symptoms could often be interpreted as somatic memories of the sexual abuse.

When somatization is part of a severe syndrome, close cooperation between psychotherapist and general physician may be necessary.

Folkloric Examples of Moderate and Severe FEARS Syndromes

Two European fairy tales allow us to compare and contrast the moderate and severe syndromes. The first tale, "Thousandfurs," is currently available in Grimms' collections (see chapter 20). The second, "Manekine," is a more obscure Hungarian tale, included as Appendix IV. Both fairy tales describe similar situations: a beautiful beloved mother dies leaving her grieving daughter and her widowed husband, the king, who vows that he will never remarry. Later, however, he becomes aware of the beauty of his daughter and asks for the hand of the princess. It is at this point that the two stories diverge, making visible the differences in the two syndromes, and their divergent family origins and interpersonal implications.

In "Thousandfurs" the princess bargains and negotiates with her father. She asks for a dress as beautiful as the sun, then for a dress as beautiful as the moon, and finally for a dress as beautiful as the stars. She is amazed and dismayed each time when her father actually meets her demands. This reframing of "taking bribes" as "staving off" the abuse is often welcomed by victims who have experienced similar moments but still view their actions as shameful rather than as representing active coping. Finally she asks for a thing that she knows is impossible, a coat made of the furs of a thousand animals. To her horror her father meets even this last, most difficult demand.

The princess, however, is resourceful. She dons the coat of a thousand

furs and in this disguise she escapes to the forest. As it happens, a neighboring prince is hunting in the forest and his hunting dogs tree the strange animal with the unique fur coat. When I read this story to incest victims they almost uniformly misunderstand this section of the story and assume that the king who captures Thousandfurs in the forest is actually her father. This error can be the beginning of a discussion about the persistence of the perception of the incest father as omnipotently manipulative and ultimately inescapable. It also opens for scrutiny the impact of the incest relationship on the victim's current marriage. Nonabused children of all ages, however, are not confused at this point and realize—as Thousandfurs is put to work in the kitchen while the prince plans a series of balls—that this story is going to be one of those Cinderella fairy tales that always have happy endings.

Thousandfurs sneaks out of the scullery to each of the prince's three balls, each time wearing a different one of her spectacular dresses. The prince pursues her each time but always finds himself ending up back in the kitchen confronting that mysterious many-furred beast. Thousandfurs tests and bargains with the prince much as she had done with her father. Once she is certain that he will not be as intrusive and destructive as her father, she lets him pull off her beast-suit, her coat of a thousand furs. Moments similar to this occur often in psychotherapy, with incest victims as the restricting defenses that they had used to control their fear and anger and flashbacks are lifted off momentarily, revealing the beautiful princess underneath.

In contrast, the Manekine story begins on a much grimmer note. In this story the king becomes terribly melancholic at the death of his wife. Playing chess with his daughter is the only amusement that distracts him. One day as they are playing chess he reaches over, takes her hand, and asks for her hand in marriage. She in turn reaches across, pulls his sword from its scabbard and cuts off the hand that her father is holding. He immediately sends her to the dungeons, commanding that she be burned at the stake.

Already we see the contrasts with the Thousandfurs family. This is a family in which aggression rapidly escalates to mutilation, incarceration, death threats, and extreme violence. Impulsive action, not negotiation, is the rule here. Emotional upset has gone out of control and become melancholy, a psychiatric disorder.

Fortunately, the court jester knows the way to avoid the death sentence. He helps Manekine make a mannequin of herself. Possibly he realizes that, given the nature of the parent/child relationship, the father will not be able to tell the difference between a mannequin and his own daughter. The jester helps Manekine to escape. She has now taken on the name of the mannequin that was burned, and to some extent its persona, as she escapes in a rudderless boat and is washed up on the shores of a new land. Like a mannequin she has now lost the power of speech. It is as if it was the real princess who was burned; only the mannequin was feelingless enough to survive. Despite this

new handicap, the king of the country in which she has landed immediately falls in love with her and marries her. Unfortunately, he is called away to a crusade and Manekine is left with her wicked mother-in-law, who immediately conspires against her. When Manekine's baby is born, the mother-in-law writes the king saying that the baby is deformed and this means that Manekine is a witch who must be burned at the stake forthwith. Thus the fairy tale princess experiences an exact reenactment of her childhood trauma. Manekine, however, is quite experienced in being burned at the stake and she makes mannequins of herself and her baby and escapes again in a rudderless boat. This time she is cast up on the shore near Rome where she becomes a beggar, but she is so poor that her baby starves to death.

Time passes. One day she is sitting at a fountain in Rome and overhears the conversation of two wealthy men dining on a porch above her. These two have to come to Rome to do penance, one for a great wrong he did to his daughter, and the other for a great wrong he did to his wife. As they speak Manekine suddenly realizes that one is her father and that the other is her husband. At that moment of realization her sèvered arm appears from out of the waters of the fountain and reattaches itself to her body. Her child too appears, lifting up his arms to her as he stands laughing in the fountain.

Most people like this story because it offers some hope for those victims of parental abuse who are most broken and hopeless. The story also illustrates many of the features of the severe syndrome. For these victims, ego changes are drastic, involving, not a constriction due to heightened defensive activity but an actual splitting off and loss of ego functions, exemplified by Manekine's loss of her hand and loss of speech. Here the self is not merely cloaked in a disguise as in Thousandfurs, but a false self, a mannequin, is constructed to bear the brunt of the pain. This is similar to the process seen in childhood multiple personality disorder patients where the child designs alternate selves which are pain immune and "not bothered" by the abuse. Manekine cannot assert herself well enough to bargain as Thousandfurs did. She continues to protect herself from abuse, but in a way that can be interpreted as mere misbehavior and thus strengthens her persecutors' case against her, rather than effectively challenging them. The final scene in this story can be seen as parallel to scenes from family or group therapy in which the men who have hurt the incest victim are forced at last to confront themselves and each other. This is a process that proves enormously healing for Manekine. I have noted the reenactments in the story involving repeated accusations and flights. There is also a reenactment in the near fatal abuse of her own child (see chapter 17).

Manekine's cutting off her hand is an apt image for the self-mutilation and suicidality found so universally in the severe syndrome. Victims attack themselves in part to make themselves less sexually attractive in the eyes of the abuser and in part to make visible the injury that the abuser insists must be kept secret and invisible. Eating disorders function in a similar way. The

self-starvation or the self-mutilation is often kept as secret as was the original abuse, allowing for complex reenactments of the old ambivalence about keeping the abuse secret versus asking for help. These behaviors may also represent dissociated memories of the abuse. For example, victims with bulimia may experience eating and regurgitation as a repetition of the sensations they underwent while performing fellatio (see chapter 18). Somatization is represented in this story through Manekine's beliefs that she can't function because her hand has been severed, that she cannot speak, and that she can't enjoy her child because he has died of hunger. Severely symptomatic victims tend to misinterpret their difficulties as resulting from physical illnesses or injuries rather from the interpersonal injury of incest.

Does Manekine have a Multiple Personality Disorder? The startlingly sudden healing process that occurs at the end of the story is not that dissimilar from the startling improvement that can occur when a fragmented incest victim reintegrates a split off part of the self. However, had the story continued, one might have seen equally startling regression in Manekine reappearing under stress, as very regressed fragments regained control (see chapter 15).

Applying the Model to Treatment Planning for the Adult Incest Victim

I have described above the clinical dilemmas that occur when an adult patient discloses prior incest midway in a treatment begun for another reason. Should the therapist proceed as if nothing has happened? Halt the treatment and reassess? This final section uses the problem-oriented approach to suggest options.

Inquiry is always indicated about physical intactness, bodily sensations, physical pain, and physiologic indicators of fear occurring during disclosure to the therapist. Review of physical problems in adulthood may reveal patterns of pelvic pain or headache which are common in incest victims. Review of pediatric records may uncover patterns of abuse which the victim has minimized or dissociated. One patient had been treated for multiple vaginal infections by her pediatrician. In another case, a brother's death certificate confirmed the patient's memory that he had been beaten to death.

Informal investigation is often undertaken by the adult incest victim, especially if amnesia obscures her own memories. Siblings are often the first collateral informants to be interviewed. In one case in which the victim had been completely amnestic for the incest for many years, a family servant was able to describe the induced abortion which had terminated the patient's forgotten incest pregnancy. Revisiting the former family home or reviewing old photo albums can clarify fragmentary memories. If entire years are lost to amnesia, I recommend that the patient make a notebook for the lost years, including photographs, old report cards, and information gained from family members, neighbors, and friends.

Legal complications are still possible, even if the disclosure comes from an adult victim.[76] Younger siblings, nieces and nephews, or the adult's own children may continue to be at risk from her abuser or other victims in the family. Potential abusers include the victim herself, who may have been driven to disclosure by her impulses to physically abuse or neglect her own child. Protective service referrals may be necessary. Other legal involvements may arise. I have treated victims who have been able with treatment to mobilize the family to have the incestuous father civilly committed for psychiatric treatment. In cases where amnesia has deprived the victim of memory of the event, adults still have 3 years, in most jurisdictions, after recovering the memory, to initiate a civil suit against the parent for damages caused; even if a parent is dead, the estate may be liable. The therapist is most helpful if aware of these potential legal entanglements.

Some adult incest victims pursue a role of family therapist, remaining concerned and involved with the abuser and his pathology and with other dysfunctional family members. Therapists narrowly focused on increasing autonomy and assertiveness may try simply to discourage such involvement. A more tolerant approach reveals multiple motives for continued involvement with the family: (1) the (sometimes unconscious) perception of the severity of the parent's pathology and realistic concerns about suicide or psychosis, (2) an attempt to use adult skills to see the family as it really is, (3) a realization that confrontation of the feared father is a direct way to challenge the entire array of fears and phobias related to victimization, and (4) an unconscious realization that many of the symptoms reflect an identification with the aggressor and an internalization of his actions, feelings, and thought patterns. The techniques of individual family therapy[77] are useful in exploring these issues. Sibling group sessions can also be helpful. Parents thought to be hostile and unapproachable can sometimes cooperate if approached in a nonthreatening way for historical information.

Confrontation and "apology" sessions with the abuser or with the nonprotective mother can be very useful but require extensive preparation of both parties.[78] The victim needs extensive work around her fantasy that the apology will occur in such a complete and perfect way that he can believe that the parent never abused him at all. Similarily, the abuser needs to understand all the ways she can admit what she did without really admitting that she really did it and that it was seriously wrong and harmful. The victim's fears of the abuser cannot be overestimated. Many victims are extremely adept at concealing their fearfulness in a face-to-face interview. However, the victim's symptoms can be reactivated by a letter, a photograph, or a gift. Confrontation at times must be approached gradually through a process akin to systematic desensitization. Use of one-way mirrors or videotape to allow physical distance during confrontation and the presence of a supportive person can ease the victim's fears.[79] If the father is realistically intimidating, even to established authority figures, a clarification of this quality of the father's

can be a great relief to the victim, who may have misinterpreted her own fears as due to weakness.

In adults, the posttraumatic symptoms are dealt with by systematically linking them to the traumatic abuse. Severely symptomatic victims are vulnerable to treatment-related relapse into self-mutilation, eating disorders, suicidal depressions, and other behaviors which punish them for their defiance of the abusive parent by disclosure. Hospitalization, multimodal treatment, multiple therapists (working collaboratively), and time-intensive treatments (four or more hours per week) are indicated in these severe cases.

CONCLUSION

A five-point problem-oriented approach to assessing and treating incest victims provides a useful framework for initial assessment of incest complaints and for planning treatment. In adults as well as in children the therapist should be alert for (1) physical, physiologic, and psychosomatic effects of the abuse, (2) the possibility that there are additional victims, (3) the possibility of legal consequences, (4) serious pathologic symptoms in the abuser and in the family, and, (5) posttraumatic symptoms in the victim.

REFERENCES

1. Russell D: *Sexual Exploitation: Rape, Child Sexual Abuse, and Workplace Harassment*. Beverly Hills, Sage, 1984.
2. Goodwin J, Attias R, McCarty T, et al: Routine questioning about childhood sexual abuse in psychiatry inpatients. *Victimology*, in press.
3. Goodwin J: Family violence: Principles of intervention and prevention. *Hosp Community Psychiatry* 36: 1074, 1985.
4. Attias R, Goodwin J: Knowledge and management strategies in incest cases: A survey of physicians, psychologists, and family counselors. *Child Abuse Neglect* 9: 527, 1985.
5. Sgroi SM: *A Handbook of Clinical Intervention in Child Sexual Abuse*. Lexington, Mass, Lexington Books, 1982.
6. Herman J: *Father-Daughter Incest*. Cambridge, Harvard University Press, 1981.
7. James J, Womack W, Strauss F: Physician reporting of sexual abuse of children. *JAMA* 240: 1145, 1978.
8. Ryan T: Problems, errors, and opportunities in the treatment of father-daughter incest. *J Interpersonal Violence* 1: 113, 1986.
9. Adams-Tucker C: The unmet psychiatric needs of sexually abused youths: Referrals from child protection agency and clinical evaluations. *J Am Acad Child Psychiatry* 23: 659, 1984.
10. Westermeyer J: Incest in psychiatric practice: A description of patients and incestuous relationships. *J Clin Psychiatry* 39: 643, 1978.
11. Masson JM: *The Assault on Truth*. New York, Farrar, Straus & Giroux, 1984.
12. Goodwin J: Credibility problems in multiple personalities and abused children, in Kluft R: *Childhood Antecedents of Multiple Personality*. Washington, DC, American Psychiatric Association, 1985.
13. Herman J: Recovery and verification of memories of childhood sexual trauma. Unpublished manuscript, 1986.

14. Tsai M, Wagner NN: Therapy groups for women sexually molested as children. *Arch Sex Behav* 7:417-427, 1978.
15. Peters J: Children who are victims of sexual assault and the psychology of offenders. Am J Psychother 30: 398, 1976.
16. Goodwin J, Sahd D, Rada RT: Incest hoax: False accusations, false denials. *Bull Am Acad Psychiatry Law* 6: 269, 1979.
17. Cantwell H: Sexual abuse of children in Denver, 1979: Reviewed with implications for pediatric intervention and possible prevention. *Child Abuse Neglect* 5: 75, 1981.
18. Jones DPH, McGraw JM: Reliable and fictitious accounts of sexual abuse to children. *J Interpersonal Violence*, 2: 27-45, In press, 1987.
19. Corwin D, Berliner L, Goodman G, et al: Allegations of child sexual abuse in custody disputes: No easy answers. *J Interpersonal Violence* 2: 91, 1987.
20. Woodling BA, Kossoris PD: Sexual misuse: Rape, molestation, and incest. *Pediatr Clin North Am* 28: 481, 1981.
21. Woodling BA, Heger A: The use of the colposcope in the diagnosis of sexual abuse in the pediatric age group. *Child Abuse Neglect* 10:111-114, 1986.
22. Rimsza MD, Niggeman EH: Medical evaluation of sexually abused children: A review of 311 cases. *Pediatrics* 69: 8, 1982.
23. Durfee M, Heger A, Woodling B: Medical evaluation, in MacFarlane K, Waterman J, Conesly S, et al (eds): *Sexual Abuse of Young Children*. New York, Guilford, 1986.
24. Tilleli JA, Turek D, Jaffe A: Sexual abuse of children: clinical findings and implications for management. *N Engl J Med 302*: 319, 1980.
25. Queen's Bench Foundation, San Francisco General Hospital: Medical management of sexually abused children and adolescents, in Jones B, Jenstrom L, MacFarlane K (eds): *Sexual Abuse of Children: Selected Readings*. Washington, DC, US Dept of Health and Human Services, Publication No. (OHDS) 78-30161, 1980, pp 129-172.
26. Herjanic B, Wilbois RP: Sexual abuse of children, detection and management. *JAMA* 239:331–333, 1978.
27. Paul DM: The medical examination in sexual offences against children. *Med Sci Law* 17:251–258, 1977.
28. DeJong AR: The medical evaluation of sexual abuse in children. *Hosp Community Psychiatry* 36:509–512, 1985.
29. Goodwin J, Willett A, Jackson R: Medical care for male and female incest victims and their parents, in Goodwin J (ed): *Sexual Abuse: Incest Victims and Their Families*. Littleton, Mass, PSG Publishing Co, 1982, pp 35–46.
30. Lusk R, Waterman J: Effects of sexual abuse on children, in MacFarlane K, Waterman J, Conesly S, et al (eds): *Sexual Abuse of Young Children*. New York, Guilford, 1986.
31. Groth AN. Patterns of sexual assault against children and adolescents, in Burgess A, Groth AN, Holmstrom L, et al (eds): *Sexual Assault of Children and Adolescents*. Lexington, Mass, Lexington Books, 1978.
32. Goodwin J, Cormier L, Owen J: Grandfather-granddaughter incest: A trigenerational view. *Child Abuse Neglect* 7: 163, 1983.
33. Anderson LA, Shafer G: The character-disordered family: A community treatment model for family sexual abuse. *Am J Orthopsychiatry* 49:445–463, 1979.
34. Phelan P: The process of incest: Biologic and stepfather families. *Child Abuse Neglect* 10:531–539, 1986.

35. American Bar Association National Legal Resource Center for Child Advocacy and Protection: *Child Sexual Abuse and the Law*. Washington, DC, American Bar Association, 1981.
36. Eth S, Pynoos RS: *Post-Traumatic Stress Disorder in Children*. Washington, DC, American Psychiatric Association, 1985.
37. Goodman GS: The child witness: Conclusions and future directions for research and legal practice. *J Soc Issues* 40: 169, 1983.
38. Terr LC: The child psychiatrist and the child witness: Traveling companions by necessity if not by design. *J Am Acad Child Psychiatry* 25: 462, 1981.
39. Satterfield S: The legal child abuse in the Jordan, Minnesota, sex ring case. Presented at the Annual Meeting of the American Academy of Psychiatry and the Law, Albuquerque, NM, October, 1985.
40. Summit R: The reluctant discovery of incest, in Kirkpatrick M (ed): *Women's Sexual Experience*. New York, Plenum, 1982, pp 112–144.
41. MacFarlane K, Krebs S: Techniques for interviewing and evidence gathering, in MacFarlane K, Waterman, J, Conesly S, et al (eds): *Sexual Abuse of Young Children*. New York, Guilford, 1986.
42. White S, Strom G, Santilli G. et al: Interviewing young sexual abuse victims with anatomically correct dolls. *Child Abuse Neglect* 10:519–529, 1986.
43. Adams-Tucker C: Early treatment of incest victims. *Am J Psychother* 38:505, 1984.
44. Goodman GS: The child witness. *J Soc Issues* 40: 2, 1984.
45. Weinberg S: *Incest Behavior*. New York, Citadel, 1955.
46. Lustig N, Dresser J, Spellman SW: Incest: A family group survival pattern. *Arch Gen Psychiatry* 14: 31, 1966.
47. Goodwin J: Persecution and grandiosity in incest fathers, in Pichot P, Berner P, Wolf R, et al (eds): *Psychiatry: The State of the Art*. New York, Plenum, 1985, vol 6.
48. Mrazek PB, Mrazek DA: The effects of child sexual abuse: Methological considerations, in Mrazek PB, Kempe CH (eds): *Sexually Abused Children and Their Families*. New York, Pergamon, 1981.
49. Adams-Tucker C: Proximate effects of sexual abuse in childhood: A report on 28 children. *Am J Psychiatry* 139: 1252, 1981.
50. Maisch H: *Incest*. New York, Stein & Day, 1972.
51. Gomes-Schwartz B, Horowitz JM, Sauzier M: Severity of emotional distress among sexually abused preschool, school-age, and adolescent children. *Hosp Community Psychiatry* 36:503–508, 1985.
52. Bagley C: Mental health and the in-family sexual abuse of children and adolescents. *Can Ment Health* 17–23, 1984.
53. De Young M: *The Sexual Victimization of Children*. London, MacFarland, 1982.
54. Emslie GT, Rosenfeld AA: Incest reported by children and adolescents hospitalized for severe psychiatric problems. *Am J Psychiatry* 140: 708–711, 1983.
55. Goodwin J: Post-traumatic symptoms in incest victims, in Eth S, Pynoos RS (eds): *Post-Traumatic Stress Disorder in Children*. Washington, DC, American Psychiatric Association, 1985.
56. American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, 3rd ed. Washington, DC, American Psychiatric Association, 1987.
57. Kardiner A: The traumatic neuroses of war, in Arieti S (ed): *American Handbook of Psychiatry*. New York, Basic Books, 1941, vol 1.
58. Meiselman K: *Incest: A Psychological Study*. San Francisco, Jossey-Bass, 1981.
59. Gelinas D: The persisting negative effects of incest. *Psychiatry* 46:312, 1983.

60. Sedney MA, Brooks B: Factors associated with a history of childhood sexual experience in a nonclinical female population. *J Am Acad Child Psychiatry* 23:215, 1984.
61. Lindberg FH, Dystad LJ: Post-traumatic stress disorders in women who experienced childhood incest. *Child Abuse Neglect* 9:329–334, 1985.
62. Donaldson MA, Gardner R: Diagnosis and treatment of traumatic stress among women after childhood incest, in Figley CR (ed): *Trauma and Its Wake: The Study and Treatment of Post-Traumatic Stress Disorder*. New York, Brunner-Mazel, 1985, pp 356–377.
63. van der Kolk B: *Psychological Traums*. Washington, DC, American Psychiatric Association, 1987.
64. Conte JR, Schuerman JR: Factors associated with an increased impact of child sexual abuse. *Child Abuse Neglect* 11:201, 1987.
65. Herman J, Russell D, Trocki K: Long-term effects of incestuous abuse in childhood. *Am J Psychiatry* 143:1293, 1986.
66. Wilbur C: Multiple personality and child abuse: An overview. *Psychiatr Clin North Am* 7: 3–8, 1984.
67. Saltman V, Solomon RS: Incest and multiple personality *Psychol Rep* 50: 1127, 1982.
68. Coons P, Milstein V: Psychosexual disturbances in multiple personality: Characteristics, etiology, and treatment. *J Clin Psychiatry* 47: 106, 1986.
69. Herman J, van der Kolk B: Traumatic antecedents of borderline personality disorder, in van der Kolk B (ed): *Psychological Trauma*. Washington, DC, American Psychiatric Association, 1987.
70. Miller A: *Thou Shalt Not Be Aware: Society's Betrayal of the Child*. New York, Farrar, Straus & Giroux, 1984.
71. Shengold LL: Child abuse and deprivation: Soul murder. *J Am Psychoanal Assoc* 27: 533, 1979.
72. Nadelson T: Victim, victimizer: Interaction in the psychotherapy of borderline patients. *Int J Psychoanal Psychother* 5:115–119, 1976.
73. Burgess AW, Hartman CR, McCormack A: Abused to abuser: Antecedents of socially deviant behaviors. *Am J Psychiatry* 14:1431–1436, 1987.
74. DeYoung M: Case reports: The sexual exploitation of victims by helping professionals. *Victimology* 6:92, 1983.
75. Goodwin J: Recognizing Multiple Personality Disorder in adult incest victims. *Victimology*, in press.
76. MacFarlane K, Korbin J: Confronting the incest secret long after the fact: A family study of multiple victimization with strategies for intervention. *Child Abuse Neglect* 7: 225, 1983.
77. Friedman EH: The birthday party: An experiment in obtaining change in one's own extended family. *Fam Process* 10: 345, 1971.
78. Trepper TS: The apology session, in Trepper TS, Barrett, MJ (eds): *Treating Incest A Multi-Modal Perspective*. New York, Haworth Press, 1986.
79. Dale P, Waters J, Davies M, et al: The towers of silence: creative and destructive issues for therapeutic teams dealing with sexual abuse. *J Fam Ther* 8: 1, 1986.

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False Accusations and False Denials of Incest: Clinical Myths and Clinical Realities

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In the psychiatric literature the definition of incest ranges from the narrow requirements of consanguinity and sexual intercourse to the more inclusive definition of child sexual abuse by an adult or older child in a parental role.[1] The purpose of this chapter is to discuss clinical aspects of false accusation and denial using case examples and to suggest guidelines in the clinical investigation of difficult cases. Our case examples conform to the broader definition of incest and include examples of father-daughter and stepfather-daughter incest accusations.

Until the 1980s, the question of false accusation was largely neglected in psychological and psychiatric research. A search of psychological abstracts from 1968 to 1978 yielded only one report, a Hungarian paper,[2] which dealt with the problem of false accusation. We reviewed 88 psychiatric papers on incest published between 1973 and 1978. Two papers presented surveys of the historical importance of false accusations of incest, [1,3] and four papers contained individual case reports of false retractions of valid incest accusations.[4–7] Detailed case reports of false accusations of incest were not published in this decade. In his 1971 forensic psychiatry text, MacDonald[8] implies that false accusations are an important forensic problem; however, most of his case examples are drawn from a book published in 1913.[9]

Although reported false accusations of incest are rare, legal and mental health professionals tend to be suspicious of incest accusations. This may be explained, in part, by the continued influence of Freud's conclusion that many reports of incest were based on fantasy.[10–12] However, it is interesting

to note that, to our knowledge, Freud never reported a detailed case example of false accusation of incest. Furthermore, he confirmed some of the accusations by interviewing family members.[13–15] The case of "Dora" documents his approach to an accusation of seduction, which the family alleged to be a lie, but which Freud validated as an actual event.[16, 17] Some writers[18, 19] believe that Freud overstated the importance of fantasy as the basis for incest accusations, and that the therapist's assumption that an accusation is fantasy may drive victims out of treatment or into psychosis.

Few published articles document the relative frequency of false accusations of child sexual abuse. Peters[3] studied 64 children seen at a hospital emergency room with a complaint of sexual assault and found four cases (6%) in which the staff concluded that no sexual assault had occurred. In a New Mexico series of 46 allegations, three (7%) were fictitious.[20] Cantwell studied 287 incest reports and found 26 to be false; 24 of the false allegations were brought by parents.[21, 22] Jones and McGraw[23] found 8% of 576 allegations to be false and cite unpublished data from the Tufts study in Boston which found that 5% of incest allegations were fictitious.

UNFOUNDED ALLEGATIONS

Several studies[22, 23] show that about 50% of incest complaints are judged by child protective agencies to be unfounded. This does not mean that these complaints represent false or fictitious accusations. Some represent valid suspicions which are ultimately found to be groundless; this is the kind of overreporting described in chapter 19, which forms a necessary background of false-positives if an adequate percentage of true-positive cases are to be detected. Other unfounded cases reflect indadequate information, as illustrated by the following example.

Case example An 8-year-old girl was brought to the office by her grandmother. The grandmother had noticed a discharge on the girl's panties and said that the girl's father had raped the child. The child was interviewed alone. She said, "My daddy did it to me. Grandma told you. Daddy pulled my pants off and would not let me go. He sat me on his lap and put his bird through my legs. He French-kissed my privates. He had my brother spy to make sure we did not get caught. That was when I was 6. This is my third year now."

Physical examination revealed a mixed vaginal infection, not gonococcal, an intact but stretched hymen, and no bruises, tears, or other evidence of trauma. Inspection of the external genitalia under magnification was not done. Interviewed together, the parents denied that incest had occurred, saying that their daughter lived in a fantasy world, lied, and read pornography. The child's teacher confirmed that the child told lies. According to the parents, the grandmother had been trying to break up their marriage for years and was repressive and moralistic about sexuality. The girl's father was unemployed because of chronic back problems. The parents said their daughter was very bright, but that her grades had fallen in the past year. Psychological testing of the child revealed an IQ of 127 and showed that she used fantasy extensively. The parents refused psychological testing for themselves. A judgment was made

that the child invented the incest story, although she persisted in saying that she was telling the truth. The parents refused a recommendation that the child receive play therapy. Two weeks later, the grandmother called back to say that the parents had moved to another city and left the child in the grandmother's care. However, the grandmother refused further contact, and the family was lost to follow-up.

Was this actual incest? Was it a hoax? What is important to realize is that there is not enough information in this investigation to make a definite judgment. This is a common situation. "The family left town." "The parents refused to be interviewed." "The child has a history of lying, and is manipulative." "The child is too psychotic (or retarded) to give a coherent history." It is true that such cases cannot always be substantiated as incest, even in the mind of the physician, much less in a criminal court. This does not mean that the child's report was false. Often it means that the caseworker, the physician, the psychologist, and the psychiatrist were unable or unwilling to stay with the disrupted child and family long enough to find answers to the difficult questions.

There remain questions in this case that are no longer possible to answer now that the family has fled treatment. What has made the relationship between parents and grandmother so bitter? Is it true that this 8-year-old reads pornography and, if so, why does she? Although accused fathers sometimes use the child's exposure to pornography to explain away a child's accusations, experienced workers assess description of pornography, like accounts of ritualism or sadism, as a sign of credibility.[23] Why are her grades falling, and in what classes? What has caused her vaginal discharge and how can it be treated? Why is the father still unemployed after his back injury? Has he had adequate medical treatment? Did the injury impair his sexual functioning? What does the brother feel at this time of crisis? Did he actually see his father sexually manipulating his sister? Has he been physically or sexually abused?

Other, more general, questions about this case are approached in the next section. Is this the way a child talks about actual incest? Is this the way a child lies about incest? Is the child's description typical of what actually occurs in incest situations? Were the results of the physical and psychological examinations correctly interpreted?

These questions can be best approached if the investigator is (1) familiar with the natural history of incest, (2) not intimidated by the possibility that the real story may never be told, (3) can anticipate the pressures the family will place upon her, and (4) can keep a consistent emphasis on the health needs of the child and family.

PATTERNS OF INCEST

In most series, stepfather-daughter, father figure–daughter, or father-daughter relationships have been the most commonly reported patterns of

incest (70% to 80% of cases), although uncle-niece, brother-sister, father-son, mother-daughter, grandfather-granddaughter, and sister-sister relationships also occur.[6, 24] Incest is the most commonly reported type of sexual molestation in childhood, with more than 75% of child sexual assaults involving a relative or caregiver as the offender.[25, 26] As we learn more about male victims, their experience is coming to seem more and more similar to that of female victims with the preponderance of sexual abuse coming from male caretakers. Mother-son incest is rarely reported (perhaps because it is more veiled in secrecy). Although cultural exceptions may be allowed in other types of incest (eg, brother-sister marriage was encouraged in Egyptian, Incan, and Hawaiian royal families to maintain the purity of the line), mother-son incest is never condoned.[27] Avoidance of sexual relationships between mother and son has been observed in the higher primates.[28, 29]

The pattern of sexual contact generally begins with genital and anal fondling and/or oral-genital stimulation in younger victims progressing to vaginal penetration.[30] It is important to remember that oral-genital contact and anal intercourse can lead to venereal infection, so sexual abuse victims need a physical examination, even when vaginal intercourse has not been alleged.[31, 32] Threats and coercion are almost universal,[27, 33] and are usually focused on enforcing secrecy. The sexual relationship tends to occur over a prolonged period, ranging from 3 months to 12 years.[34] The child is usually over 2 years old although there is one report of an infant victim who died from suffocation during attempted fellatio.[35] For years, the modal age for incest has been between 8 and 12 years[36, 37]; however, with increased reporting, the age has fallen and in some areas more than half of complaints involve children under 6.[38] In at least 30% of families with more than one child, multiple children are involved in the incest.[39] Physical abuse or neglect of one or more of the children, in addition to incest, occurs in 50% of incest cases reported to protective services.[34] In 25% of cases there is a history of incest in one or both parents.[40] The father is alcoholic in about 50% of protective service cases,[33, 41] and in at least 5% of cases a suicide attempt will occur in the family after the accusation is made.[42]

Families in which incest occurs often have intense shared fears of family disintegration.[43–48] These are dysfunctional families who tend to isolate themselves from the rest of society.[25] Sexual relations between mother and father are impaired in more than 40% of cases at the time incest is disclosed.[46] The mother has often ceded many of her functions to the daughter. Both parents may seem superficially well adjusted; however, careful life histories will reveal early abandonments of these parents by their own parents, and lifelong and extreme inhibitions and confusions about sexuality.[43] On psychological testing, both parents may show signs of paranoia, denial, and rationalization.[44]

Many physicians are unaware of how commonly incest occurs. Freud believed that the frequency of incest was less than one case per million.[25]

The actual incidence is closer to one per thousand.[49] One in 1000 emergency room visits will report child sexual abuse.[42, 50] As many as 30% of women who present for psychiatric treatment will report a history of incest.[51] Five percent of children who present for treatment at a child psychiatric clinic will be experiencing incest.[52] If one examines girls in a juvenile detention home, the percentages are higher; about 50% of female runaways are incest victims.[53] Twenty-five percent of women with three or more illegitimate pregnancies will have histories of prior incest.[54] In studies of prostitutes it has been reported that 50% are incest victims[55] and, in severe drug abusers, over 40% of the women have been found to be incest victims[56] In women who have been raped three or more times, 33% are incest victims.[57] It has been reported that 74% of men incarcerated for sexual perversions (rape, exhibiting, pedophilia) had been sexually involved with a family member.[58, 59] One wishes that these male and female incest victims could meet in group treatment rather than on streets in a rape encounter.

When 500 women in the general population in New Mexico were surveyed, 3% reported a prior incest experience, and 1% had been involved in incest with a father.[40] A study of Ivy League freshmen reported a higher frequency; 9% of those women reported a sexual experience with a family member.[60] Almost every known psychiatric syndrome has been reported as a sequela to the incest experience: frigidity, promiscuity, delinquency, suicidal depression, phobia, psychosis, postpartum psychosis, anorexia nervosa, hysterical seizures, and anxiety attacks. In one study of 26 incest victims followed into adulthood, 11 (about 40%) were either promiscuous or engaged in some form of acting out.[36] Five subjects (20%) complained of frigidity, four (about 20%) complained of depression, and six (about 20%) had a good adjustment. Another study reports that three fourths of adult incest victims, including many who are promiscuous, have some kind of orgasmic dysfunction.[33]

The child incest victim usually presents with symptoms. In a German study of 70 forensically identified victims, 22 (31%) presented with school failure; 18 (25%) were having behavior problems, of which lying, promiscuity, running away, and truancy were most prominent; 20 (28%) were depressed; 14 (20%) had psychosomatic symptoms; and 11 (16%) were having severe sleep disturbances.[27] Only about one third of the 70 children were not given a psychiatric diagnosis. Other studies have found that depressive symptoms, school problems, or behavior problems are present in almost all victimized children at the time they complain.[6, 43]

The incest experience is often revealed by the child at a point when a new family crisis has emerged, ie, excessive interference of the father with the child's dating, the initiation of a younger child into the incest, or a rebellious conflict between the child and her father based on her view of him as a hypocrite carrying a guilty secret. Many children refuse to speak about the incest; others may show a grim determination to bring the father to justice,

and many describe what happened with "brazen poise."[61] The family's fears of separation and dysfunctional reactions to those fears—in particular, the parents' search for nurturing from the victim child—undoubtedly contribute to the poor adult adjustment of these victims.

THINKING ABOUT UNFOUNDED CASES

If we return now to the case which opened this chapter, it is clear that the review of the literature about patterns of incest has brought us to firmer ground. The 8-year-old was at a typical age for incest to be revealed. The description of the 2.5 year duration of the relationship is typical, as is her description of penile rubbing between the girl's legs, a technique which will not usually rupture the hymen. The caseworker, naive about this sexual technique, believed the child was describing intercourse when she said, "He put his bird between my legs," and thought that the intact hymen proved the child was lying. Genital examination using magnification might have revealed microscopic damage.

The parents' feeling of being put upon and in danger of being separated is what would be expected in a dysfunctional family where fears of separation are prominent, and where defenses are few. In a German study of fathers actually convicted of incest, over 80% denied the allegation throughout the criminal process.[27] It has been reported in another study that 75% of mothers did not act to end the incest once it had been revealed.[33] Far more rare than the incest hoax is the situation in which it is the father who brings the family for treatment. One treatment program estimates that about 50% of the parents of incest victims will still be denying that incest occurred at the end of treatment despite having made significant gains.[62] The pressure on the victim is great and many seriously consider withdrawing and retracting the accusation they have made[6] (see False Denial of Incest below).

The child's lying and school failure would be expected in an incest victim, and her brazenly graphic description of the sexual activities is not atypical. The increased use of fantasy found on psychological testing may be the expected reaction of a latency-age child to neglect and trauma.[63]

Although this interesting case is quite typical of the most difficult accusations, too many unanswered questions remain for it to be useful as an example either of an actual incest situation or a false accusation.

FALSE ACCUSATION BY A DAUGHTER

The medicolegal literature contains a few sketchy cases. In one a teenager accused a hated stepfather of incest to shield the boyfriend who had impregnated her. In another a girl was coaxed and bribed with candy to make the accusation. Both girls ultimately admitted that they had lied.[8, 9]

False accusations of incest by children appear to be opportunistic lies

rather than symptoms of a specific hysterical or delusional syndrome. A desperate child decides the benefits of the lie outweigh the risks and has, at hand, the information necessary to fabricate an incest story.[64] In the reported cases the child often has an adult confederate, and the child readily admits the lie on direct questioning.[9] Where the child has made more than one false accusation, more specific pathologic aspects may be found.[8, 65] Jones and McGraw[23] found that only five (24%) of 21 fictitious sexual abuse allegations were fabricated by the child alone. Four of the five fabricating children had been sexually abused in the past. They estimate that only 2% of all incest allegations are fabricated by children.

Cases 1 and 2 illustrate false accusations by a daughter.

Case 1 A pathologically jealous mother, who had recently married a man 15 years younger than she, dreamed that her new husband raped her 10-year-old daughter. Several weeks later she noticed a rash in the daughter's genital area. Mother questioned the daughter angrily, using very specific questions derived from her recent dream. The daughter answered each question in the affirmative. Physical examination of the girl showed an intact hymen. The stepfather was eager to be interviewed and seemed appropriately angry. In an individual interview, the daughter said that she had supported her mother's explanation of the rash in order to conceal the masturbation which the child believed had caused the rash. Psychological testing showed that the child saw herself quite literally as an extension of her mother's body. The mother had chosen a young husband whose age was exactly intermediate between her own age and the age of the daughter. The girl's sense of fusion with mother made it more difficult for her to admit an independent sexual exploration than to admit to a sexual experience with her mother's mate.

Case 2 Maria was a 13-year-old who complained to her school counselor that her stepfather was "beating" her. During the interview, it became clear that the stepfather was shadow-boxing with her in a teasing way, and that it was the teasing that alarmed and angered her. She said that the night before, he had come into her room and "fondled" her. As she spoke, she became more panicked and distraught, saying that her mother would never love her again, When the parents were interviewed, Maria's mother said that Maria had known her new stepfather as a neighbor long before he met her mother. Maria felt that their marriage had ruined her special relationships with each of them. The stepfather said that on the night in question he had been very drunk and had gone into the wrong room of their small apartment. He had taken off his clothes, then "groped around" for the bed. When Maria began screaming, he became so confused and frightened that he made a hole in the wall in his attempt to get out of the room. The mother said that Maria had seemed to understand at the time that he had come into the room by mistake. By this time, however, Maria was so agitated that the family agreed to have her placed until she could feel more comfortable at home. Physical examination of Maria revealed a pneumonia with a high fever and hyperventilation. After treatment of the pneumonia in the hospital, Maria's panic about her stepfather resolved and she said that she knew he had not been sexually attacking her. However, because of her refusal to accept her mother's remarriage, the family decided that she should live with other relatives.

In case 1 the child's need to lie to avoid disclosing her masturbation practices was abetted by her mother's delusional conviction that her new husband was sexually betraying her. In case 2 an actual incident was misinterpreted by the child, in part because of a wish to be included in the mother's remarriage, and in part because the child was near delirium from pneumonia and could not clearly distinguish fantasy from reality. Similar patterns are seen in manic patients who may be acutely panicked about the danger of incest when manic; as confusion and hypersexuality resolve, these fears abate.

MATERNAL DELUSIONS OF INCEST

Lustig et al [44] report a mother who had an encapulated delusion that incest was taking place between her husband and her daughter. In that case, actual incest eventually did occur, possibly provoked and unconsciously engineered by the sick mother. Another case reported a psychotic mother who eventually murdered her husband because of a delusion of incest.[8] Jones and McGraw[23] found paranoid, hysterical, and posttraumatic diagnoses in mothers who made fictitious allegations. Case 3 is illustrative.

Case 3 Mrs W is a 35-year-old housewife with a long history of hospitalization for schizophrenia. Previous psychotic breaks had been associated with the birth of her first child and with the marriage of her father to a younger woman. She had recently delivered her second daughter, and during the pregnancy her father died. Despite this, she appeared stabilized on phenothiazines. When her baby was 4 months old, Mrs W complained to her psychiatrist that her husband was sexually abusing her daughters by fondling their genitals. Her psychiatrist believed the accusation, referred the family to a protective services agency, and helped Mrs W initiate divorce proceedings.

Mr W was cooperative with the child protection agency and denied sexual abuse. He admitted tickling his daughters and said he had cleaned the baby's vulva several times at Mrs W's request. He gave a complete sexual history and was concerned that recent increased sexual experimentation in the marriage may have upset his wife. The 9-year-old daughter was interviewed and denied that her father touched her genitals. Projective testing of father and daughter showed that both had excessive and overt sexual concerns. Mr W said that when his wife was psychotic, her sexual preoccupations upset everyone in the family.

Two months after her initial accusation, Mrs W was hospitalized with florid schizophrenic symptoms. She said God was telling her to have sex and that her husband was trying to make her homosexual. She gave a history of intercourse since age 9 and blamed her father for having let her run wild.

The investigating agency made a judgment that Mrs W's accusations of sexual abuse were delusional, based on displaced anger at her father who had allowed her to have intercourse as a child and who had married a woman young enough to be his daughter. Her father's death had revived these issues.

The judgment was not communicated to Mrs W's treating psychiatrist, who continued to discourage visits by Mr W and to encourage the patient to proceed with the divorce. Mrs W's psychosis continued to worsen until she was transferred to another hospital and another psychiatrist. On recovery, she said that nothing sexual had happened between her husband and her daughters.

This case shows how expressed fantasies about incest can be as devastating to a family as actual incest.[66] The delay in fully exploring the mother's accusation and the precipitous overreaction to an allegation not yet investigated probably interfered with prompt and appropriate treatment of her psychosis. The antagonized father was unwilling to accept a recommendation that he and his daughter receive psychotherapy.

In more severe cases, failure to recognize a maternal delusion of incest may place the child at risk for physical abuse by the psychotic mother. The following case is illustrative.

Case 4 Mrs O brought her 7-year-old daughter to the emergency room saying that the child had been sexually abused by her uncle, Mrs O's brother, and that the sexual relationship had been ongoing for many years. She kept shouting to her daughter, "Tell them the truth; tell them what happened." The child began to cry, saying "That's why I got the spanking." In an individual interview, the child convincingly denied any sexual contact. The only positive physical finding was the presence of bruises on the child's arms and buttock inflicted by the mother when she beat the child with a belt buckle to make her "tell the truth." The child was placed with her godparents, and the mother was psychiatrically hospitalized. Further investigation revealed that the mother had been sexually involved in childhood with the same brother that she feared was assaulting her daughter.

FALSE DENIAL OF INCEST

Several cases have been reported in which a child victim falsely retracts an allegation of incest because of threats from the father, infatuation with the father, or guilt about upsetting the family.[34] In these instances, the child's lie is in the service of covering up a sexual assault that actually occurred. Refusal to talk or testify about the incest is more common than false denial and may occur on the part of as many as 30% of victims.[6] Jones and McGraw found that of 309 children alleging sexual abuse that was substantiated by investigators, 9% actually recanted, often in the face of substantial physical evidence.[23]

Case 5 Eleven-year-old Veronica and 9-year-old Melissa ran away from home, saying their stepfather was beating them. While the charge of physical abuse was being investigated, one of the girls hinted that sexual abuse had also taken place. Physical examination of Veronica showed a ruptured hymen and a wide vaginal canal. In a tearful interview Veronica described a yearlong sexual relationship with the stepfather that had begun while the mother was in the hospital having a baby. The relationship was rationalized as sex education and Veronica colluded in it because she enjoyed intercourse. Veronica decided to expose the relationship because the stepfather had recently begun the sexual education of the younger sister. Melissa confirmed this. Veronica was heavily made-up and appeared much older than 11.

The mother was most concerned with her own mother's insistence that she leave the stepfather because of the girls' accusations. Mother revealed that as a teenager she had been involved in incest with her own father. Mother said that she would not leave the stepfather even if she believed her daughters'

accusations. The stepfather would not agree to being interviewed, even by telephone, but the mother said he denied having had sex with the girls. The stepfather was chronically unemployed and both parents drank heavily.

At the next family interview, the mother and both daughters said the accusation was a hoax. They said the girls had been coached by unidentified older girls to accuse the stepfather in the hopes that this would make mother leave him. Veronica repeated this story woodenly in the individual session but refused to elaborate on it. Melissa began weeping in the individual session and admitted that the retraction was a lie invented by the mother.

De Francis[34] cites data which indicate that untrained interviewers often accept false denials of incest at face value, and speculates that this is one factor that has led to the underestimation of the incidence of incest and to the assumption that many accusations are false.

GUIDELINES

Verification of an accusation of incest is often technically difficult. Frequently, however, a thorough psychiatric examination of the family indicates a firm diagnosis and suggests appropriate intervention strategies. Where such psychiatric investigation is indicated, we have found the following guidelines to be useful.

1. The investigator must be aware of his biases. Teenagers, schizophrenics, and immature characters can elicit strong irrational reactions, both positive and negative. Excessive horror of incest can lead to precipitous action.

2. If the family has reached an impasse of mutual denials and accusations in the crisis phase, the interviewer can continue to work on clarifying and redefining the family's situation, stating clearly that it seems that nobody really understands yet what has happened, but that something has to be seriously wrong. This approach can establish an alliance with the family to find out what is wrong, even if they are protesting the need to form an alliance to understand and stop the incestuous relationship.[67]

Offering physical examination to parents who have chronic physical complaints or hidden physical fears can often be the key to establishing trusting relationships. Treatment of a parent's alcoholism can often be initiated more easily in the context of a medical examination than in a psychotherapeutic relationship. The family will want to talk about who is to blame. The physician must persist in refocusing on what care is needed. Behind the family's preoccupation with blame are often fears that whoever is to blame will be cast out, destroyed. The family needs to talk about these fears and they need information and modeling from the interviewer that can help them to realize that there are alternatives other than blindly denying all problems or losing everything valuable in the family.

3. Ideally the investigator should see individually every family member directly involved. The supposedly uninvolved siblings should also be inter-

viewed to clarify family dynamics, to rule out other incestuous partnerships, and to identify psychopathologic or behavior problems. Open lines of communication should be maintained, and family members should be confronted with the puzzling fact that stories do not tally and should be asked for their opinions and feelings about this. The investigator's insistence on clarity can be therapeutic, especially in chaotic families with poor reality testing. The incest victim herself may be eager to avoid facing the truth, using familiar family defenses such as denial, projection of blame, or even withdrawing into a hypnoid state where repression can obliterate the reality and exchange it for fantasy.[68]

4. A detailed sexual, psychosocial, violence, and family history should be obtained from each parent.

5. The affective responses of each family member should be carefully noted. This is not the place for the traditional child guidance approach where family members are interviewed by different therapists. Decisions about whether a person is lying are subtle and subjective.[69] If multiple interviewers are involved, each interviewer should see all available family members.

6. The investigation should not be made more traumatic for the family than the alleged sexual abuse.[50, 61, 70] In all cases the alleged victim should have a complete physical examination. Projective testing of family members can be helpful, especially in the case of the father who may have very subtle paranoid symptoms.[46, 71] We have found kinetic family drawings particularly useful in identifying family pressures that may be motivating the daughter. Children who have experienced incest have great difficulty drawing the perpetrator, and their drawings often reflect fears of men or of being in their own houses (see chapter 5).

Other specific investigative techniques should be considered. Hypnotic age regression has been helpful in eliciting detailed descriptions of the alleged incestuous events.[2] Sequential polygraph testing of the child in one of our cases helped confirm our clinical impression that the child's retraction of the incest accusation was false. However, in the majority of difficult cases, polygraphy only muddles the situation; perpetrators with antisocial personality and/or dissociative disorders will deny as convincingly to a machine as to human interviewers. Also, interviews with amobarbital or hypnosis may yield statements about sexual events that combine fact with memory and dreams,[72] even more confusingly than occurred in initial interviewing.

7. The investigator should know the typical family profile in paternal incest, but should use the knowledge flexibly and be alert for exceptions.[24, 36, 43, 73] In the typical pattern, the father is rigid, moralistic, and patriarchal; he may have chronic problems with alcohol abuse or with unemployment. The mother, typically, has relinquished many maternal functions to the child victim. The child victim tends to be pseudomature and very protective toward the mother.

8. The investigator should keep in mind that actual paternal incest is fairly common in psychiatric patients (5% to 30% in women and girls[51,73]) and that incest delusions and hoaxes are probably quite rare. Our findings and other studies[2] indicate that a small percentage (5% to 10%) of incest accusations are fictitious. However, increased enforcement of child abuse laws has made false accusations a more potent manipulative weapon for children and teenagers. For this reason, if for no other, questionable accusations should be carefully investigated.

On the other hand, the judgment that an accusation is false should be made positively and not by inference or exclusion. For example, lack of physical evidence of criminal penetration and persistent denial of the accusation by the parents may occur in cases of actual incest. If an incest accusation is false, thorough investigation will reveal precipitants of the hoax, psychodynamic explanations for this behavior, and the step-by-step development of the hoax.[20]

INTERFACES BETWEEN MEDICAL AND LEGAL APPROACHES

Families that choose incest as a defensive strategy tend to resist outside intervention. The investigator or physician who sees the family first needs to be aware that her diagnostic manuevers may be the only treatment the family will allow unless a legal hold is obtained. Most treatment interventions tend to be helpful: supportive treatment for the mother, play therapy for the child, group treatment for the father in a fathers' group. Treatment for the child is often most acceptable to the parents, and other treatment recommendations can spin off from this focus on the child's adjustment. Family therapy may be seen at first as threatening, until it can be linked to specific goals, ie, improving the parents' sexual relationship, improving the child's school performance, increasing the mother's homemaking skills.[74, 75] Specific time-limited contracts for treatment may be more acceptable to the family than a more general recommendation for psychiatric care. If the gynecologist or pediatrician who sees the child initially develops a good relationship with the family, that physician may elect to follow through with brief therapy for the child or for a parent with consultation from a psychiatrist or psychologist.

The careful physician will develop a long list of goals for the incest family. These might include: getting a dental bridge for the battered wife; improving the child's school performance; helping the family to develop a bedtime ritual for the insomniac victim that is more age-appropriate than genital fondling by the father; getting medical treatment for the father's impotence, which might include alcohol detoxification and films on nongenital and genital pleasuring; involving the victim's married sister in

an adult victims' group. For certain of these goals, the prognosis is bound to be fair or good.

In terms of the central goals of protecting the child and her siblings from further abuse and from further sequelae, the most secure situation is one in which at least one family member, and preferably more than one, has learned to call for help. The investigator who has responded appropriately to felt needs is most likely to be called.

The program designed by Henry Giaretto[76, 77] in Santa Clara County, California, has given us the best data on prognosis. In this program, which is part of the perpetrator's probation, each family member participates in group, individual, or family therapy for 3 months or more. Ninety percent of fathers confess under this treatment regimen and the recurrence rate for incest is less than 1%. Eighty-five percent of the marriages remain intact and over 90% of the victims return to live with one or both parents. There is some evidence[27] that full disclosure of the incest to a monitoring agency will stop the incest in most cases, even without involving the courts; however, the exceptions to this rule are alarming.[33] In a system that cannot legally enforce treatment recommendations, the percentage of victims living away from the parents is likely to rise, as is the percentage of divorces in incest families, and the recurrence of incest with the identified child or a sibling.[67, 68]

In the incest situation it is easy to confuse the goals and methods of the forensic system with those of the medical system. A forensic decision that no incest occurred will not cure a child's gonorrhea or prevent the mother from becoming infected if the medical incest is not treated. If medical evidence leads to forensic decisions that lead to incarceration of the father, this may leave the inadequate mother and the guilty daughter even more in need of treatment than before. Physicians sometimes try to set themselves apart from the legal system by refusing to become involved at all in the legal aspects of incest. The risk here is that the family will experience the physician as making the same sort of "bargain with the devil" that the father and the rest of the family have already made. "We are too weak and the dangers are too great. We cannot follow the rules that everyone else follows." If the physician is seen to join too closely with the family's position, the opportunity to help change the family may be lost. Maisch, in his study of incest families, found one father who reported the incest himself.[27] He gathered the entire family around him, told everyone what he had done, and told them that he did not know what would happen when they told the authorities but that he thought this had to be done to make things right again. The approach of this father is one of the best blueprints we have found for how the professional can talk with the family when a report must be made, without blaming the family, without giving them the message that they are being abandoned to a forensic system, and without entering into a devil's bargain which tells them it is impossible to change.

INCEST ALLEGATIONS ARISING IN THE CONTEXT OF CUSTODY DISPUTES

Several recent articles have reported rates of false allegations ranging from 30% to 50% in small series of cases referred for forensic evaluation when incest was alleged in the context of divorce and disputed child custody.[79–81] One problem with these studies is that they fail to place these difficult cases into the context of the real population from which they are drawn—all divorce cases in which custody is contested. Once population-based data are available we may find that this is indeed a population in which incest allegations occur more commonly than the 1% to 5% expected. That increase probably will include an increase in: (1) valid allegations (with incest having been part of what led to the divorce or with incest having been disclosed after the separation when the child felt safe), (2) valid suspicions which are unfounded (with concerns about prior abusing behavior in the accused spouse or severe symptoms in a child), (3) cases in which there is inadequate information (with the forensic context instrumental in narrowing the availability of information), and (4) fictitious allegations. However, it is unlikely that in an inclusive population the rate of fictitious allegations will be much more than the 5% to 8% found in other populations.[82]

The most dangerous misinterpretation of these case reports of false allegations would be to assume that the presence of divorce is an indicator of false allegation. The opposite is true: Divorce is a risk factor for actual sexual abuse.[2] In some series over 70% of validated father-daughter alliances have been disclosed in a divorced or divorcing family.[83] The greatest difficulty in the bitterly contested cases is the multiplicity of grave family problems. Both parents may have serious psychiatric diagnoses that interfere with impulse control and with reality testing.[84] The investigator must often reframe the central question as, "Is either parent capable of caring for this child?" rather than focusing on "Did incest occur?"

SUMMARY

Expertise in investigating incest accusations is essential for psychiatrists. Because the law requires the reporting of sexual abuse of children, the psychiatrist or psychologist will have access to investigatory data from the legally mandated agency—a social agency or the police. What the clinician can add is persistent and methodical diagnostic interviewing which usually yields a consensually credible view of what happened and which can be compared to the view assembled by legally mandated investigators. In order to make a diagnosis of incest hoax, the physician must thoroughly understand the mechanics of the hoax and the psychodynamics of the perpetrator. Failure to recognize a delusional hoax can delay treatment for the perpetrator of the hoax. Failure to recognize a child's fabrication can subject the family to unnecessary legal action and unwittingly support the use of a similar

manipulative technique by other susceptible children. Failure to recognize the false retraction of an incest accusation may leave the victim in danger of further sexual abuse or of physical punishment for having revealed the secret.

REFERENCES

1. Rosenfeld AA, Nadelson CC, Krieger M, et al: Incest and sexual abuse of children. *J Am Acad Child Psychiatry* 16:327–329, 1977.
2. Majlath G: On the veracity of injured juveniles and on the general possibilities of drawing up an adequate psychological expertise in cases of deprivation and incest. *Pszichologiai Tanulmanyok* 2:623–640, 1968.
3. Peters JJ: Children who are victims of sexual assault and the psychology of offenders. *Am J Psychother* 30:398–421, 1976.
4. Parker G: Incest. *Med J Aust* 1:488–490, 1974.
5. Huntington D: Forensic gynaecology. *Practitioner* 216:519–528, 1976.
6. Nakashima I, Zakus GE: Incest: Review and clinical experience. *Pediatrics* 60:696–701, 1977.
7. Brant RS, Tisza VB: The sexually misused child. *Am J Orthopsychiatry* 47:80–90, 1977.
8. MacDonald JM: *Rape: Offenders and Their Victims*. Springfield, Ill, Charles C Thomas, 1971.
9. Thoinot L, Weysse AW: *Mediocolegal Aspects of Moral Offenses*. Philadelphia, FA Davis, 1913.
10. Freud S: *Correspondence with Wilhelm Fliess*. London, Imago, 1954 (letter of September 21, 1897).
11. Freud S: My views on the part played by sexuality in the aetiology of the neuroses [1905], in *Standard Edition*, London, Hogarth, 1963, vol 7, pp 274–276.
12. Freud S: On the history of the psychoanalytic movement [1914], in *Standard Edition*, Strachey J (trans-ed). London, Hogarth, 1963, vol 24, pp 17–18.
13. Freud S: Heredity and the aetiology of the neuroses [1896], in *Standard Edition*, Strachey J (trans-ed). London, Hogarth, 1963, vol 3, pp 152–156.
14. Freud S: Further remarks on the neuropsychoses of defense [1896], in *Standard Edition*, Strachey J (trans-ed). London, Hogarth, 1963, vol 3, pp 163–166.
15. Freud S: The aetiology of hysteria [1896], in *Standard Edition*, Strachey J (trans-ed). London, Hogarth, 1963, vol 3, pp 203–208.
16. Freud S: Fragment of an analysis of a case of hysteria [1901, 1905], in *Standard Edition*, Strachey (trans-ed). London, Hogarth, 1963, vol 7, pp 3–124.
17. Erikson EH: Reality and actuality: An address. *J Am Psychoanal Assoc* 10:451–474, 1962.
18. Ferenczi S: Confusion of tongues between adults and the child. *Int J Psychoanal* 30:225–230, 1949.
19. Litin EM, Giffen ME, Johnson AM: Parental influence in unusual sexual behavior in children. *Psychoanal Q* 25:37–55, 1956.
20. Goodwin J, Sahd D, Rada R: Incest hoax: False accusations, false denials. *Bull Am Acad Psychiatry Law* 6:269–276, 1979.
21. Cantwell H: Vaginal inspection as it relates to young girls. *Child Abuse Neglect* 7:171–176, 1983.
22. Cantwell HB: Sexual abuse of children in Denver, 1979. Reviewed with implications for pediatric interventions and possible preventions. *Child Abuse Neglect* 5:75–86, 1981.
23. Jones DPH, McGraw JM: Reliable and fictitious accounts of sexual abuse of children. *J Interpersonal Violence* 2:27–45, 1987.

24. Swanson L, Biaggio MK: Therapeutic perspectives on father-daughter incest. *Am J Psychiatry* 142:667–674, 1985.
25. Weinberg SK: *Incest Behavior*. New York, Citadel, 1955.
26. Tsai M, Wagner NN: Incest and molestation: Problems of childhood sexuality. *Resident Staff Physician* 129–136, 1979.
27. Maisch H: *Incest*. New York, Stein & Day, 1972.
28. Bourgeois M: Shunning of incest in human and nonhuman primates. Preliminary note. *Ann Med Psychol* 137:1008–1020, 1979.
29. Goodall J: *The Chimpanzees of Gombe: Patterns of Behavior*. Cambridge, Mass, Belknap/Harvard University Press, 1986.
30. Gebhard PH, Gagnon JH, Pomeroy WB, et al: *Sexual Offenders: An Analysis of Types*. New York, Hoeber Medical Books, 1965.
31. Goodwin J, Fried J: Rape. *N Engl J Med* 298:167, 1978.
32. Greenberg N: The epidemiology of childhood sexual abuse. *Pediatr Ann* 8:289–299, 1979.
33. Meiselman K: *Incest*. San Francisco, Jossey-Bass, 1978.
34. De Francis V: *Protecting the Child Victim of Sex Crimes Committed by Adults*. Englewood, Colo, American Humane Association, 1969.
35. Sgroi SM: Sexual molestation of children. *Child Today* 4:18–21, 1975.
36. Lukianowicz NE: Incest: Paternal incest. *Br J Psychiatry* 120:301–313, 1972.
37. Finkelhor D: Psychological, cultural and family factors in incest and family sexual abuse. *J Marriage Family Counselors* 4:41–49, 1978.
38. Khan M, Sexton M: Sexual abuse of young children. *Clin Pediatr* 22:369–372, 1983.
39. Tormes Y: *Child Victims of Incest*. Englewood, Colo, The American Humane Association, 1968.
40. Goodwin J, McCarty T, DiVasto P: Prior incest in abusive mothers. *Child Abuse Neglect* 5:1–9, 1981.
41. Virkunnen M: Incest offences and alcholism. *Med Sci Law* 14:124–128, 1974.
42. Goodwin J: Suicide attempts in sexual abuse victims and their mothers *Child Abuse Neglect* 5:217–221, 1981.
43. Kaufman T, Peck AL, Tagiuri CK: The family constellation and overt incestuous relationships between father and daughter. *Am J Orthopsychiatry* 24:266–279, 1954.
44. Lustig N, Dresser J, Spellman SW: Incest: A family group survival pattern. *Arch Gen Psychiatry* 14:31–40, 1966.
45. Gutheil TG, Avery NC: Multiple overt incest as a family defense against loss. *Fam Process* 16:105–116, 1977.
46. Weiner I: Father-daughter incest: A clinical report. *Psychiatr Q* 36:607–632, 1962.
47. Sahd D: Psychological assessment of sexually abusing families and treatment implications in Holder W (ed): *Sexual Abuse of Children*. Englewood, Colo, American Humane Association, 1980, pp 71–86.
48. Brant RST, Tisza VB: The sexually misused child. *Am J Orthopsychiatry* 47:80–90, 1977.
49. Goodwin J: Developmental impacts of incest in Noshpitz J (ed): *Basic Handbook of Child Psychiatry*. New York, Basic Books, 1987, pp 103–111.
50. Eaton AP, Vastbinder E: The sexually misused child. A plan of management. *Clin Pediatr* 8:438–441, 1969.
51. Rosenfeld AA: Incidence of a history of incest among female psychiatric patients. *Am J Psychiatry* 136:791–795, 1975.

52. Browning DH, Boatman B: Incest: Children at risk. *Am J Psychiatry* 134:69–72, 1977.
53. Kempe CH: Sexual abuse, another hidden pediatric problem. The 1977 C. Anderson Aldrich Lecture. *Pediatrics* 62:382–389, 1978.
54. Malmquist C: Report on females with three or more illegitimate pregnancies. *Am J Orthopsychiatry* 36:476–484, 1966.
55. Flugel J: *The Psycho-Analytic Study of the Family*. London, Hogarth, 1926.
56. Densen-Gerber J, Benward J: *Incest as a Causative Factor in Antisocial Behavior: An Exploratory Study*. New York, Odyssey Institute, 1976.
57. Miller J, Moeller D, Kaufman A, et al: Recidivism among sex assault victims. *Am J Psychiatry* 135:1103–1104, 1978.
58. Hammer EF: Symptoms of sexual deviation: Dynamics and etiology. *Pscyhoanal Rev* 55:5–27, 1968.
59. Groth N, Burgess AW: Sexual trauma in the life histories of rapists and child molesters. *Victimology* 4:10–14, 1979.
60. Finkelhor D: Risk factors in the sexual victimization of children. *Child Abuse Neglect* 4:265–273, 1980.
61. Bender L, Blau A: The reaction of children to sexual relations with adults. *Am J Orthopsychiatry* 7:500–518, 1937.
62. Gottlieb B, Dean J: The co-therapy relationship in group treatment of the sexually mistreated adolescent. Read before the Second International Congress on Child Abuse and Neglect, London, September 12–15, 1978.
63. Sarnoff C: *Latency*. New York, Jason Aronson, 1976.
64. Burton RV: The generality of honesty reconsidered. *Psychol Rev* 70:481–499, 1963.
65. Selling L: The psychiatric aspects of the pathological liar. *Nervous Child* 1:358–388, 1942.
66. Heims LW, Kaufman I: Variations on a theme of incest. Am J Orthopsychiatry 33:311–312, 1963.
67. Molnar G, Cameron P: Incest syndromes: Observations in a general hospital psychiatric unit. *Can Psychiatr Assoc J* 20:373–377, 1975.
68. Silber A: Childhood seduction, paternal pathology and hysterical symptomatology, the genesis of an altered state of consciousness. *Int J Psychoanal* 60:109–116, 1979.
69. DePaulo B: Humans as lie detectors. *J Communication* 30:129–139, 1980.
70. Henriques B, Wells NH: Sexual assault on children. *Br Med J* 2:1628–1633, 1961.
71. Cavallin H: Incestuous fathers: A clinical report. *Am J Psychiatry* 122:1132–1138, 1966.
72. Glenn TJ, Simonds JF: Hypnotherapy of a psychogenic seizure disorder in an adolescent. *Am J Clin Hypn* 19:245–249, 1977.
73. Henderson JD: Incest: A synthesis of data. *Can Psychiatr Assoc J* 17:299–313, 1972.
74. Berlin IN: A developmental approach to work with disorganized families. *J Am Acad Child Psychiatry* 18:354–365, 1979.
75. Dale P, Waters J, Davies M, et al: The towers of silence: Creative and destructive issues for therapeutic teams dealing with sexual abuse. *J Fam Ther* 8:1–25, 1986.
76. Giaretto H: Humanistic treatment of father-daughter incest, in Helfer RE, Kempe CH (eds): *Child Abuse and Neglect in the Family*. Cambridge, Mass, Ballinger, 1976.

77. Giaretto H, Giaretto-Einfeld A: Involving the community in the treatment of incest. Read before the Third International Congress on Child Abuse and Neglect. Amsterdam, April 21–25, 1981.
78. Cormier BM, Kennedy M, Sangowicz J: Psychodynamics of father-daughter incest. *Can Psychiatr Assoc J* 7:203–216, 1962.
79. Benedek EP, Schetky DH: Allegations of sexual abuse in child custody and visitation disputes, in Schetky DH, Benedek EB (eds): *Emerging Issues in Child Psychiatry and the Law*. New York, Brunner/Mazel, 1985, pp 145–158.
80. Green AH: True and false allegations of sexual abuse in child custody disputes. *J Am Acad Child Psychiatry* 25:449–456, 1986.
81. Schuman D: False accusations of physical and sexual abuse. *Bull Am Acad Psychiatry Law* 14:5–21, 1986.
82. Corwin D, Berliner L, Goodman G, et al: Allegations of child sexual abuse arising in custody disputes: No easy answers. *J Interpersonal Violence* 2:91–105, 1987.
83. Mannarino AP, Cohen JA: A clinical demographic study of sexually abused children. *Child Abuse Neglect* 10:17–23, 1986.
84. Breese P, Stearns GB, Bess B, et al: Allegations of child sexual abuse in custody disputes: a therapeutic assessment model. *Am J Orthopsychiatry* 56:560–569, 1986.

3

Credibility Problems in Multiple Personality Disorder Patients and Abused Children

Jean Goodwin

"It takes two to speak truth—one to speak and another to hear."—Henry David Thoreau, *A Week on the Concord and Merrimack Rivers*

Recent research is identifying a growing number of factors linking the syndrome of Multiple Personality Disorder to child abuse. Putnam et al,[1] in a survey of 100 multiple personality patients undergoing treatment, found that 97% of those studied had been abused during their early years. More cases of multiplicity are being identified, in which protective service records clearly document the chaotic and psychotic family situations that dominated these patients' childhoods.[2] This chapter focuses on yet another parallel between multiplicity and child abuse—the incredulity that both inspire in physicians.

One need look back only as far as papers and textbooks published in the 1960s and 1970s to document this incredulity factor. Most present-day psychiatrists were confidently taught, and tried to believe just as confidently, that multiple personality did not occur, but might be mentioned at times by female patients who were malingering or attention-getting, or who had been persuaded that this was their diagnosis by clumsy or cunning hypnotists[3–5]; and that intrafamilial childhood sexual abuse (incest) did not actually occur, but might be mentioned at times by female patients who mistook their oedipal longings and fantasies for realities.[6]

The credibility problems in multiple personality epitomize the difficulties faced by the abuse victim within the mental health care delivery system. In these cases, professionals are incredulous not only of the existence of the

disorder and of the patient's narratives about extremely severe childhood abuse, but most physicians also have difficulty believing even the most commonplace, concrete, and prosaic of the patient's statements. This incredulity is created by the patient's own habits of concealment, adaptive for survival in a traumatic childhood, but terribly confusing when they operate outside of awareness in adulthood. The following is an example:

> A multiple personality patient experienced increased agitation and ultimately overdosed during an exacerbation of her chronic pelvic pain. The psychiatric crisis nurses who interviewed her did not believe the patient was really upset or in pain, or that she had overdosed, but admitted her to a psychiatric hospital when blood levels of the sedative she had ingested were found to be elevated. Staff in the psychiatric hospital did not believe she had multiple personality. They diagnosed her as having a Borderline Personality Disorder with a factitious syndrome. The gynecologist, who, after several years, had come to believe that the sadistic sexual abuse she described really had taken place, believed the patient was experiencing remembered pain (her father had repeatedly manipulated her cervix with an ice pick). However, ultrasound studies revealed multiple cysts on both ovaries, and the patient was scheduled for surgery. At this point, the anesthetist did not believe the patient when she said she was allergic to adhesive tape. As a consequence, the surgery, although it relieved her pelvic pain, left the patient with an uncomfortable and completely preventable rash.

Clinicians who have worked extensively with patients suffering from multiple personality disorder know that this vignette is excerpted from an almost endless series of disbeliefs and misunderstandings. What is remarkable in this pattern is its similarity to patterns of disbelief of accounts given by abused children in general, and of reports made by sexually abused children in particular. Since sadistic sexual abuse is among the most characteristic abuse patterns in the life histories of patients who develop multiple personality disorder, it is possible that the credibility problems in both groups of victims share and stem from common sources.[7] If patients with multiple personalities can be understood as abused children in adult bodies (whose childhood traumata and responses to those traumatizations have been preserved through time by dissociation), their problems in being believed are likely to be similar to the problems encountered by children who attempt to tell their stories at an earlier point in their lives.

This chapter reviews the history of professional disbelief of abused children and the possible causes for this "credibility gap," as they relate both to the defensive styles of professionals and to the modes of expression typical of abused children. In the spirit of Thoreau's aphorism about truth-telling, I will be listing the obstacles that interfere with the child abuse victim's ability to speak his or her particular truth, and with the physician's capacity to hear it.

PROFESSIONAL INCREDULITY ABOUT CHILD ABUSE

Iwan Bloch, a contemporary of Sigmund Freud, stated, "Children's declarations before the law are, for the truly experienced knower of children

. . . absolutely worthless and without significance; all the more insignificant and all the more hollow the more often the child repeats the declaration and the more determined he is to stick to his statements."[8]

Child abuse, although well described by the French forensic physician, Tardieu, in 1860,[9] was not "officially" discovered by physicians and psychiatrists until Henry Kempe and Brandt Steele made child abuse a public policy issue in the 1950s.[10] Before this time, physicians found it easier to believe that infants who presented with multiple fractures, multiple bruises, and subdural hematoma exhibited a genetic syndrome, rather than consider the possibility that such injuries indicated that they might have been beaten.[11] Cases in the contemporary literature still describe children whose complaints about beatings are disbelieved, and who later meet violent deaths after being returned to abusive parents.[12]

Several reviews of deaths attributed to child abuse report that most children who are over 6 months old at the time of death had been previously referred for child protective services; often social workers had closed these cases with a note to the effect that they did not believe abuse to be a serious problem in the soon-to-be murderous families (see chapter 18).[13] Many professionals continue to balk at laws that require the reporting of child abuse. For example, as recently as 1972, private pediatricians accounted for only eight of 2300 child abuse reports in New York City.[14] Despite evidence that half of psychiatric patients were abused in childhood, psychiatrists have yet to implement standard interview schedules that would make questioning in this area routine.[15]

Childhood sexual abuse is the category of abuse with the longest and most fascinating history of disbelief. Victim credibility has been the central issue in such cases since the Inquisition.[16] As he began working with female patients who reported childhood seductions, Sigmund Freud came to realize that sixteenth-century inquisitors had been processing similar narratives. "Why are their confessions under torture so like the communications made by my patients in psychological treatment?" he wrote of the accused witches.[17] The inquisitors interpreted the sexual accusations of those they interrogated as evidence that the devil had assumed the guise of a male relative in order to consummate intercourse with the woman who was, therefore, obviously a witch (see chapter 19). Freud ultimately came to believe that such complaints represented oedipal fantasies that had been disguised as memories of actual sexual contact with the father.[8] Curiously, both interpretations focused on the complainant, highlighting her pathologic features and encouraging her to alter or to disavow her complaint, which now could be reformulated as consorting with the devil or failing to distinguish an oedipal fantasy from an incestuous reality. In both systems, the accused male relative might never be interviewed, and the female complainant's very account could be used to indict her perceptions of reality.

Freud's ultimate endorsement of incredulity as the appropriate scientific response to a child's sexual accusations was in conformity with the

contemporary wisdom of his day, that children and hysterics were not to be believed. There are, in fact, many sound arguments in favor of using developmental sensitivity in interpreting the communications of children; for example, to return to the Inquisition, witch-hunting went most out of control in those jurisdictions that allowed children to testify.[18] However, the incredulity that Freud championed goes beyond this. For example, Freud published several cases in which a patient's account of prior sexual abuse was corroborated by a covictim, a witness, or by the adult participant.[19] He never published a case of a corroborated false account of sexual abuse. Yet, Freud later expressed embarrassment at his "credulity" in having believed stories of sexual seduction in childhood.[20]

His incredulity was the more defensible stance, regardless of the evidence. This was underlined for me recently when a psychoanalytic colleague staunchly refused to believe that sexual abuse existed in a family where three daughters, one granddaughter, and one grandson had complained, and where medical evidence was available. Medical evidence itself is often misinterpreted to support an incredulous stance. Although French physicians in the 1800s published clear data that sexual assaults on children often occurred repeatedly and over long periods of time without leaving physical signs, the absence of such signs was, until recently, taken as irrefutable evidence that the child was lying.[21]

In 1885, Brouardel, a contemporary of Freud, wrote that of 100 complaints of sexual abuse, 60 to 80 are unfounded.[22] It is an ironic curiosity that these figures are similar to those found currently among another group, the parents of sexually abused children. Even after a legal finding of sexual abuse, 50% to 80% of these parents persist in alleging that the child lied.[23] However, recent figures from professionals estimate that no more than 4% to 8% percent of accusations are fictitious, and if one considers only those cases in which the child has made a statement, the figure drops below 2%.[24–26]

Most false accusations of sexual abuse are made by adults. The credibility issue that has become prominent now in this area is whether one can believe the child who says sexual abuse did not occur. As many as one third of children who have been sexually abused consider falsely retracting their complaints under pressure from distraught parents and incredulous professionals.[27] Often, children are openly coerced into retracting their statements. They are confronted with threats of psychiatric hospitalization, exile from the family, or physical punishment if they persist in their complaints. There is, in addition, a more subtle pressure on the child to produce a version of reality that respected adults are willing to acknowledge, even if this must be constructed at the price of dissociation and amnesia. It is likely that in the past physicians mistook these false retractions for truth and, thereby, overestimated the incidence of false accusations. Once again, it is not a new discovery that children tend to lie to protect their parents. Tardieu, in his 1860 monograph, described

a child who was kept locked in a chest, beaten regularly, and vaginally penetrated with a block of wood. She invented falls and accidents to explain her injuries.[9] Still, historically, the tendency of physicians has been to be more credulous of children's retractions than of their complaints.

SELF-PROTECTIVE ASPECTS OF THE PHYSICIAN'S INCREDULITY

"It is more ignominious to mistrust our friends than to be deceived by them."—La Rochefoucauld, *Maxims*

In this section I do not consider those aspects of physician incredulity that are appropriate responses to the child's narration; these will be covered in the next section. Here, I consider only those factors that interfere with a physician's ability to be credulous of a particular account, regardless of the child's narrative style or reality contact. These are the aspects of the physician's incredulity that are rooted in personal defenses against fear, guilt, and anger.

Incredulity can be understood as an intellectualized variant of derealization; and, like the dissociative defenses, incredulity is an effective way to gain distance from terrifying realities. Thus physicians can be counted on to routinely disbelieve child abuse accounts that are simply too horrible to be accepted without threatening their emotional homeostasis. Stories that will be disbelieved include those involving genital mutilation; the placing of objects into the vaginal, anal, or urethral openings; incest with multiple family members; incest pregnancies; and the protracted tying down or locking up of children. By placing limits on what we believe, we maintain for ourselves a more sane and manageable world. An example will, perhaps, clarify this point. In treating a woman with multiple personality, many of her alternate personalities (alters) described witnessing her father rape and murder girls and women. I suggested that she report these emerging memories to the authorities. When the authorities reported that three rape-murders had occurred in the 2 years since her father had moved to a nearby small town, I realized, in a wave of panic, that I had hoped the patient was merely fantasizing; and that I had been unprepared to accept the horrors of her narrative as truth.

Incredulity functions, as well, to combat more subtle anxiety, allowing the physician to believe that the patient and family are not as ill as they seem. Just as we hope that the positive guaiac test will be an error, or that the shadow on the chest film is only an artifact, we try to find as benign a view as we can of an accusation of child abuse. Incredulity protects both the physician and the family from unpleasant realities, such as investigating the physical and psychological consequences to the child, inquiring about other victims, going to court to protect the child, or making a commitment to the hundreds of hours of treatment that may be necessary.[28] As Sgroi et al stated, " I

know of no other clinical situation in which the intervenor's payoff for denial ... equals or exceeds ... the participant's."[29]

In these cases, if the therapist is in any empathic contact at all with either one of the parents or with the child, guilt is unavoidable. The parent who has failed to control impulses, the parent who cannot show tenderness or who has failed to protect, the child who believes she is experiencing something that no other child has endured—and then has broken the secret of that terrible something—all suffer intolerable guilt. Disbelief is a way of undoing this series of transgressions and freeing the physician from worries about his or her own (or his or her parents') lack of impulse control, inability to care or to protect, and memories of painful, secret experiences.

Incredulity also shields the physician from the powerful anger and rage in these families. Parents who are clinically or subclinically paranoid may respond to confrontation about abuse with tirades that are simultaneously so pitiably persecuted and grandiosely terrifying that the physician is driven to recant as surely as is the child victim.[30] Also, the victim is angry and preoccupied with revenge fantasies. This anger may be expressed in such indirect ways (eg, in the victim's persistent experiencing of the physician as a monster, a sadist, a rapist, or a murderer) that the physician may not even recognize his or her own responsive indignation before this translates into incredulity, one of the few expressions of anger permitted to the physician. Since, as physicians, we are prohibited by law and custom from abandoning bona fide patients, we must redefine intolerable patients as nonpatients in order to escape from them.[31] Thus the redefining of the angry child abuse victim as unabused can be likened to the redefining of the intractable pain patient as being without pain, or to the redefining of the disappointed, disabled patient as malingering.

Finally, believing a child's report about a sadistic sexual assault leaves the physician vulnerable to a barrage of sexual feelings. How does one react to the 6-year-old who lifts her skirt and invites the therapist to tickle her underwear? It is all too easy for the clinician to overlook the query about the safety of the relationship, the crucial question that is always embedded in the child's "seductiveness,"[32] and to become convinced that repetitive behaviors or discussions about the prior sexual abuse are deliberately intended to sexually entice or stimulate.[33] Patient seductiveness is the rationalization typically brought forward by therapists who have become sexually involved with patients who are adult incest victims, or who have multiple personality disorder.[34] Such involvements are not rare, and are merely the most personally and professionally disastrous of a spectrum of readjustments in sexual feeling and thinking that can be triggered by entering the world of these patients. Among the lesser hazards to the physician are decreased sexual desire, orgasmic dysfunction, withdrawal from physical contact with one's own children, and intense discomfort with the current balance of power between men and women.

WHY CHILDREN ARE NOT CREDIBLE

"If she be a witch, she will not be able to weep."—Malleus Maleficarum, in Kors and Peters, *Witchcraft in Europe, 1100-1700*

"Wiping hands during testimony is almost always a sign of lying."—Anonymous judge, in Slovenko, *Psychiatry and Law*

Consistency, association of appropriate emotions, calm confidence in the credibility of a narration—these are some criteria for truthfulness mentioned in world folklore and in forensic psychiatry textbooks. What is not clear is whether any of these criteria apply at all to normal children or, much less, to children who have been traumatized, who are experiencing dissociative symptoms, or who have strong desires not to be believed because of loyalty to and identification with the aggressor.[35]

Let us consider, first, the purely developmental issues (see chapter 8). The child, prior to the development of operational thinking, will mix accounts of fantasy and accounts of actual events, and may express memories through sensorimotoric reenactments, play, or physical symptoms rather than words. In latency, the child is able to narrate better, but still may fail to meet credibility criteria because the prepubertal suppression of sexuality precludes "appropriate" emotional responses (ie, those responses experienced by adults); these include sexual interest, attraction, jealousy, or horror of rape. When a child of this age describes a rape without weeping, her "brazen poise," as it was once called, may be taken as a sign that she is not describing an actual event.[36] Unfortunately, when the incest victim in adolescence does, at last, develop "appropriate" emotional reactions to sexuality, she may be perceived as still lacking credibility, now by virtue of being "seductive" or "manipulative." Time and again, one observes teenage victims disclosing their incest experiences at the precise moment when they are least likely to be believed; for example, when they have been caught breaking a rule, or when they have become pregnant by a boyfriend. Although this pattern makes emotional sense in terms of the teenage victim's disillusion with her parents and scorn of their authority, these crisis-related complaints can be misconstrued easily as opportunistic lies.

With traumatized children, credibility problems multiply. Lenore Terr, a child psychiatrist, interviewed 23 of the 26 grade school children involved in the 1976 Chowchilla, California, school bus kidnapping.[37] These children had been held by their kidnappers for 27 hours. Three masked men blocked the road with a van, took over the school bus at gunpoint, drove the children around in vans for 11 hours, and then transferred the children to a buried truck-trailer, which they covered with earth. The children spent 16 hours buried there before two of the older boys dug them out and all the children escaped. Interviewed between 5 and 13 months after the incident, 14 of the 23 children had major perceptual and cognitive distortions about the incident.

Five had distorted memories of the appearance of the kidnapper; six had formulated theories about a nonexistent fourth kidnapper still dangerously at large; and three hallucinated entire scenes. Inaccurate time sequencing occurred in the narratives of eight children. Distortions were experienced even by the adolescents on the bus. They were the ones most active in efforts to escape and organize their own rescue, and the impact of their experiences upon their perceptions must influence our expectations for court testimony by traumatized children.

Traumatization can induce distortions. Despite these distortions, however, amnesia, repression, and suppression were notably absent from the children's accounts; it may be that this developmentally linked, unflinching completeness is part of what makes it so difficult for adult physicians to listen to children's narratives of pain.[38] In addition, all children had symptoms of fear or anxiety; five children exhibited compulsive retelling of the story; six had elaborate aggressive revenge fantasies; and nine were in depressive states with regressive, dreamlike behaviors. Any of these trauma-related symptoms might be used to question a child's credibility.

Trauma-related distortions multiply when a family member has traumatized the child, when this person has enlisted the child as an accomplice in a conspiracy of silence, and when a lifetime's experience has convinced the child that he or she is a second-class citizen without rights. The distorted narrative that emerges from these pressures in incest situations has been described by Roland Summit as the "accommodation syndrome."[39] The incest victim does not complain, sometimes for years; she does not tell her mother, run away, or call for help. When she does tell someone, she may do so in a partial or cryptic way, may insist on secrecy, or may pledge that if police are involved, she herself will disavow her story. She may be deeply cynical about the good intentions of those in authority. She will feel guilty about her disloyalty in betraying her parents, and often will appear guilty or uncertain to her examiners. Sacrificing truth for acceptance and stablility may be a familiar way of life by the time incest is disclosed. As many as 20% of incest victims develop a pattern of conduct disorder that includes lying, as well as running away, school problems, and drug use.[40] Those child abuse victims who develop the full sociopathic syndrome present credibility problems that may defy currently available psychotherapeutic approaches.

If, in addition to all of above, this incest victim is able to persuade herself at moments that nothing really happened, she becomes incredible indeed. Partial memories and derealized memories are routine in incest victims; some feign sleep during the sexual contact, which is often initiated while the child is actually asleep. Even partial amnesia or mild dissociation can be associated with dreamlike, stereotyped, affectless impersonal accounts, which vary with each retelling. The child's wish that the abuse not be happening (which triggered the initial dissociation) persists as a wish that her narration not be believed, so that both she and her parents can avoid facing their real

relationship.[41] If actual multiplicity is at issue, the victim's credibility is further impaired by her tendency to talk about herself in the third person (which may be associated with tendencies to refer to alters or imaginary playmates as if they were real others) and by the differing partial memories and screen memories that each personality has for a single event.

WHY PATIENTS WITH MULTIPLE PERSONALITY ARE NOT BELIEVED

"Fact or fiction—in the end you can't distinguish between them—you just have to choose."—Graham Greene, *Monsignor Quixote*

What does this analysis of the problems that professionals experience in believing abused children tell us about multiple personalities?

First, it leads us to the hypothesis that patients with Multiple Personality Disorder are the least credible of victims because they are among the most severely abused. The multiplicity of types of abuse, of perpetrators, and the bizarre sadistic details in their stories make doctors, more horrified, more angry, and, therefore, more likely to defend by disbelieving. The more severely traumatized children are, the more likely they are to lie, to repeat woodenly, to hallucinate, to dissociate, to retract, and to not complain; they are, therefore, difficult to believe. Multiple personality patients who have experienced a lifetime of abuse at different developmental stages, and who have alters of various ages, display, in turn, the credibility problems associated with each developmental stage.

Second, we must ask how much the familial and professional disbelief of child abuse furthers the development of dissociative mechanisms in the child. A child with low self-esteem and great need for approval will manage her memories to suit the assertions of important adults. We have seen alter personalities emerge in one child when a parent disbelieved an abuse complaint. Part of the function of altering in personality, or otherwise repressing a traumatic event, is to make it easier for the child to participate in the family myth that nothing happened. When professionals join the family in insisting that nothing happened, these dissociative defenses are strengthened. Erik Erikson described the problem in Freud's teenage patient, "Dora," as a crisis of fidelity that developed after her maritally unfaithful father abandoned her to be seduced by his friend.[42] Erikson postulated that what such patients seek in a therapist is the capacity for fidelity. This implies more than credulity on the part of the therapist. It means a commitment to setting the historical record straight so that the patient's own identity and future can unfold; it means an absolute openness to the emotional truth of the patient as this emerges in associations, symptoms, transference, and, ultimately, in abreaction.

A third hypothesis generated from this review is that we observe, in

interactions with patients with Multiple Personality Disorder and abused children and their families, a shared negative hallucination. In medicine, we have given so little thought to this negative type of distortion that we do not even have a name for it. There is no named entity with which to contrast malingering and hysteria. To talk about "denial" of illness minimizes the extent of the reality distortion that occurs in these negative illusions. "Flight into health" conveys a more accurately eerie impression of the patient clambering onto a broom for a midnight flight. For example, pseudocyesis is a well-defined hysterical symptom. But, until recently, very little had been written about its opposite; that is, about those women who remain oblivious of actual pregnancies until delivery, and who keep families and physicians in the dark, as well.[43] In many ways, this last is the more remarkable phenomenon.

When we treat patients with Multiple Personality Disorder, we discover that behind their well-described hysterical conditions—the paralysis, the pain, the factitious fevers—there lie real conditions desperately camouflaged and cryptically expressed by the somatoform symptoms.[44] This concealed reality almost always includes sadistic abuse in childhood. The Multiple Personality Disorder patient and the physician cling to the series of false symptoms and false diagnoses in proportion to their mutual need to blot out the reality of the multiplicity, and to blot out the unbearable experiences of real pain that triggered it. Part of choosing to believe abused children and adult patients with Multiple Personality Disorder is choosing to confront our own complicity in the wishing away of these unbearable childhood experiences.[45, 46]

REFERENCES

1. Putnam FW, Post RM, Guroff JJ, et al: 100 cases of multiple personality disorder. Paper presented at the Annual Meeting of the American Psychiatric Association, New Research Abstract No. 77, New York, May, 1983.
2. Kluft R: Multiple personality in childhood. *Psychiatr Clin North Am* 7:121–134, 1984.
3. Kampman R: Hypnotically induced multiple personality: an experimental study. *Int J Clin Exp Hypn* 24:215–227, 1976.
4. Leavitt HD: A case of hypnotically produced secondary and tertiary personalities. *Psychoanal Rev* 34:274–295, 1947.
5. Harriman PL: A new approach to multiple personalities. *Am J Orthopsychiatry* 13:636–642, 1943.
6. MacDonald JM: *Rape: Offenders and Their Victims.* Springfield, Ill Charles C Thomas, 1971.
7. Saltman V, Solomon RS: Incest and the multiple personality. *Psychol Rep* 50:1127–1141, 1982.
8. Bloch I, quoted by Masson JM: *The Assault on Truth: Freud's Suppression of the Seduction Theory.* New York, Farrar, Straus & Giroux, 1984.
9. Tardieu A: Étude médico-légale sur les services et mauvais traitements exerces sur des enfants. *Ann Hyg Publique Med Legale* 13:361–398, 1860.
10. Kempe CH, Silverman FN, Steele BF, et al: The battered child syndrome. *JAMA* 181:17–24, 1962.

11. Caffey J: Multiple fractures in long bones of infants suffering from chronic subdural hematomas. *Am J Roentgenol* 56:163–173, 1946.
12. Elmer E: *Children in Jeopardy: A Study of Abused Minors and Their Families*. Pittsburgh, University of Pittsburgh Press, 1967.
13. Scott PD: Fatal battered baby cases. *Med Sci Law* 13:197–206, 1973.
14. Helfer RE: Why most physicians don't get involved in child abuse cases, and what to do about it. *Child Today* 4:28–32, 1975.
15. Carmen EH, Rieber PP, Mills T: Victims of violence and psychiatric illness. *Am J Psychiatry* 141:378–383, 1984.
16. Hilberman E: *The Rape Victim*. New York, Basic Books; and Washington, DC, The American Psychiatric Association, 1976.
17. Freud S: *The Origins of Psychoanalysis: Letters to Wilhelm Fliess. Drafts and Notes, 1887-1902*. Bonaparte A, Freud A, Kris E (eds). New York, Basic Books, 1954.
18. Monter EW: *Witchcraft in France and Switzerland*. Ithaca, NY, Cornell University Press, 1976.
19. Balmary M: *Psychoanalyzing Psychoanalysis*. Baltimore, Johns Hopkins University Press, 1982.
20. Freud S: *An Autobiographical Study*. Strachey J (trans). London, Hogarth Press, 1935.
21. Goodwin J, Willett A, Jackson R: Medical care for male and female incest victims and their parents, in Goodwin J (ed): *Sexual Abuse: Incest Victims and Their Families*. Littleton, Mass, PSG Publishing Co, 1982, pp 35–46.
22. Brouardel, cited in Masson JM: *The Assault on Truth: Freud's Suppression of the Seduction Theory*. New York, Farrar, Straus & Giroux, 1984, p 45.
23. Defrances V: *Protecting the Child Victim of Sex Crimes Committed by Adults*. Englewood, Colo, American Humane Association, 1969.
24. Goodwin J: Helping the child who reports incest: a case review, in Goodwin J (ed): *Sexual Abuse: Incest Victims and Their Families*. Littleton, Mass, PSG Publishing Co, 1982, pp 1–16.
25. Goodwin J, Sahd D, Rada R: Incest hoax: false accusations, false denials. *Bull Am Acad Psychiatry Law* 6:269–276, 1979.
26. Cantwell HB: Sexual abuse of children in Denver, 1979: reviewed with implications for pediatric interventions and possible preventions. *Child Abuse Neglect* 5:75–86, 1981.
27. Nakashima I, Zakus GE: Incest: review and clinical experience. *Pediatrics* 60:696–701, 1977.
28. Ounsted C, Oppenheimer R, Lindsay J: Aspects of bonding failure: the psychopathology and psychotherapeutic treatment of families of batterd children. *Dev Med Child Neurol* 16:447–456, 1974.
29. Sgroi S (ed): *Handbook of Clinical Intervention in Child Sexual Abuse*. Lexington, Mass, Lexington Books, 1982.
30. Goodwin J: Persecution and grandiosity in incest fathers, in Pichot P, Berner P, Wolf R, Thaw K (eds): *Psychiatry: The State of the Art*. New York, Plenum, 1985, Vol 6, pp 309–322.
31. Goodwin J, Vogel A: Knowledge and use of placebo among house officers and nurses. *Ann Intern Med* 91:106–110, 1979.
32. Krieger MJ, Rosenfeld AA, Gordon A, et al: Problems in the psychotherapy of children with a history of incest. *Am J Psychother* 34:81–88, 1980.
33. De Young M: Case reports: the sexual exploitation of incest victims by helping professionals. *Victimology* 6:92–101, 1981.
34. Watkins JG, Watkins H: Hazards to the therapist in the treatment of multiple personalities. *Psychiatr Clin North Am* 7:111–119, 1984.

35. Rees K: The child's understanding of his past. *Psychoanal Study Child* 33:237–259, 1978.
36. Bender L, Blau A: The reaction of children to sexual relations with adults. *Am J Orthopsychiatry* 7:500–518, 1937.
37. Terr L: Children of Chowchilla: a study of psychic trauma. *Psychoanal Study Child* 34:552–623, 1979.
38. Terr L: The child as witness, in Schetky DH, Benedek EP (eds): *Child Psychiatry and the Law*. New York, Brunner-Mazel, 1980.
39. Summit R: The child sexual abuse accommodation syndrome. *Child Abuse Neglect*. 7:177–193, 1983.
40. Maisch H: *Incest*. New York, Stein & Day, 1972.
41. Dickes R: The defensive function of an altered state of consciousness: a hypnoid state. *J Am Psychoanal Assoc* 13:356–403, 1965.
42. Erikson E: Reality and actuality: an address. *J Am Psychoanal Assoc* 10:451–474, 1962.
43. Silverblatt H, Goodwin J: Denial of pregnancy. *Bull Birth Psychol* 4:13–25, 1983.
44. Stoller R: *Splitting: A Case of Feminine Masculinity*. New York, International Psychoanalytic Library, 1974.
45. Benedek E: The silent scream: countertransference reactions to victims. *Am J Social Psychiatry* 4:49–52, 1984.
46. Miller A: *For Your Own Good*. New York, Farrar, Straus & Giroux, 1983.

4

Physical Conditions That May Be Mistaken for Sexual Abuse

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Jean Goodwin

Physicians working in the area of physical abuse have described several physical findings that can be mistaken for physical abuse, that is, organic syndromes which cause easy bruising, physical conditions which cause failure to thrive,[1] and cultural practices such as coin-rubbing in southeast Asia,[2] which may leave bruises but is not experienced as abuse. Until recently, the problem of underdiagnosis of sexual abuse has been so extreme[3] that there have been few diagnostic errors of this type. In this chapter five cases are described in which physical findings caused by infection, congenital defect, or trauma were mistakenly attributed to sexual abuse. Although the error led to legal action in only one of these cases, in all cases the physician's patience and persistence in looking beyond the possibility of sexual abuse were critical to the care of the child.

Timely and appropriate diagnosis of sexual abuse is important for the involved child and her family.[4,5] Although many cases of bona fide sexual abuse are associated with *no* physical findings and must be diagnosed by history alone,[6,7] the child who has been sexually abused may also be brought to medical attention with a definite complaint referable to the genital system. It is important to consider sexual abuse when a young child presents with vaginal discharge or bleeding[7,8] or when there are suspicious lesions around the genitalia. However, not all situations suggesting sexual abuse on first encounter will ultimately have this diagnosis. For the pediatrician or family practitioner who does not deal frequently with sexual abuse, such situations may present perplexing problems. It is important neither to minimize the problem nor to "panic." Keeping an open mind to differential diagnostic

possibilities, utilizing the skills of other disciplines and, at times, observing physical findings over a period of time may all be helpful in arriving at an accurate impression of whether or not a particular situation is sexual abuse.

Case Examples

Case 1 Sally, an 8-year-old girl, was seen in a pediatric clinic for evaluation for possible sexual abuse. She had a history of vaginal bleeding and discharge of approximately 4 years' duration. Over this period of time she had had extensive evaluations by many different physicians; workups had included pelvic examinations, cystoscopy, vaginoscopy, and bimanual pelvic examination under anesthesia. She had no clinical or laboratory evidence of precocious puberty. She had responded to empirical treatment with sulfisoxazole (Gantrisin). However, on discontinuation of the antibiotic, she again developed vaginal discharge and bleeding. The mother had confided to a social worker that the child was sleeping with the father. The child was brought for examination because it was felt that recurrent sexual abuse was the most likely cause of her symptoms.

The family constellation included Sally, a 4-year-old brother, the father aged 37, and the mother, aged 26. The family seemed stable. The mother was cooperative although not medically sophisticated. Sally, although cooperative, was clearly embarrassed by the vaginal discharge and bleeding and the attention being focused on it. Both mother and child, interviewed separately, denied the possibility of sexual contact.

On examination there was yellowish, bloody, foul-smelling discharge. The hymenal ring appeared intact. Vaginal, throat, and rectal cultures were negative for gonococcus. Sally was again empirically placed on sulfisoxazole and referred for follow-up to her private pediatrician.

Approximately a month later she was again examined under anesthetic by her pediatrician and a gynecologist. The examination revealed gross bleeding from an inflamed cervix, and the smear revealed *Enterobius vermicularis* (pinworms). Sally was treated with one dose of pyrantel pamoate and has since remained asymptomatic.

Case 2 Wendy was a lively, attractive 6-year-old who performed at a superior level in school. Her mother brought Wendy to the family physician when Wendy returned with a vaginal discharge from a visit with her father, the mother's former husband. Wendy's mother was concerned that something sexual had happened, but did not want to question the child for fear that the questioning might be traumatic. The child's pediatrician was convinced that the discharge resulted from sexual abuse.

In a joint psychiatric interview with Wendy and her mother, Wendy stated that she hoped the discharge would go away soon and that she thought it had been caused by germs. She readily understood the interview questions about whether she had been frightened by an adult or touched under her panties by someone. She answered with a thoughtful no and said if that did happen she would tell her mother or her teacher. She said that if no one else were available she would even tell the psychiatrist, but that would be a little embarrassing since it was not a person she knew well. Wendy's mood and manner did not change when her mother left the room. She was able to draw her father and talk about him and her sadness about the divorce in an unrestricted, matter-of-fact way. She denied masturbating. When freed from diagnostic tasks, she built a fort and had the interviewer help her to defend it from imaginary Indians.

Further medical workup in this case revealed a monilial infection and a family history of diabetes.

Case 3 A 6-month-old boy, Eddie, was being followed in a maternity and infant care clinic. At several weeks of age he had had a severe ulcerated diaper rash so that the perineal area could not be adequately inspected. There were concerns on the part of the clinic staff and public health nurse regarding the care he was receiving from his young, unwed mother. He was subsequently brought in by his paternal grandmother who had assumed the role of primary caretaker. At this time he was noted to have an unusual rash in his perineal area, which the grandmother said she had not noticed before. There was a purplish semicircular lesion which superficially resembled a "hickey" or "love bite" between the base of his scrotum and his anus. Sexual abuse was considered. However, as the infant was observed over several weeks, the lesion remained absolutely unchanged. A diagnosis was made of hemangioma in an unusual location.

Case 4 At 5 months of age, Patsy was seen in a pediatric clinic with bruises on her buttocks, left lower leg, and face, as well as evidence of vaginal bleeding. Examination revealed a 1-cm tear of the posterior vaginal fourchette. A diagnosis was made of physical and sexual abuse but protective service workers could not be certain of the identity of the perpetrator. The social situation was dysfunctional. Patsy was being cared for by her teenage mother, Betsy, her teenage father, Richard, and a friend of his. Both of the young men were working as projectionists in a pornographic movie house. A protective service worker attempted to work with the family, but the situation remained in turmoil. At 8 months of age the infant was placed in protective custody with the grandmother. Following involvement of both the baby and her mother in a therapeutic preschool program, plans were made for gradual return of the child to the parental home.

At 1 year of age, following an overnight visit to her parents, Patsy was noted to have a 1- × ½- in. purpuric area on her right labium majus. This was felt initially by the pediatrician to represent evidence of new sexual abuse. Concerns about the father's refusal to participate in therapy and about the young mother's slow progress in treatment crystallized around this physical "evidence" of recurrent sexual abuse. However, on continued examination the area remained unchanged and it finally became clear that this was a birthmark rather than a bruise.

Case 5 A 1-year-old toddler was brought to the hospital in critical condition after being attacked by a dog. Physicians became concerned about the accuracy of the history because: (1) the boy had an unusual type of circumferential anorectal tear which had been reported previously only in small children who had been sodomized, and (2) because the bite marks were slitlike and relatively symmetric, almost as if they had been made by a knife in the hands of a sadist, rather than by a dog. A forensic pathologist was asked to investigate the case (J. Weston, personal communication). Unfortunately, the case was referred for prosecution and publicized as a case of child abuse before this investigation was completed. The investigator made the following observations: (1) There were reliable witnesses who saw the boy being attacked by the dog, and (2) the dog in question was a wolf-shepherd crossbred as a watchdog and not fully grown. The animal was subsequently sacrificed and autopsied, and his teeth were examined by a forensic dentist. The thin, pointed teeth of this immature half-wild dog matched the slitlike

marks on the child, but were quite different from the bite marks of mature domestic dogs which are more familiar to physicians. A veterinary pathologist, expert on animal attacks on humans, was consulted about the pattern of wounds. Apparently, wild dogs tend to attack prey first on one side and then on the other, leaving a symmetric pattern of wounds. They will often lunge for the animal's rump, taking a deep bite, so they can flip their prey into the air.

A diagnosis was made of trauma secondary to attack by a mixed domestic and wild dog.

DISCUSSION

Both pinworms and foreign bodies can be causes of chronic vaginal discharge in young girls.[8] In case 1 several facts mitigated against the diagnosis of sexual abuse: (1) There were no definite behavioral indicators of sexual abuse, either in this child or in her mother, and (2) the family seemed genuinely concerned about the vaginal bleeding and discharge and had gone to great lengths to have the child evaluated for it, with no hints of any "secrets" to hide. The key to this case was a thorough examination which included the differential diagnostic possibility of pinworms. It was also helpful to document that there was no evidence of vaginal penetration. The pediatrician who routinely examines a child's genitals as part of the physical examination can be authoritative when the question arises as to what is normal and what indicates probable penetration. It was also important to have obtained cultures for gonococcus, since the finding of a positive culture would have been strongly suggestive of sexual abuse.[9]

Psychiatric evaluation of the child may be sought in some of these ambiguous situations to confirm the physician's clinical impression that the child is telling the truth when she says she was *not* sexually abused. This is the reverse of the more usual clinical question about whether the child is telling the truth when she says she *was* sexually abused. However, in view of the intense pressures that many children feel to protect the abuser, and because concealment of abuse and false retractions do occur, it is an important clinical question.[3]

In the psychiatric interview reported in case 2 there were many elements that are simply not seen in a child who is making a false retraction. Wendy was open and trusting with the interviewer, but was also respectful and protecting of herself. There was no change in affect when her mother left the room. Anxiety and aggression were not excessive or intrusive. Wendy did not show guilt about asking for help. She did not minimize her problems. She could talk about her vaginal discharge and other sexual topics, but was obviously much more interested in age-appropriate fantasy play.

In cases 3 and 4 observation over time convinced the physician that skin lesions which were initially suggestive of bruises that could have been inflicted during sexual contact were, in fact, congenital marks. In case 4 where recurrent sexual abuse was a distinct possibility this was an especially

important diagnostic decision. These examples are akin to the error of mistaking mongolian spots for the bruises of physical abuse. The appearance is superficially similar, but the lesions do not go through the normal evolution of bruises and they have different pigmentary characteristics.

In case 5 it was especially tragic that the parents were disbelieved and suspected of concealing or perpetrating a sadistic sodomy on their child at a point when they were having to cope with a catastrophic accident and with their child's critical physical condition. It is of note that in this extreme case the intact family reacted to the investigation with a reasonableness and calm, absolutely uncharacteristic of families where sexual abuse is actually occurring. This case highlights the need for the physician (1) to not panic, (2) to keep an open mind to the diagnostic possibilities, (3) to get the best expert help, and (4) to take time before making a diagnosis.

CONCLUSIONS

As noted initially, in many instances of sexual abuse there are no physical findings and it is important to rely on history.[6] In the examples given above there *were* definite physical findings which could have indicated sexual abuse yet ultimately did not yield this diagnosis. The following suggestions summarize our experience and our advice to the physicians faced with such a problem:

1. Do not panic at the idea of sexual abuse. That will tend to stampede you into either refusing to consider sexual abuse, or into blundering into the diagnosis even when the physical findings do not really support it. Keep in mind the different diagnostic possibilities. In cases where one is not sure it may be appropriate to share this uncertainty with the family—to say, "We have to be concerned about sexual abuse, but there are other possibilities as well." This may provide an opportunity to introduce involvement with a social worker skilled in dealing with sexual abuse.
2. Utilize expert help and creative approaches. As our five cases illustrate, the needed expert may be a psychiatrist, psychologist, or a social worker, but one may also need to call on a veterinarian, a forensic pathologist, or an anesthesiologist.
3. Observation of certain physical findings over time may help to differentiate between a lesion inflicted as part of sexual abuse or some other stable skin finding such as a birthmark. It is, of course, important to assess whether the child is adequately protected while this waiting period occurs.
4. The importance of careful history taking, physical examination, and observation of child and parents cannot be overemphasized. It is the physician's anxiety in these cases that can interfere with completing a standard systematic examination.

It may be misleading to end this chapter with the impression that the

pediatrician will always be able to make a diagnosis of either sexual abuse or of some other physical syndrome—infection, birthmark, trauma. We see situations in which both occur—a physical condition affecting the genitals together with sexual abuse. Chronic, mixed bacterial infections are not uncommon in prepubertal girls experiencing sexual abuse. Such children can be as upset by the chronic vaginal discharge as they are by the sexual abuse itself. Just as sexual abuse can cause organic disease, so organic genital problems can lead to sexual abuse. It is not uncommon to find that a child begins to be sexually abused by a family member only after she has been raped traumatically by a stranger. It is as if the crisis generated by the rape shifts a new sexual focus to that child which places her at higher risk for sexual contact within the family. We have noted elsewhere that blind, epileptic, retarded, or other physically special children seem to be at higher risk for sexual abuse.[10,11] Physical problems that affect the genitals may be especially prone to weaken the incest taboo protecting that child. In one of our cases, the child experienced signs of precocious puberty at age 2. Symptoms remitted after appropriate treatment, but she was subsequently abused sexually by two different family members.

REFERENCES

1. Schmitt BD, Grosz CA, Carroll CA: The child protection team: A problem-oriented approach, in Helfer RE, Kempe CH (eds): *Child Abuse and Neglect—The Family and the Community. Cambridge*, Mass, Ballinger, 1976.
2. Yatman GW: Pseudobattering in Vietnamese children. *Pediatrics* 58:616–618, 1976.
3. Goodwin J, Sahd D, Rada R: Incest hoax: False accusations, false denials. *Bull Am Acad Psychiatry Law* 6:269–276, 1979.
4. Kempe CH: Sexual abuse. The 1977 C. Anderson Aldrich Lecture. *Pediatrics* 62:382–389, 1978.
5. Stechler G: Facing the problem of the sexual abuse of children. *N Engl J Med* 302:348–349, 1980.
6. Schechter MD, Roberge L: Sexual exploitation, in Helfer RE, Kempe CH (eds): *Child Abuse and Neglect–The Family and the Community*. Cambridge, Mass, Ballinger, 1976.
7. Tilelli JA, Turek D, Jaffe AC: Sexual abuse of children. *N Engl J Med* 302:319–323, 1980.
8. Pascoe DJ: Management of sexually abused children. *Pediatr Ann* 8:309–316, 1979.
9. Farrell MK, Billmore E, Shamroy JA, et al: Prepubertal gonorrhea: A multidisciplinary approach. *Pediatrics* 67:151–153, 1981.
10. Goodwin J, Zouhar M, Bergman R: Hysterical seizures: A sequel to incest. *Am J Orthopsychiatry* 49:678–703, 1979.
11. Friedrich WN, Boniskin JA: The role of the child in abuse: A review. *Am J Orthopsychiatry* 46:580–590, 1976.

5

The Use of Drawings in Incest Cases

Jean Goodwin

Psychiatrists, pediatricians, and gynecologists tend to find the task of evaluating an alleged incest victim troubling and perplexing. The physician who evaluates such a child will often be asked to testify in court about whether the child's complaint about incest is true. Physicians are uncomfortable in this role of truthfinder, especially when the child involved seems to need rest from the trauma of family upset rather than more lengthy interrogation about the sexual allegations. In addition, preschool children may not have the abstracting skills, the ability to assess duration, or the ability to sequence events that are necessary to describe in words what has happened to them. However, a detailed understanding of the child's sexual complaint may be necessary in order to protect the child and to plan necessary medical treatment. This chapter describes how drawings can be used with the child victim, both to obtain more information about what happened to the child sexually, and to respond to the child's need to escape from the traumatic situation into fantasy and play.

This chapter is based on 19 consecutive interviews with girls aged 5 to 16 years who were suspected incest victims. Drawings were collected in each interview and analyzed together with other diagnostic information about the child and her family. The child's drawing of the alleged perpetrator was particularly helpful in understanding the allegation of incest. The use of drawing was introduced in the evaluation of each victim, but a particular drawing task often became an important metaphor that regularly recurred throughout the child's treatment.[1]

STUDY POPULATION AND METHODS

The author worked as psychiatric consultant to a protective service agency which treats approximately 50 incest cases a year. Cases in which substantiation is difficult are referred for psychiatric consultation. This series of 19 consecutive cases represents the author's experience over an 18-month period. All 19 children were girls; father-daughter incest was suspected in ten cases and stepfather-daughter incest in nine cases. Fourteen of the girls were eventually judged to have been victimized by the suspected father figure. This judgment was reached as a consensus by the treatment team after studying other medical and family evaluations as well as results of the psychiatric interview with the victim. Five children were judged by the same procedure to be nonvictims. Three of these girls were younger siblings of actual victims and had not themselves alleged incest. Two girls, one aged 5 years and one aged 13, were judged to have made false accusations. Both were seriously emotionally disturbed and the 5-year-old had been a victim of actual incest before making the false accusation against an innocent family member. This preschooler was also mildly retarded and had difficulty differentiating present from past experiences. The 13-year-old was being physically and emotionally abused by her father and was later diagnosed as schizophrenic. This adolescent was extremely hostile toward the father and intermittently delusional. Schizophrenics sometimes have delusions about incest which may be related to the core schizophrenic experience that one's thoughts, words, and actions are being forcibly controlled by someone else[2] (see also chapter 2). The frequency of false accusation is higher in this referred population than the frequency (less than 5%) in the program's total incest caseload.[2]

All children were asked during a playroom session to draw whatever they wanted. The children were then asked to draw a picture of the whole family doing something together and then to draw a picture of the perpetrator. Depending on problems expressed in the interview, some children were asked to draw a picture of their house, of the inside of their bodies, or of a dream. For example, a child with a possibly psychosomatic symptom might be asked to draw her body, or a child whose mother reported the child's frequent nightmares would be asked to draw the frightening dream. In three cases, male siblings of actual victims were seen and asked to do a similar set of drawings. The draw-a-person task is given during the routine psychological testing, which was also done with these children,[3] and so was omitted from this series of drawings.

RESULTS

All nine children under 12 drew freely and completed at least three drawings. However, of the ten children aged 12 and older, only two would draw at all. Except as indicated, the following results apply only to children under 12.

Draw-the-Perpetrator

This drawing task was developed by the author after it became apparent that children refused to draw the incest event as frequently as they refused to talk about the event. Figure 5-1 shows with its many false attempts that even the more neutral task of drawing the perpetrator was often painfully difficult for these girls. Of the seven actual victims under 12, three could not draw the father at all, x-ing out repeated attempts and finally giving up. Three others were able to draw the father but drew the figure with an obvious phallus as shown in Figures 5-1 and 5-2. Children who drew such figures identified the apparent phallus as a "decoration" or said it was "nothing." Only one of the seven actual victims was able to easily produce a nonphallic drawing of the perpetrator. Both of the nonvictims under 12 did this easily. Alcoholic perpetrators were often drawn without hands or feet. Other studies indicate that nonabused children

Figure 5-1 A 10-year-old girl's drawing of her sexually abusive father. (Reproduced with permission from Goodwin J: Use of drawings in evaluating children who may be incest victims. *Child Youth Services Rev* 4:269–278, 1982.)

Figure 5-2 A 5-year-old girl's drawing of her sexually abusive father. (Reproduced with permission from Goodwin J: Use of drawings in evaluating children who may be incest victims. *Child Youth Services Rev* 4:269–278, 1982.)

rarely draw genitalia; on a free drawings, 10% of sexually abused children will depict genitalia.[4]

One girl was referred for evaluation of possible incest when she drew a picture of her father for her therapist. The father was drawn after many unsuccessful attempts without legs or feet, in a dress, and with an obvious

phallus. Investigation revealed that the father had become an alcoholic after his wife abandoned him and his small daughter. He and the girl had been involved in an incest relationship for 5 years. Further evaluation of the father indicated that he had initiated the incest relationship in part to defend against the masculine shame and the homosexual anxiety he felt in assuming the maternal role. The daughter's perception of her father's dilemma about sexual identity could not be verbalized, but emerged in her drawing.

Another incest victim drew her father holding a baseball bat; the bat was touching the obvious phallus in the drawing. This father had engaged in mutual masturbation with his daughter before and during severe physical beatings.

In two cases the child's drawing was the first clue to psychosis in the father. The father was drawn surrounded by small, disembodied heads which represented his "voices."

Kinetic Family Drawing

In this drawing task the child is asked to draw a picture of the whole family doing something together. This allows the child to represent overall family relationships and her view of her own role in the family.[5] Johnson[6] has found evidence of isolation (manifested by drawing the family members in separate compartments), and evidence of role reversal (seen by drawing the child larger than the mother) in the drawings of incest victims and in the drawings of children raped by strangers.

Two of the kinetic family drawings in this series were particularly eloquent depictions of the child's situation. One 10-year-old girl had been expelled from her family because of an incest accusation (judged to be true) which both parents angrily rejected as a lie. Her kinetic family drawing depicted a vast barren mountain with only a few thornbushes and no people. In another case, an 8-year-old girl drew her family with an extra person standing between herself and her father. "That's the watcher," she said. Her alcoholic father was still drinking heavily and she was afraid that without the monitoring of the protective services caseworker, incest would recur.

Draw-Your-House

Incest victims are often frightened of bedrooms and of houses in general. They may express this by drawing themselves carefully outside of a house they have drawn or, in play, by removing all the child dolls from the dollhouse. The house in Figure 5-3, with front and back doors wide open, was drawn by a 5-year-old who was afraid to sleep in her own bed. Other children compulsively draw walls in their house picture, as if in an effort to keep family members in their assigned places.[3]

Reluctant-to-draw older girls will often become interested in helping

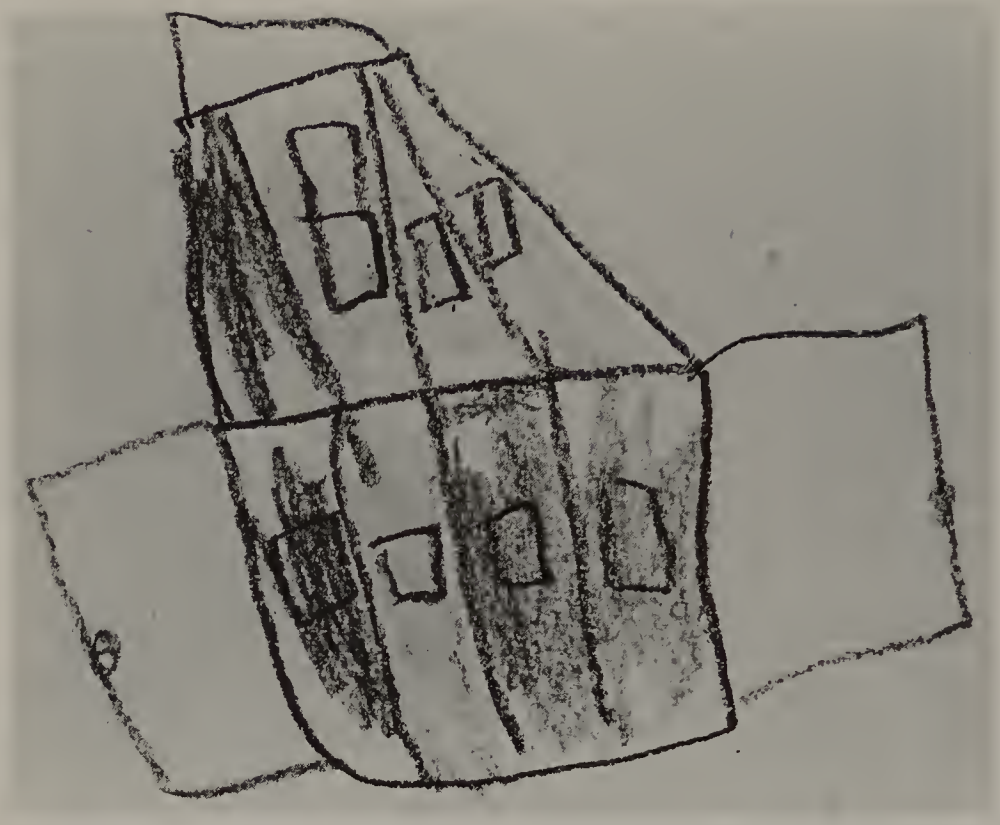

Figure 5-3 Drawing of her house by a phobic 5-year-old incest victim.

the therapist to draw a floor plan of their house. Rene Spitz recommended this technique for adult analytic patients who denied exposure to the primal scene. Confronted with their own sketched floor plan of the house in which they were reared, patients realized that they must have been exposed to the sights and sounds of parental intercourse (D. Metcalf, personal communication, 1982).

Such a floor plan is very helpful in understanding the lack of privacy and the bizarre sleeping arrangements that make the incest situation possible. In one family the father had built the home himself and had placed the bedrooms of the four daughters in a long wing extending between the parents' bedroom and the only bathroom. Each daughter had to pass through the parents' bedroom to get in or out of her room, and the father had to go through each daughter's room in turn to get to or from the bathroom.

Draw-the-Inside-of-Your-Body

About 20% of child incest victims complain of somatic symptoms such as stomachache or headache.[7] Some child victims asked if they had been "ruined" by the experience or assumed that they could never have children

because of what had happened. Children with these problems were asked to draw their body as though the skin were transparent and one could see through to the inside. A girl who had presented with pharyngeal gonorrhea drew a recognizable vagina where the pharynx should have been. She was experiencing recurrent nausea and vomiting, and expressed great relief when the therapist explained that one could not be impregnated through oral intercourse.[8]

The physician or therapist can often proceed from this drawing to using drawings to help clarify the child's questions about her own and the perpetrator's genitals.

Draw-a-Dream

About 15% of child incest victims suffer nightmares or other sleep disorders.[6] Some of these children will draw a dream as their free drawing. A 9-year-old drew a dream picture which showed herself in a wedding dress standing outside a house in a field of flowers. As she discussed the dream and her drawing, the child revealed her own longing for a new father and a new wedding for her mother, and her fears that her mother might be unable to divorce the incestuous father. Flowers like those depicted in this dream are often seen in the drawings of these children who feel "deflowered." One depressed 7-year-old victim drew page after page of drooping flowers without petals. Another 7-year-old drew a weeping tree surrounded by black flowers.

In another case, a 9-year-old girl's drawing of a dream about camping showed a zipped-up tent. She was inside the tent, but in the drawing a phallic-appearing tree intrusively overlapped the tent despite the careful zipping. As she described her drawing of the dream, this girl told about an earlier attempt to escape the incestuous relationship. Several years before, she had told a boy in her class about her incest relationship with her father. The two had decided that she must leave home and had gathered together a tent and camping equipment in a vacant lot near their school. Their runaway was discovered after a few hours, but the motive for running away to the tent did not emerge until the incest was revealed[3] (see also chapter 7).

Drawings by Brothers

Families are often determined to keep an incest problem secret from uninvolved siblings. Yet a recent study shows that a year after the incest accusation it is the uninvolved siblings who are the most distressed family members.[9] Recently, I have begun asking brothers to do the same set of drawings that victims are asked to do and, in addition, to draw the victim. Brothers are often less stressed by the task of drawing the father of the family than is the actual victim. Playroom evaluations of these boys show they have

Figure 5-4 Drawing of his house by the 9-year-old brother of an incest victim.

much sensitivity to the family's problems despite parental attempts to shield them from information about the incest accusation.

Figure 5-4 is a free drawing by a 9-year-old boy who had moved out of the family home with his mother and sister after an incest accusation was made. His drawing shows a large phallic tree splitting his house in two. At the time of this interview, he was desperately homesick for the old house; he drew this fractured house repetitively until his mother found an apartment of her own. This fractured house is reminiscent of a previously published drawing by a 13-year-old victim who depicted her house as being lifted up into a phallic tornado.[10]

A brother in another family drew as his free drawing a picture of the older sister who had been the father's incest partner. The drawing shows the sister battered and bruised like a prize fighter, but dressed and with the proportions of a young toddler. This was a very accurate portrait of the sister's feelings after the father was acquitted in a criminal incest trial that had been, for her, a humiliating battle. Bringing the brother into joint sessions between mother and daughter helped the family to integrate the court's verdict with their experience that actual incest had occurred.

DISCUSSION

The use of drawings is usually helpful in evaluating incest victims under the age of 12. The majority of teenage victims will not draw at all, and those who did so in a compliant way revealed little in the drawings. However, teenage victims can become interested in sketching house plans or anatomic diagrams.

With the younger child, drawings can be used in pediatric settings and in the gynecologic examination as well as in the psychiatric interview. During the forensic pelvic examination, the pediatrician and the child victim can use the paper sheet that covers the examining table to draw pictures of what part of the body was touched, of the person who did the touching, of the place where all this happened, and of the parts of the body that hurt now or that might be damaged.

Diagnostically, the drawings are helpful in understanding the child's fears and anxieties, her view of the family, and her self-image. Fear and anxiety emerge in the repeated, unsuccessful attempts by incest victims to draw the fathers and also in their drawings of phallic objects intruding into homes. Children who drew their alcoholic incestuous fathers without hands or feet and with an obvious phallus convey elements of both their conscious and unconscious images of the father. Drawings of the victim as a defeated prize fighter or a flower without petals convey in a singularly rich way the child's self-image.

Such drawings, by themselves, are not sufficient to make a diagnostic decision. It is the child's increasing sense of being able to communicate and her experience of being understood that are helpful to the clinician in reconstructing what is happening in the family. The discovery of a workable avenue of communication in also helpful in reducing the anxiety of a child whose enmeshment in family secrets has often blocked verbal means of asking for help.

Children usually show relief when asked to draw. Asking a child to draw conveys many messages: that the child needs to be treated as a child, that the child in play can create something the physician values, and that the child can defend herself from traumatic experience through play and drawing without having to resort prematurely to the defensive strategies of the adult world.

Often, the next step in therapy is to help the child to draw with other people[10] such as with the therapist, with other children in a victims' group, with her siblings, or with her mother. In a group for incest victims aged 9 to 12, it has become a standard procedure to drape one wall of the group room with white drawing paper. Group members are encouraged to use that space to write, draw, or paint anything they feel like expressing during, before, or after the group. The mural is removed after group members leave in order to maintain confidentiality. Children who are reluctant to draw often scribble

affirming comments under the drawings of other group members. Poems are added to the mural as well as critical comments about the group experience. For victims who have been burdened for years with prohibitions against revealing their incest secret, the mural is a challenging and liberating exercise.

Drawings of the self can be used to monitor progress in treatment. The child's portrayal of herself will show less preoccupation with the genitals and more structure and definition with fewer missing body parts as recovery proceeds. Asking the child intially to draw the self as she was prior to the traumatic event can be helpful in monitoring the return to baseline.[11] Previous drawings can also be sought for comparison from family members[11,12] or teachers.

Drawings can be helpful in court settings because they convey the power of conflicts and the presence of unconscious perceptions in a more direct way than can the explanations of expert witnesses. When the subjective plight of a child is being ignored or misunderstood in a court proceeding, the discussion of the child's drawings can be useful.[13]

REFERENCES

1. Goodwin J: Use of drawings in evaluating children who may be incest victims, *Child Youth Services Rev* 4:269–278,1982.
2. Goodwin J, Sahd D, Rada R: Incest hoax: False accusations, false denials. *Bull Am Acad Psychiatry Law* 6:269–276,1979.
3. Sahd D: Psychological assessment of sexually abusing families and treatment implications, in Holder W (ed): *Sexual Abuse in Children*. Englewood, Colo, American Humane Associaton, 1980, pp 71–86.
4. Hibbard RA, Roghmann K, Hoekelman RA: Genitalia in children's drawings: An association with sexual abuse. *Pediatrics* 79:129–137,1987.
5. Burns RC, Kaufman SH: *Action, Styles and Symbols in Kinetic Family Drawings*. New York, Brunner-Mazel, 1972.
6. Johnson MSK: Dynamic themes in the psychosocial diagnosis of sexually mistreated children. Presented at the Second International Congress of Child Abuse and Neglect, London, Sept, 1978.
7. Maisch H: *Incest*. New York, Stein & Day, 1973.
8. Thomas J: Yes, you can help the sexually abused child. *RN* 43:23-29,1980.
9. Kroth JA: Family therapy impact on intrafamilial child sexual abuse. Presented at the Second International Congress of Child Abuse and Neglect, London, Sept, 1978.
10. Stember CJ: Art therapy: A new use in the diagnosis and treatment of sexually abused children, in Jones B, MacFarlane K (eds): *Sexual Abuse and Neglect: Selected Readings*. Washington, DC, US Dept of Health and Human Services, Publication No. (OHDS) 78-30161, 1980, pp 59–63.
11. O'Connor J: Conference on posttraumatic stress covers effects of combat, crime and sexual abuse. *Hosp Community Psychiatry* 36:309–319,1985.
12. Burgess AW, McCausland MP, Wolbert WA: Children's drawings as indicators of sexual trauma. *Perspect Psychiatr Care* 19:50–58,1981.
13. Uhlen DM: The use of drawings for psychiatric evaluation of a defendant in a case of homicide. *Ment Health Soc* 4:61–73,1978.

6

What Families Say: The Dialogue of Incest

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Jean Goodwin

Myths and legends about incest often describe riddles and their solutions. A medieval legend tells about a king who demanded that each of his daughter's suitors answer a riddle. None of them could solve the riddle, so suitor after suitor was sent away. Finally, one of the suitors realized that the answer to the riddle was that the king wanted his daughter for himself. The suitor who finally understood the riddle was also banished angrily by the king.[1]

Those of us who work with incest families often feel that the family members are speaking to us in riddles. If we misunderstand these messages, we lose our relationship with the family. Sometimes, even if we understand the messages correctly, the relationship is placed in jeopardy by this new understanding.

Several years ago we began collecting quotations from children and parents who were in treatment for problems related to incest. We knew that these statements, like the riddle in the story, were valuable keys to understanding the families. We also realized that such statements could be puzzling, shocking, or alienating, especially to inexperienced therapists. We looked in particular for statements that therapists at first dismissed as unreal, exaggerated, or deceptive, but that later came to be understood as a serious description of the family's reality.[2,3] The following is an example of the kind of statement that therapists brought to us.

> A mother described how she had come home from work and had opened the door of her 7-year-old daughter's bedroom to find her husband and her

daughter naked on the bed. Her husband ran for the closet. The mother opened the closet door and noticed her husband's full erection. "It's not what you think!" he said. The social worker at first thought that the mother was being derisive about this feeble attempt at explanation, but then went on to experience a sense of helpless incredulity as the mother explained that her husband had completely reassured her that nothing was wrong.

We began to suspect that therapists who rejected as fabrications children's statements about incest were experiencing similar feelings of incredulity related to difficulties in understanding the family's dialogue about incest.

Orienting therapists and social workers to the communications they could expect to hear from family members became a useful way to introduce the values, needs, fears, and conflicts that characterize incestuous families. We also found that careful attention to statements made by family members could be helpful even to experienced therapists in resolving certain impasses that developed in treatment.

In this chapter direct quotations are presented in the order in which the therapist is likely to hear them as she interviews an incest family: First, quotations from child victims, then from the mother, then from the father. Except as specified in the text, father- or stepfather-daughter incest was the problem in all families. Quotations from victims have been arranged in a developmental sequence from toddler and preschool victims, to latency age victims, to early and late adolescent victims. We have found it helpful to catalogue quotations in this way in order to gain a more precise sense of the kinds of statements about sexual worries that children are able and inclined to make at various ages (see also chapter 8).

This "dialogue" of incest is presented as a series of individual quotations, in part to clarify the concerns of each family member, but also because the communications often occur as isolated statements made into a relative vacuum. Family members seem not to hear fully many of these statements and are often unable to respond to them. It is not surprising that the taboo against talking about incest has rendered families—and therapists as well—inexperienced and incompetent in communicating in this area.[4] (see also chapters 20 and 21). Family therapy, group therapy, and bibliotherapy with materials like *Kiss Daddy Goodnight*[5] and *I Never Told Anyone*[6] may all rely for effectiveness on providing families with words about incest, and with practice in using those words so that the painful and recondite dialogue of incest can be transformed into normally empathic conversation.

WHAT VICTIMS SAY

Typically, incest is revealed when the victim gives some clue about her distress to a neighbor, a relative, a baby sitter, a teacher, or a physician. In most cases similar clues have previously been given to the mother, but they have not been deciphered by her.

Victims Aged 2 and 3 Years

A child under 4 years of age cannot be expected to make a definitive statement alleging incest; therefore, it is necessary to take seriously any possibly sexual complaint expressed by a very young child. The following statements were made by 2-year-olds experiencing digital penetration from the father.

— "Daddy hurt my pee-pee."
— "My ya-ya hurts."
— "My heinie hurts."
Another 2-year-old said simply, "I hurt," as the first clue.

Jones and Krugman recently reported on a 3-year-old who was able, with developmentally appropriate questioning, to describe, identify, and testify against the man who had raped her and abandoned her in a cess pit.[7,8]

Victims Aged 4, 5, and 6 Years

Language development enables a child, aged 4 to 6, to say considerably more about a sexual contact, but one still needs to listen for simple statements. A 4-year-old girl who had been violently raped by her mother's boyfriend said, before surgery, "That man hurt my bottom!" A 4-year-old boy who was being abused by his 13-year-old female cousin told his mother, "That girl says we're fucking." Another 4-year-old girl said, "This is the third time it happened, only this time I started to bleed and Daddy wiped it away." Fortunately, someone asked what "it" was.

Sometimes the child's entry into the complaint sounds deceptively innocent. "He gives me an ice cream cone," said a 4-year-old girl. The grandmother asked, "What for?" "If I let him touch me," the 4-year-old replied. The mother's boyfriend had been fondling the child.

It is common for these preschoolers to slip in a clue about the secret of incest into other complaints or conversation. One 5-year-old who was being violently abused by her 14-year-old stepbrother told a neighbor, "My brother does naughty things. He eats in his room when he's not supposed to, and he does naughty things to me." "Did you tell your parents?" asked the neighbor. "Yes, but my stepfather sent me to my room." "What naughty things?" "He hits me, that's all ... no, he does something else, but I don't know what it is." The 5-year-old then hid her face in a cushion, turned red, and pointed to her vagina and said, "He hurts me with his dick sometimes when he baby-sits me. My sister told last summer and daddy spanked her." Another victim of brother incest said, "My brother does things he's not supposed to." When asked what, she said, "Oh, he plays piggyback in the house and looks in my sister's purse and he puts his tail in my butt. My brother stuck his tail in my bottom, and he asked me to suck on it. It's supposed to be a secret. I don't like how it tastes, but I didn't want my brother mad at me. I don't want to

get him in trouble. He'll be mad at me for telling." The child's drawings identified the tail as the brother's penis.

Once a 5-year-old trusts the interviewer, the child can make surprisingly descriptive statements:

— "He put his thing in my mouth. It's yucky. It tastes like food, like milk going down the back of my throat. He told me not to tell."
— "Dad tickles me. He starts on the inside of my leg and then rubs between my legs. I tickle him on the outside of his underwear."

Accepting, but sad, comments about the mother's inadequacy are heard again and again in children of this age. One articulate 5-year-old with gonorrhea of the throat and vagina had a mother who had repeatedly refused to get medical treatment for the child. The daughter said, "I can't sleep at night. When I take my bath my bottom hurts. It keeps hurting all night. I felt sick last night. I asked mama to take me to the doctor. She promised she would. This morning she went out of town. I don't know how long she'll be gone. I guess she forgot." The baby sitter with whom the child had been left did not know either how long the mother would be gone.

Quotations from other children describe this sense of abandonment by the mother:

— "There are no grown-ups here."
— "Mom brought me in here so I'll straighten up. I drive her up the wall."
— "Will you be my mommy? My mommy is too busy."
— "Dad gets on top of me when mother is gone."
— "I like to sleep with papa. He doesn't get mad at me the way mom does. He takes care of me. He gets me up for school and makes my breakfast."

When these children are placed in foster care, one of their major worries is, "Who's going to take care of mom when I'm gone?" One 5-year-old living in a foster home told her mother reassuringly, "I have my own home now."

Worry about the mother acts together with fear and respect for the father to make many of these children hesitate to talk about the incest:

— "I told my mom. Mon told me it was a lie. But just because someone says it's a lie doesn't mean it is a lie."
— "Will you help me to tell my mom?"
— "He'd spank me if he knew I didn't like it."
— "Ain't no way I'm going home. They'll be too mad."

Victims Aged 7 to 10 Years

Fears of losing their families or hurting the parents are the major obstacles that prevent latency-age children from describing secret sexual events in the

family. Some children simply refuse to admit the sexual event, even if an adult has witnessed it. However, if the therapist can break through the child's fear of telling the secret, a child in this age range can make explicit and direct statements about what happened. For an inexperienced interviewer, this directness can be disconcerting. An interviewer who has not talked about sex with many latency-age children may misinterpret these flat, graphic, bald statements as clues that the child is fabricating the complaint.

— "My brother's been screwing me."
— "Dad uses us in bed."
— "He's been doing it to me."
— "He sticks his finger in my vagina."
— "He made me take off my panties. Then he would lay on top of me and rub his thing on me. He tried to get it in but couldn't. He tried front and back but never got it in."
— "He takes us to the bedroom and jumps on us, one at a time."
— "He put his wiener in my thing this morning while it was still dark and blood came out. He made me throw my panties away. My dad tells me I have to do it with him because my mom doesn't like to do it with him any more."
— "He took my panties off and laid me on my back. He had a stick on his body. He put it inside me right between my legs."
— "He took me into his room and told me we would play a game. He got out the game, but then he locked the door and he did something to me. He put his thing in me all the way inside. Down below. We were both undressed."
— "You know what mom and dad do in bed together? That's what dad was doing to me."
— "He takes his wiener out and makes me touch it, but when mom comes in he covers himself quickly."
— "He got on top of me and hurt me. He hurt me 2 or 3 times."
— "Dad wanted me to go to bed with him. He came to my bed when mom was asleep and lay on top of me. He said, 'Give me some.' I'm afraid of him. I hate him. He would rub me up and down. Sometimes he hurt me. He'd stick his wiener inside me."

One hears many statements from children that reflect the parents' inability to protect the child and the child's inappropriate overprotectiveness about the parents.

— "I told my mother. She whipped me and told me to talk to my dad about it, not to bother her."
— "Maybe it was a dream. Mom says it was a dream."
— "I don't believe mom any more. I told her he put his hand in my pants and she didn't believe me."

— "Is mom going to jail? She told me she might and it would be because I told the police officer what he did to me."
— "Once I told my dad I didn't like him; he went up to his room and cried all night."
— "I told my mom that I needed to move out and get a house of my own."
— "I can't count on mom. She sends my sisters to sleep with grandpa (the abuser) but I won't go. I scream when he touches me. I get nervous and run away. I'm just a little girl. I run home to my dog. He protects me."

Victims Aged 11 to 13 Years

Children aged 11 to 13 are more aware of and curious about the dangers and the implications of the incestuous event. The following quotation from a retarded 13-year-old has the matter-of-fact concrete quality that is more characteristic of early latency than of preadolescence. Asked by her teacher what she had done over the weekend, this girl said, "I've been screwing my brothers. They take off their clothes and I take off mine. He gets his thing hard and spreads my legs and puts his thing in mine. It's yucky and it hurts. He wants to make me a baby." A 13-year-old who was functioning cognitively at her age level described her incest experience in a more complex way, "I still dream about it. My uncle took me to the movie. He took my clothes off and had intercourse with me. He told me he'd kill my family if I told. I decided he couldn't hurt me any more than he already had, so I told my mother. She said she had suspected .... Why did she let me go with him? I guess she didn't realize." This more characteristically preadolescent account describes the event in the context of the motivations that led up to it and the consequences that may follow. There is more fear, dread, and anger about the relationship. It is no longer seen as something to be blindly accepted.

Fears about pregnancy and about damage to the pubertal body, a body that already seems frighteningly unpredictable, are connected with the increased sense of danger and the focus on consequences. The following comments illustrate these fears:

— "I feel sick today. Do you think I am pregnant?"
— "I'm sure I'm pregnant."
— "I want to be checked out by a doctor so I can get on with the rest of my life."

In the face of these dangers preadolescent children now require some explanation or quid pro quo from the perpetrator if they are to continue to comply with his sexual demands. They describe their fathers as offering simple threats, excuses, rationalizations as sex education, or protestations of romantic love.

— "I was afraid to tell. He said he'd kill my brother if I told."
— "He comes into my room and climbs into bed with me and tries to talk me into intercourse. He told me not to tell or he'd be mad."
— "He tried to unzip my pants on the way home from bowling. I told him to stop or I'd tell. He said no one would believe me."
—"He did it, but, if I tell, it might make mama get a divorce."
— "I asked my stepfather what rape meant because my friends at school were talking about it. I didn't know he would show me."
— "Dad read me the *Joy of Sex* and then he did cunnilingus. I cried. Later he told me if I didn't want it next time I should just say so."
— "He said he thinks about me all the time. He promised to stop, but he did it again."

These older girls still describe the mother as unavailable to help them control their fears and worries.

— "Mom told me not to worry about it."
— "Why did she marry him?"
— "Why did she go back with him?"
— "Why didn't she listen to me?"
— "Mom would walk right by us and dad would be lying on top of me on the couch and she never noticed."
— "Mom says I'm a bad influence because I talk about how I feel."
— "Mom gets so mad at me. She blames me now that dad is gone. I can handle the kids better than she can."

The protective feeling toward the mother that characterized the younger child is now being replaced by criticism, recrimination, and hostility.

Preadolescents who appear asymptomatic on the surface often reveal in treatment burdensome, pent-up anxieties, violent fantasies, and feelings that they are about to lose control. The following communications occurred after trust had been established in a victims' group for preadolescents.

— "I'm going to run away. I don't want to be at home. I don't want to go to school."
— "I feel out of control. I might kill myself."
— "I'm a teenager on the surface and a 3-year-old underneath."
— "Maybe I'll just cut my wrists; no, I was just kidding."
— "I'm afraid there might be bloodshed."
— "I'll fix him. I'll get a gun."
— "The only person I can talk to is my teddy bear."
— "Who would I have told?"

Victims Aged 14 to 18 Years

Teenage victims understand more fully that the intrafamilial relationship is not only dangerous but illicitly sexual. They often refer to the incest contact as "rape" and are sometimes strong and motivated enough to resist, so the contacts more literally resemble a rape. Their adolescent developmental interest in mastering sexuality, in competing sexually, and the increased capacity to enjoy genital stimulation tend to make these adolescents feel even more guilty about continuing the relationship. The following statements illustrate how adolescents assume more responsibility and blame for the sexual events they describe.

— "I know it was my fault. He'd give me money and buy me something and I'd let him do it."
— "The problem with my younger sister is that she likes it."
— "I'm more developed than my younger sister. I just don't know why he went for her instead of me."
— "I got in trouble and dad said I could have 14 swats with the paddle or intercourse with him. I chose intercourse because I was not a virgin and it would be a one-time thing. But then he did it twice a week. He played tapes of him and my stepmother having intercourse to excite me and sometimes taped our intercourse too. I told my stepmother. I was crying. She said I was lying. She said he never could have intercourse with her so how could he have it with me."
— "He's been touching me sexually and tried to get in bed with me. He asks me to have sex with him and when I get angry and say no, he says, 'You wouldn't reject a boyfriend's request; why do you refuse me?' He kisses my ear and tries to get to me."

Revealing the situation is difficult for these adolescents and can be associated with pervasive feelings of disloyalty and guilt about the whole range of steps toward individuation that they are beginning to take. Accusations of incest tend to be carefully justified by the adolescent victim. Teenagers who finally decide to ask for help often feel an additional burden of guilt because they have not told earlier in the relationship.

—"He did it to me for 4 years but when I walked in and saw him doing it to my little sister, I had to tell. My older sister had his baby."
— "I can't forgive him the way mother asks me to. Too much has happened. My mother says my sister forgave him so why can't I."
— "I never wanted to hurt him. I didn't think he could take it. I never told anyone. I was afraid he couldn't take a confrontation."
— "After 5 years I finally said no and he said to me, 'Why didn't you say no in the first place if you didn't like it?' "

Necessary adolescent exercises in individuation are at times directly distorted by the incestuous relationship. For example, dating or evening rehearsals or jobs may be prohibited. The following statements describe additional examples.

— "Dad would get out of the shower with a hard-on and make me ejaculate him. I couldn't have friends spend the night because he'd come into my bedroom and talk about sex. He'd point between our legs and say, 'You know your thing there, guys are always after it.' "
— "He comes into the bathroom when I'm taking a shower."
— "He bumps into me in the living room, and he has the whole living room to walk in."

Despite their deliberately rebellious actions and critical statements, adolescents often have a significant nostalgia for the families they must shortly leave. Their fears of prematurely losing precious ties can make them vulnerable to discounting the seriousness of their complaints or to aborting efforts to stop the incest.

— "I don't know what you're planning to do with my father, but I don't want to hate him always."
— "I'm confused about why mother won't do anything. It's hard to run away to my sister's."
— "I tried to refuse him but I was raised never to say no to an adult and he was my father. I was raised to respect adults."
— "It took me a long time to become aware that I had a right to say no. The greatest fear is to lose dad's love and acceptance. I needed someone to go to."
— "I know it is true. It happened to me too, but I can't say, because I'll lose mom." (Her younger sister had alleged intercourse with the father.)
— "My head says he thought I was mom. Like mom and dad said, he had a concussion and didn't know what he was doing. In my heart I know he did it on purpose."
— "When I was small, a man looked just like my dad and got in bed with me. My parents say that's what must have happened."
— "It's okay as long as mom is happy."
— "I don't know why I ran away. I have everything I want at home."
— "I do crazy things. I threatened to cut my wrists when they told me I would have to go home."

Adolescents are already expressing worries about how the incestuous relationship will affect their success as a wife and mother.

— "I think I am gay because I have no feeling around guys."
— "I never told him I couldn't be around guys because of him."
— "I always thought I was gay. My uncle raped me to show me I wasn't gay and how much I could enjoy sex with a man."
— "I knew it was wrong, so I learned how to turn my sexual feelings off. How do I turn them back on?"
— "I hope I never have a girl child. I could never trust my husband with her. I could never trust any man."

WHAT MOTHERS SAY

Mothers in incest families resist recognizing and putting a stop to the incest and are often described as passive. However, close attention to their words shows that this passivity is a paradoxically active process. It is not that the mother has been unable to perceive what was happening; in many cases, she has become aware enough to actively flee from her own perceptions.

— "I blacked out when I heard. It happened right there in front of me and I didn't notice. My neighbor said, 'He's fondling your daughter.' Things had gotten so bad I wasn't even seeing it."
— "When my daughter started to tell me I just ran out the door. I didn't want to hear it."
— "When I first saw it, I wanted to kill myself. I prayed for God to help me."
— "When she told me last night, I just left. I didn't want to confront him."

Some of the mother's motivations for avoiding a confrontation may be stated by her quite explicitly. Fear of the perpetrator's violence and fear of losing her family are common.

— "He'd wake me up in the middle of the night, jealous. I've been like a prisoner."
— "I had another dream that he killed me. He came at me with a knife. I decided to press charges. I refuse to be threatened by him anymore."
— "He couldn't have done it. He is the best man I've ever had. He is so good to both of us.... I don't know his last name; I just met him Tuesday." (The 6-day-old daughter had been violently raped by this boyfriend.)
"I can't confront him on this, we haven't been married long enough." (This mother had just married her second sexually abusing husband.)
— "He's the best man I've ever been involved with. He helps support the family and is very good to the kids."
— "My new husband [the abuser] fills me up. I have this vision of how things can be. We're friends as well as lovers."
— "We have always been a close-knit family. I talked to my husband. I feel it wasn't all his fault. She's to blame too. I told him I'd stand beside him."

— "I can't press charges. I feel sorry for him. He is an old man."
— "I know he is molesting her but he promised me inheritance benefits." (The victimized daughter was 4.)
— "I feel powerless about finding a new house and making it on my own. . . ."
— "I could never go through dating again. I'd feel too guilty."

Other mothers describe being sexually rejected by the husband for an enviable younger rival.

— "My husband doesn't find me attractive anymore. He wants a younger girl."
— "He told me he liked her better because she is tighter. . . ."
— "Sometimes I feel like everyone is against me."

These mothers seem to be avoiding the reality of the incest in order to avoid being possessed, like the wicked queen in *Snow White*, by feelings of envy and envious rage.

Defensive techniques of denial, repression, and minimization help these mothers to disavow the necessity of confronting the incest situation.

— "I believe it was only one incident and no penetration occurred."
— "There was no intercourse." (Oral and rectal penetration had taken place.)
— "I know he wouldn't abuse his own children."
— "Yes, he abused his stepchildren, but he wouldn't do it to his own kids. He was just trying to get back at me."
—"I don't know what to believe. I don't believe it ever happened."
— "I always knew he went into our daughter's bedroom, but I thought they just stayed up all night talking."
— "He couldn't have done it; if anything, he spoils her. I've seen him in bed with her, but I didn't think anything of it since he's her dad."
— "You don't have to hate him. Hate grows too thick. I used to think he was just close to the kids." (This mother had refused to believe the first daughter who reported incest. The second daughter was impregnated by the abusive uncle.)
— "I asked my new husband and he told me he had just explained the facts of life to her. He just stepped over the bounds. I asked her not to condemn him. He just made a mistake."
— "He is just oversexed. He fondles her in the bathtub or when she changes clothes. He seems to pick on her more than the other kids. I can't let my child keep me home all the time. I feel like a prisoner." (This mother placed her 5-year-old outside of the home and remained with her husband.)

Mothers often resent it terribly when a child goes to an outsider for help, and they can be very effective at keeping their daughters from complaining.

— "We could have worked it out if she hadn't told."
— "(To the daughter) "If you bring that up again, I'll tell your father what you are saying about him."
— "If you tell anybody about what he does to you, I'll beat the hell out of you." (The abuser was her boyfriend. Her daughters were 7 and 9.)
— "So she misses me; she should have thought of that before she told."

However, the child is often driven to complain elsewhere because the mother's own protective maneuvers for the child have been so hopelessly feeble. The mother is not a good protector; in part, because her perception of the situation is so distorted by minimization; in part, because she is too afraid of her own anger to be tough; and in part, because she has so few resources.

— "He couldn't have. I never leave him alone with the kids. I couldn't trust him."
— "I told the girls to call for help if he tried to get in bed with them again. I told them to call for help. I'd wake up and he'd be out of bed. Later, I'd go look for him and he'd be in the girls' room."
— "I'm afraid of him. I try to stay late at work so I don't have to be around him. I just tell the girls to lock themselves in their bedroom." (This mother's 6- and 8-year-old daughters were being sexually abused by her 16-year-old stepson.)
— "I didn't want this to happen, but they just do what they want."

When complaints about sexual abuse can no longer be denied or suppressed, these mothers can still explain them away in various ways.

— "He attempted incest with my daughter [5 years old]. I came home and found him [the boyfriend] attempting to put his penis in her mouth. I have no intention of pressing charges because he's been in trouble ever since someone made him the subject of a voodoo plot."
— "That pest down the street told you. I think the girls mixed him up with someone else. It couldn't have been him. My daughter is sick. She needs an evaluation."
— "My sister is vicious. She put her [the daughter] up to this."
— "Her natural father sold her a bill of goods. He wants her to think I'm a bad mother." (The 11-year-old daughter had complained to her natural father about ongoing sexual abuse by the stepfather.)
— "Her father's new wife told her to say this so he could get her back."
— "I was worried about her [the daughter], but I found out all she needed was glasses. She does not need to see you now."
— "She got gonorrhea from the sheets, then she touched herself and put her fingers down her throat." (The 5-year-old daughter had oral and vaginal gonorrhea.)

One of the most effective ways for mothers to make these problems go away is to blame or disbelieve the complaining daughter. This maneuver maintains the mother's alliance with her husband, removes by displacement the mother's guilt about having chosen the husband or having failed to protect the daughter, and reduces the pressure on the mother to respond to the complaint with constructive change. The mother who focuses on the daughter's fatal seductiveness avoids fears that she is no longer attractive to her husband, while, at the same time, allowing herself to vent in a disguised way her envy of the rival daughter's attractiveness.

— "What man could have resisted a 14-year-old throwing herself at him? I understand."
— "I'd die without him. The child is emotionally disturbed. She's sick. He is so gentle. I'll choose my husband over her [the daughter] any day. She's a psychopathic liar, a sociopath. My husband is a fastidious man. He couldn't possibly be attracted to her; she's so repulsive and unclean."
— "No way I could see her with this lie standing between us. I'm on the verge of a nervous breakdown; seeing her would push me over the edge."
— "My daughters are all whores. They're a bad influence."

Mothers can use almost these same words when they blame the social worker or the therapist for the family problems. The following statements to therapists could easily have been made to daughters.

— "It's all your fault; he is innocent."
— "You people picked out names out of the phone book. You just pick out names to call." (The 6-year-old daughter had gonorrhea.)
— "You social workers are just jealous of my job. That's the reason you are taking my daughter from me."
— "I can't see any point in talking to you since you think my husband did it. No one else in the world is in a situation like ours. Any contact from you serves to upset me terribly."
— "You've got to tell me the truth."
— "Please don't leave. I'd take it out on my daughter."

During these angry storms, it can be helpful for the therapist to remember that she is bearing the brunt of blame that would otherwise be heaped on the victimized daughter.

If the therapist can weather such storms and remain in empathic contact with the mother's feelings of guilt, jealousy, rejection, isolation, and fear of her own rage, mothers can become insightful cotherapists for their families.

— "We take our anger at him out on each other."
— "The girls are spoiled. I try to discipline; then he tells me I'm a bad mother."
— "I'm the one who needs help. I don't know how to show my husband love."

WHAT FATHERS SAY

One clinical advantage of transcribing statements made by incestuous fathers is that their rationalizations seem much less plausible on paper than they do in person.

Sex education has a long history as a rationalization for incest.[9] Not only is the incest activity justified as sex education, but sexual misinformation is used to convince the child to participate. In the renaissance incest case described in Shelley's *Cenci*, the father tells his daughter that she must have intercourse with him because any child conceived between father and daughter will automatically become a saint.[10] The following statements made to victims are more recent efforts in this genre.

— "I do this because you are my second wife."
— "Let me put it in you so it won't hurt when a boyfriend puts it in you."
— "You are old enough to have a baby and I want you to do that."
— "When her baby brother was born, I wanted to keep her from hurting him so I tried to explain where babies came from."

Underlying the attempt to educate are the father's own lack of knowledge, inhibitions, and fears about sexuality.

— "After my wife had the tubal ligation, there was no point in having sex with her any more; she couldn't reproduce."
— "I know sex is wrong."
— "This is too crude for me to discuss with a woman."
— "It stopped for a while, but then she started developing. I wanted to see it. I couldn't let her develop without watching. I guess she wanted her privacy."

Achieving control of the sexual knowledge and actions of the child may compensate the father for his sense of being out of control of his own sexuality. One father said to his daughter, "I could mess with your mind and make you do anything I want you to do."

In addition to the didactic rationalizations for the incest, there are several other excuses and explanations that are heard repeatedly.

— "I must have been drinking. I don't remember."
— "I couldn't resist her because she looked so much like my wife."
— "My wife and I are sexually incompatible."
— "Penetration never took place."
— "I never knew she didn't want me to do it."
— "I never realized it hurt the kids."
— "I've been charged with this before but the child lied."
— "That kid will go to jail for perjury." (He was referring to his 9-year-old stepdaughter.)

— "We can do whatever we want to do in our own home and nobody can interfere."
— "If she wanted something—money, a bike—I'd get it for her and ask her what she'd give me for it."
— "The 11-year-old girl next door and her uncle do it every night. It's all right."

This last statement is reminiscent of the Marquis de Sade's rationalization for incest in *Eugenie de Franval*. "Is not the world full of such weaknesses? Is not this how man had to begin populating the earth? . . . Let us crush these disgusting prejudices which are hostile to happiness."[10]

Loss of control is an important aspect in the father's descriptions of the incestuous event. It is as though the fathers feel it is unfair to expect them to control their sexual impulses.

— "She came and got into bed with me naked. What could I do?"
— "She got into the bathtub with me. What could I do?"
— "She grabbed me by the balls. What could I do?"
— "If you put ten men in a room with my daughter, what do you think those ten men would do?"
— "When she started sucking on my penis, what could I do?"
— "I did what any man would have done."
— "I couldn't help it. I'm in love with her."

When fathers describe the incest event, they often seem to be describing an unfortunate but unavoidable accident.

— "I never ask her to come into the bedroom. I just leave the door open."
— "The only reason my daughter was in bed with me was because she came into the room and was feeling bad and asked me to pray for her. So I prayed for her and then asked if she'd rub my back. You see, she was already in the bed."
— "I was just trying to get her warm after her bath."
— "I wanted to save water and they couldn't get clean by themselves."
— "One of the girls was getting into the tub and she slipped on my hand."
(The father was explaining digital penetration of daughters aged 6 and 9.)

Since it is so difficult for the fathers to feel any responsibility for what has happened, they often end by attributing excessive power to the child.

— "I know it is my fault, but how did a 14-year-old get so good at it?"
(He had begun abusing her when she was nine.)
— "I never thought she would hurt me like this."
— "She is a little witch."

Many fathers are so isolated they have no one with whom to check out their assumptions and confusions about sexuality. The child is their closest companion, and she is too young to help.

— "The loneliness kills me."
— "If you want to talk about anything intimate, I think you'd better see my wife alone." (The father was speaking to a marital therapist.)
— "Loneliness is a weapon; it can destroy someone."
— "I'd sleep with any of the girls whenever there was room in the bed because I didn't want to sleep with my wife."
— "I just wanted to turn loose sexually and I did it with the wrong people."
— "I tried to forget about it but I couldn't. I wanted to talk to someone but I didn't know who to tell."

Fathers who are feeling helpless and confused can respond with indignation when others treat them as though they did something wrong or imply that someone else is the victim in the situation.

— "My wife has been cold and distant since this thing with my daughter. I don't know why."
— "My wife is jealous of me because I am close to the kids."
— "Stop picking on me."

DISCUSSION

Statements made by incest victims, by their mothers, and by their fathers make several points that are useful to the inexperienced therapist.

Children do not talk about sexuality in the same way adults do. Two-year-olds talk about hurting. Four-year-olds make cryptic, offhand comments which must be expanded with adult support. Eight-year-olds either refuse to talk or recount sexual details in a graphic, matter-of-fact way. Ten-year-olds describe dread of the sexual encounter but also feel entrapped by the father's threats and enticements. Fourteen-year-olds describe the relationship in a way that casts blame upon themselves. They feel guilty and disloyal about revealing the incest and doubly guilty because they feel they should have told earlier or resisted more effectively.

Mothers in incestuous families resist allying themselves with the complaining daughter even if she is telling the truth. The mother's fear of her husband, and her fears of losing her maternal role, her marriage, and her self-image act as powerful motivations for disbelieving the daughter, for minimizing what happened, and for blaming the daughter for the incest.

Fathers in incestuous families will resist acknowledging what they have done. They feel too isolated, confused, and out of control of their sexuality to take responsibility for their incestuous sexual activity.

More experienced therapists may find additional lessons in this material. As one examines these statements, one realizes that therapists often intervene in ways that cut off the expression of pressing anxieties.[2] It is an almost automatic response to tell a 5-year-old victim not to worry about her mother, while telling the mother not to blame the child for what happened. We tell adolescent victims that the incest was not their fault and tell fathers that they must accept responsibility for what they have done. If these simple interventions fail, it may be helpful to return to the individual's original statements and try to explore why the 5-year-old worries more about her mother than the mother allows herself to worry about the child, or to talk more about the ways in which the teenager takes on more blame for the incest than the father is able to feel. As family members perceive the meanings and the relationships that support their communications, they may then be able to use reassurance or confrontation to change them.

Reviewing family members' statements also raises developmental questions. Will the child who has experienced incest at age 4 to 8 inevitably begin to feel fearful about what happened as she enters preadolescence? Will she become guilty about the experience in adolescence? In adult victims' groups there does seem to be reversed developmental unfolding of feelings about the incest. Typically adults present with developmentally adult problems about how the incest experience is interfering with motherhood and marriage. They go on to struggle with adolescent issues of whether they were to blame for the incest and then with latency issues of whether they must continue to protect the father. Earlier memories about the incest often emerge at this point. Group members express more fear and confusion as they remember the sexual activity. Like preadolescents, they begin to criticize the mothers for being unavailable, and then, like preschoolers, they begin to feel how intensely they needed the mother. Finally, like the 2-year-olds, some women reexperience a sense of desperate hurt and vulnerability, and a need for comfort, feelings that may have been disguised for many years.

CONCLUSIONS

Social workers and therapists who are familiar with the dialogue of incest are less likely to misinterpret statements made in incestuous families. If the mother says her daughters are psychopathic liars, if the 8-year-old "victim" refuses to talk, if the 14-year-old "victim" is seductive and promiscuous, if the father denies everything, an inexperienced therapist may assume it is safe to close the case, unless she recognizes this as the type of communication that occurs in families where actual incest is a factor (see chapter 1). When the therapist begins to feel incredulous or alienated from the family, it can be helpful to attend more closely to the exact words family members are using, and to ask whether one is cutting off or discounting important communications before having fully understood them. The exact words used by family

members can often be more effective in conveying their plight to a judge or to another therapist than can diagnostic paraphrases.

REFERENCES

1. Hesse-Fink E: *Etudes sur le thème de l'inceste dans la litterature Française*. Berne, Herbert Long, 1971.
2. Watzlawick P, Beavin JH, Jackson DD: *Pragmatics of Human Communication*. New York, Norton, 1967.
3. Ekstein R: Borderline states and ego disturbances, in Sholevar GP, Benson RM, Blinder BJ (eds): *Treatment of Emotional Disorders in Children and Adolescents*. New York, Spectrum, 1980, pp 403–413.
4. Butler S: *Conspiracy of Silence: The Trauma of Incest*. San Francisco, New Glide, 1978.
5. Armstrong L: *Kiss Daddy Goodnight: A speak-Out on Incest*. New York, Pocket Books, 1979.
6. Bass E, Thornton L: *I Never Told Anyone: Writings By Women Survivors of Child Sexual Abuse*. New York, Harper & Row, 1983.
7. Jones DPH, Krugman RD: Can a three-year-old bear witness to her sexual assault and attempted murder? *Child Abuse Neglect* 10:253–258, 1986.
8. Yates, A: Should young children testify in cases of sexual abuse? *Am J Psychiatry* 144:476–480, 1987.
9. Justice B, Justice R: *The Broken Taboo: Sex in the Family*. New York, Human Sciences Press, 1979.
10. Maisch H: *Incest*. New York, Stein & Day, 1972, p 16.

7

Persecution and Grandiosity in Incest Fathers

Jean Goodwin

Parents who victimize children sometimes act in the deliberate or unconscious belief that they are solving an internal or family problem or that the victimization will lead to some kind of magical deliverance or renewal (see chapter 20).

Infanticide, for example, has been practiced as a ritual sacrifice which promises to ensure the well-being of the surviving members of the family. It was as such a sacrifice that Theseus was sent to the Minotaur. Similarly, it was said that the walls of Jericho became impregnable because the king had sacrificed his eldest and youngest sons and buried their bodies in its foundations.[1]

In other folkloric contexts, infanticide is described as a strategy for maintaining the parent's life-force intact, rather than letting it dwindle toward death as it diffuses into the life of the child. Thus, in parts of the Punjab, funeral services are held for the husband when the wife is in her fifth month of pregnancy.[2] It is this view of the economics of parental vitality that leads Hercules to massacre his wife and children[3] as his first act in his journey toward heroic immortality.

In clinical cases of infanticide, the homicidal parent often shows a mixture of persecutory and grandiose distortions, with the parents first exaggerating the unbearable hopelessness of his situation and then suddenly perceiving the child's death as a restorative, reparative solution.[4, 5]

Ritual practices and beliefs about incest show similar derivatives in persecution, grandiosity, and protective magic. In some cultures, incest is

permitted only before a battle, or before the hunting of a dangerous animal, or if one of the incest partners is ill. In these contexts the act of incest is believed to confer magical power against death.

Nabokov, in his novel *Lolita*, describes how pedophilia can produce this intoxicating illusion of invulnerability and eternal youth:

> With patience and luck I might have her [Lolita] produce eventually a nymphet with my blood in her exquisite veins, a Lolita the Second . . . indeed, the telescopy of my mind or un-mind was strong enough to see in the remoteness of time a 'viellard encore vert' . . . practicing on supremely lovely Lolita the Third the art of being a granddad.[6, 7]

In folklore, the restitutive, sacrificial similarities between the violent and the sexual victimization of children are clear. It often happens in folk tales that a single child, as in the story of Oedipus, is sacrificed both to infanticide, or attempted infanticide, and later to incest, while the parents continually assert that they are merely doing what is necessary for their own self-preservation and survival.[8] Clinical cases often make the same point that was made in the Greek tragedies:

> To long for immortality is very human. The tragedy, however, lies in the fact that when this longing is acted out in incest and the father succeeds in seducing his children and grandchildren, the result is not immortality, but rather individual suffering and the eventual destruction of the family.[7]

In this chapter, I explore the clinical importance in the genesis of overt incest, of ideas of persecution and grandiosity. A case is described in which a man persuaded his common-law wife and her two teenage daughters into an incest situation by coercively converting them to a survivalist-like belief system. The family group believed that world catastrophe would imminently destroy all men on earth except the husband-father. They practiced military drills because they believed they would someday have to defend themselves against mutants and monsters spawned by the catastrophe. On the grandiose side, however, they believed that family members would not only survive the cataclysm, but live forever and inherit the earth, and that the husband-father would eventually become God. Because of the persecutory and grandiose elements in the belief system, no one in the family had any desire to relinquish the incestuous relationships, even after incarceration forced separation and an opportunity to escape the situation.

Findings in this case are compared with two other cases in which incest was perpetrated by a paranoid father and led to a shared paranoid state with a family member.[9, 10] The psychotic and paranoid incest father, although rare, is important to recognize because of his potential for violence.[11] Some previous studies of incest fathers have reported subtle signs of paranoid ideas even in nonpsychotic fathers who seem to be well-functioning.[12, 13] If fantasies about persecution and grandiosity are present in nonpsychotic fathers and shared by other family members, this could account for some of the mother's extreme overestimation of and dependence on the incest father.[14]

This could also explain the victimized daughter's exaggerated sense of her father's power and invulnerability and her persecutory conviction that life would be even worse without father than it is with the incest. (see chapter 8).

In this analysis, the term *paranoia* is used to describe a group of thoughts and behaviors that include persecutory ideas, intense jealousy, preoccupation with violence, grandiose ideas, social isolation, energetic and complex activities, lack of guilt, and the capacity for these thoughts and behaviors to be translated into a somewhat plausible belief system which another person may share.[15] This paranoid system may or may not be accompanied by hallucinations. It occurs in many different psychiatric illnessess: the paranoid disorders, affective disorders, character disorders, toxic or organic conditions, or schizophrenia. The term *incest* is used to describe the sexual exploitation of a child by an adult in a parental role; thus "incest" will describe relationships between genetically unrelated family members as well as those occurring between first-degree relatives.

THE CASE OF FERNANDO AND RITA

Rita is a 43-year-old Hispanic woman who was arrested in a jewelry store with her daughters, aged 19 and 15, after the store owner became suspicious of the check and identification she presented. Rita later admitted she was purchasing wedding rings for her daughters as a surprise sign of obedience to her common-law husband, Fernando, aged 36, with whom she had lived for 6 years. Fernando had legally married Rita's older daughter by a first marriage (Lena) when that daughter was 15. At that time, Rita had protested the marriage so fiercely that Fernando, as he says, "had to" tie her to a chair for four days, and threaten Rita with a gun. Now Lena had just delivered a second son of Fernando's and the younger sister was pregnant by Fernando. One of Fernando's justifications for sex with the daughters was his need for progeny which Rita could not supply, having undergone a hysterectomy 10 years previously. Rita wanted to show Fernando, by purchasing wedding rings for both daughters, that she had accepted his sexual relationships with them.

The adolescent daughters were released and, 6 years later, are still at large, presumably living in remote "bomb shelters" continuing in the family belief system. Fernando, however, joined Rita in jail, after an anonymous tip had led police to the family's household cache of survivalist supplies and weapons (14,000 rounds of ammunition were found) and to the computerized system of over 100 false identities that allowed the family to finance their survivalist activities through filing claims for welfare, tax refunds, and credit cards in all these various identities. Fernando also had to finance a marijuana habit which helped him to daydream.

Fernando said that he began to daydream about preparing for the end of the world about 4 years before he met Rita, when he was tried and acquitted

for raping the 9-year-old daughter of his then girlfriend, Brenda. Fernando describes his trial for raping Brenda's child as "the destruction point of my life. Up to then I had been trying to get back into my family. After that, I just went out to the mountains to live alone." Fernando did attempt one liaison with a woman named Lily before meeting Rita. Lily left him when she became suspicious that he was sexually abusing her daughters. Fernando says, "I'm going after Lily someday and marry her and her daughters."

Rita was a more successful partner for Fernando. "I met her at a dance. . . . I noticed her because she was dancing filthily with all the men. She was acting like a whore." Shortly thereafter Fernando moved in with Rita, and within a few months was routinely and severely battering her. "When she started to drink, all she wanted to do was whore around. . . . I was so mad, I could have killed her. I'm glad I hit her. It made me happy to hit her. Through any means necessary, I cleaned her mind and body. I used to hold a gun to her head, handcuff her, and tie her up with ropes and beat her. No one will understand my methods, but my hand was guided." The beatings usually ended with Rita "making confession" to Fernando and doing "penance," usually either shaving her head or fasting for a prescribed length of time.

Fernando had never succeeded in extracting penance from the first "whore" in his life, his mother. Fernando described his mother as "a whore, and I hated her for what she did to my dad; and my dad hated me because she would tell him that I was not his son." Fernando spent his teenage years following his mother from town to town, intruding on her liaisons with men. Several of his juvenile arrests were for assaulting his mother's boyfriends.

The most severe beatings were triggered by Fernando's jealous rages. Once when Fernando saw Rita talking to another man he beat and kicked her, and then "I started to bite her all over and she started to bleed very bad. I still couldn't stop. And then she passed out and I got real scared that she was dead."

Despite Fernando's suspicions, Rita says she has been faithful to Fernando through all the years they lived together. Fernando's suspicious jealousy extended to the daughter-wives as well. "I would get my belt and whip them, too, until they would confess their sins. Even the day my son was born, I had to whip Lena."

Perhaps, because he had such painful personal experience of jealousy, Fernando was meticulous about punishing jealousy in his women. Rita said, "My daughters and I just got used to sharing him. The jealousy part is over. Every mother wants her daughters to be with her forever. One of the girls mentioned a couple of times about going out with boys, about missing it. She'll forget that."

Other family punishments included Fernando's sending mother and daughter outside into the snow for the night. Fernando made plans to kidnap Rita's third daughter, and actually did kidnap one of Rita's nephews for several months. The daughters tried to run away twice, but were recaptured by Fernando.

The benefit in this system for Rita and her daughters came in Fernando's promise of eternal life. In the years of shame and exile in the mountains, Fernando had imagined himself in daydreams as emerging someday, because of this very exile, as the only survivor from a future world disaster. "All I have to do is sit back and wait for everybody to kill each other off. I don't have to start a revolution, to be a Che Guevara or a Zapata or nothing like that. All I have to do is wait and the world is mine." World cataclysm thus became the imaginary instrument of Fernando's revenge, as well as becoming the stage on which he could demonstrate his unique powers. He had developed the conviction that he could not die out of several experiences, including several failed suicide attempts after his trial for child rape. Also, he was prevented from going to Vietnam by one of his numerous skirmishes with Marine discipline, and felt that this had kept him from being killed together with all his buddies. Fernando also felt it was a sign of being "above death" that when he was 11, his father had recovered completely from months of coma after a near-fatal accident. Fernando believed that with his gift of survival he would be the only male to survive the cataclysm. "Rita knows we are the chosen ones. Through her daughters with my seed I will repopulate the earth. I can't save any males because they are in competition with me. Only one will be saved and he will inherit the earth and become God. It will take me 500 to 1000 years to become God because now I am just beginning to learn."

While Fernando's life experiences led him to cope through persecutory inflation and displacement of blame and to fantasize himself as a righteous rescuer, Rita's life experiences had left her hopeless, depressed, and guilty—in short, most ready to confess, do penance, and be saved. Like Fernando she came from a large, poor family (nine in Fernando's sibship, 11 in Rita's). In contrast to Fernando, who was unexpectedly reprieved from suffering the death of his father, Rita as a teenager watched her mother's slow death from stomach cancer. She said, "At the end mother didn't want to live. I don't believe in cancer. I think it is very possible that I will not die.... Even if Fernando is in prison, we'd always wait for him.... We have faith." Rita's father was an alcoholic as was her first husband, now disabled because of liver cirrhosis. Rita was beaten frequently by the first husband, and in the process of leaving him became alcoholic, promiscuous, and intermittently depressed with one suicide attempt. Her guilt about leaving her husband and about her drinking was intensified when she was the driver in an auto accident in which a man was killed. It was in this state that she met Fernando, and his forced regimens of sobriety, outdoor exercise, fasts, and constant activity seemed to help Rita's depression. Rita says, "I want to get out of the crying stage. I've always been such a crybaby." Perhaps, in part, secondary to numerous head injuries suffered in alcoholic fights and car accidents, Rita's current intellectual functioning is in the dull-normal range. Rita separated once from Fernando early in their relationship, but now feels utter devotion to him and his beliefs. She says that her experiences in jail, where one of her daughters was raped, have strengthened her belief that Fernando's system

is better than society's system. She believed him when he told her they would never be caught in their criminal activities and now believes him when he says he will suppport the family by becoming heavyweight champion of the world. She tries to communicate with him telepathically as he instructs her to do in letters. "If Fernando hadn't beat me, I wouldn't have stayed with him. He gave me the discipline my father did not; my father was never around."

Fernando was diagnosed as having paranoia with cannabis dependence and sociopathic personality and Rita was found to have a shared paranoid disorder, a dysthymic disorder, and alcoholism by history.

SIMILAR CASES OF PARANOIA AND INCEST

Schreiber and Arieti described the case of Joseph Kallinger, a paranoid schizophrenic father, who went on a homicidal spree after a humiliating court appearance in which he was accused of physical abuse of the 13-year-old natural daughter with whom he was also sexually involved.[9] Like Fernando, Kallinger believed that his criminal activities would result in his becoming God. However, in Kallinger's system, this had to be achieved by his killing with knives everyone on earth, not by mere passive waiting. Like Fernando, Kallinger had been severely abused and neglected as a child. Both were told they were illegitimate. Kallinger was made to kneel on sandpaper to be beaten with a cat-o'-nine-tails. Fernando was hit in the face with a chain. Both believed themselves sexually impaired. Fernando thought he was sterile. Kallinger was told by his parents that hernia surgery at age 6 had "fixed" his penis so it would never grow or get hard. Both men were intensely and intrusively involved with their children. Both were fiercely and abusively jealous of their incest partners.

In addition to the incestuous intrusiveness with his daughter, Kallinger involved one son as his crime partner, and another son he killed and mutilated, keeping a piece of the child's penis as a trophy. The partner son became converted to Kallinger's paranoid system and shared the disorder, participating in three homicides before the pair were caught. The intrusiveness with the family alternated, however, with sudden bizarre demands for seclusiveness with Kallinger retreating into an underground shrine he had dug. Neither Fernando nor Kallinger felt guilt about their criminal activities. Unlike Fernando, who only visualized himself in daydreams, and again only with the assistance of marijuana, Kallinger had bizarre, intrusive visual and auditory hallucinations.

A third case, reported by Simonds and Glenn, describes shared paranoid disorder in a 10-year-old girl, sexually abused by a stepfather with paranoid psychosis.[11] Although in this case the father himself refused evaluation, interviews with the child and her mother revealed persecutory and grandiose

ideas similar to those described for the other two cases. This man kept his daughter, Susan, out of school because he feared the other children would beat her; he accepted it as his "duty" to marry the child. At the time of her hospitalization, Susan was hearing her stepfather's voice coming out of her thumb and armpit. This man, too, engaged in energetic and complex activities, but his were in a more legal realm, as constantly applying and reapplying for welfare and veteran's benefits. Like Kallinger, this man had basic confusions about the human body, fearing on one occasion that the daughter's influenza would turn into cancer.

It is likely that this type of paranoid father accounts for many of the incest situations that end in the father's killing himself, another family member, or the entire family and then himself.[11] (see chapter 12). This may also be the type of father that those incest victims who later develop multiple personality are trying to describe when they talk about witnessing murders and mutilations, about being locked in barns, buried in the ground up to the neck, and so forth.[16] These histories are sometimes disbelieved by therapists because the material is so reminiscent of masturbatory fantasy; it may be, however, the acted-out masturbatory fantasy of the disturbed father, rather than that of the child. Therapists also at times assume the family's fear of an incest father is based on distortion, guilt, or dependence. If the father in question has the paranoid system of a Fernando or a Kallinger, the family's fears should be taken quite seriously.[17] It may be important, also, whenever the psychiatrist diagnoses a paranoid system with violent fantasies or acting out, to enquire about the life of the children in the family.

DISCUSSION

The incest fathers described above have persecutory delusions, paranoid jealousy, a history of violence beginning with childhood victimization and going on to the victimization of their own children, grandiose delusions, social isolation and seclusiveness, a pattern of energetic and complex activities, lack of guilt, and the ability to present elements of the paranoid system convincingly in order to recruit partners. Protective service involvement tended to exacerbate the father's symptoms. Fathers were most dangerous when hallucinating.

Does this syndrome have any relevance to the findings in ordinary cases of incest? Weiner found, on psychological testing, evidence of paranoid trends in incest fathers: an acute sensitivity to minutiae in the environment, a distrust of the obvious, considerable suspiciousness, hostility to others, and the projection of hostility, and a tendency to deprecate others.[12] There were also tendencies to identify with women and children, rather than with adult males, and to use defensively a well-organized system of intellectualization and rationalization. Weiner noted the grandiose quality of these rationalizations. "Many even argue they would have been remiss as fathers had they not

engaged their daughters sexually." One of Weiner's incest fathers experienced, 2 weeks after testing, a psychotic break with extreme religiosity and thought disorder.[12] Cavallin[13] and others[18,19] have confirmed the presence of paranoid thinking, projection, and weak psychosexual identity in incest fathers even though the incidence of overt psychosis is low.

Sophocles may have been the first to describe paranoid traits in incest families.[7] Laius, the father of Oedipus, had persecutory delusions. Although Laius was the passive parent in Jocasta's liaison with Oedipus, he resembles the actively incestuous fathers described here in clinical cases. First, Laius developed the belief that he had been made impotent by the curse of King Pelops whose son he had raped; later he developed the paranoid belief that the infant Oedipus would kill him. In his paranoia, Laius felt it necessary to pierce the feet of little Oedipus so that this newborn would not crawl down from the mountain where he had been abandoned and take revenge. Part of this antipathy for the son related to the paranoid jealousy and possessiveness that Laius displayed toward Jocasta. He was afraid this helpless newborn would steal the affections of his wife. Laius had lived his life in violence, conflict, and antagonism. In childhood he had been abandoned and exiled by rivals for his throne. His sadistic rape and kidnap of King Pelops' son Chryssipus was deemed unacceptable, even in Greek society which was tolerant of homosexual acting out with boys. Laius is remarkably consistent in his violence, from his attempted infanticide of his son to his high-handed rudeness toward the stranger-son he meets on the highway and orders his charioteer and groom to kill. The grandiose delusion that motivates Laius is more difficult to discern than the persecutory ideas, but it is equally powerful. Fundamentally, Laius is committed to undo the oracle's prediction that he will die. Like Fernando and Kallinger, Laius will accept nothing short of eternal life and engages in complex energetic activities to attain this unattainable goal. Like them, too, Laius is seclusive and isolated. Jocasta must intoxicate and seduce Laius to achieve the single intercourse that produces the conception of Oedipus. Like so many fathers in incest families, Laius is threatened by his wife and has a poor sexual relationship.[14] Laius is also incapable of guilt, which he parries with deft shifting of blame and projection of hostility. Laius orders the infanticide of his son in typical blame-shifting fashion, saying, "Jocasta, hand the baby to the servant for the mountain to dispose of."[7] It is no wonder that by the end of the story, Jocasta assumes she must be to blame for everything and kills herself (see chapter 12). Oedipus, too, is taken in by his father's paranoid system. He never questions the grandiose and persecutory assumption that his father truly would live forever if only Oedipus would get out of his way and stop being such a danger. Oedipus assumes, too, that fathering himself is his own rightful task, rather than the failed job of Laius. Oedipus is ever reluctant to ask for, or accept, help or advice from substitute fathers like Tiresias. Oedipus, also, despite himself, acts to complete the interrupted infanticide

on which Laius had determined, gouging out his own eyes and cursing his own sons.

RECOMMENDATIONS

The following checklist is designed to help the therapist identify elements of what Ross[7] has called "the Laius complex" in incest families. Depending on the structure of the father's ego, these persecutory and grandiose fantasy structures may appear as hallucinations (Kallinger); as acted out, narcissistically restorative daydreams (Fernando); or they may be dissociated or repressed and denied.

1. Is the father feeling persecuted?

The father may feel persecuted by the seductiveness of the incest victim or by the disloyalty of the victim or other family member who broke the incest secret. He may also feel frightened and victimized by an illness in the family or by his wife's pregnancy, hysterectomy, or menopausal changes, or by the victim's normal pubertal changes which can feel confusing and terribly upsetting to the father who has never gained control over his own postpubertal body.

2. Is the father tormented by jealousy?

The father may be envious of his daughter's youth, and of her female sex role which seems so much easier than his own patriarchal role. The father may be jealous of the daughter's relationship with the mother, which may be much closer to the symbiotic comradeship that he yearns for than he finds in his own sexual relationship with his wife. The incest may serve at once to destroy this envied mother-daughter relationship and to make it the father's own. The father's interference with the daughter's relationships with girlfriends and boyfriends may similarly function to preserve the father from the unbearable feelings of jealousy he would experience in witnessing his daughter in the longed-for relationships that he feels have been denied to him because of male gender, but that are actually deficient because of childhood neglect.

3. What is the father's violence history?

One needs routinely to ask about neglect and physical and sexual abuse in childhood, physical fights, weapons, juvenile, criminal, and military records, wife-battering, and bizarre forms of family discipline. The severely disturbed paranoid father may have fantasies of complex murder-suicide of family members, and fantasies of mutilation or cannibalism. Lord Raglan has hypothesized that the primordial magical ritual may have involved the killing, dismemberment, and cannibalism of a child of incest.[20] The most psychotic of the clinical cases seem to approach this primordial prescription.

4. Are there grandiose ideas underlying the father's rationalizations of the incest?

Does the father consider himself, as many kings and emperors have in

the past, somehow above the incest rule? Is the incest part of a paranoid plan to "perfect" the child victim? Is the father's role of family rescuer based on reality or based on living out internal fantasies which cast him in this role?

5. How socially isolated and seclusive is the father?

Therapists familiar with the incest family will ask about lack of intimacy in the marital relationship, rules against the children visiting with friends, and paucity of family social ties. One must also inquire about unreasonable demands that the father may make for privacy which may stand in contrast to the general family policy he enforces of intrusive, symbiotic relatedness.

6. Is there a paranoid quality to the father's energetic and complex activities?

Therapists may be so relieved at identifying the father as the most effective person in the incest family that they may not be alert for a driven, primitive quality in the father's activity. Many of these fathers, like Kallinger, are very involved in the child's school and activities, but the involvement proceeds not from a solid developmental base in generativity, but from the persecutory and grandiose ideas and fantasies that have led to the incest. For Kallinger this was the kind of relatedness that demanded a helpless, mindless, or ultimately a dead child partner[2,9] Activities of the father, which at first seem unrelated to maintaining the incest relationship, such as founding a new church or building a new house, may in treatment prove to be part of a complex system of rationalization and facilitation of the incest situation. In one case, the father's new church isolated the daughter victim from anyone who might believe her incest story. In another case, the new house the father built was designed to allow him access to the children's rooms.

7. Is the father capable of acknowledging guilt?

The father's tactics for shifting and denying blame may be subtle and successful (see chapter 6). Repeated confrontation with reality in small doses may come to be the most workable mode of therapeutic communication.

8. Have other family members accepted the father's persecutory and grandiose ideas?

Children and mother may come to believe that the father, because of the specialness of his person and situation, is justified in making sexual demands and exerting tyrannical control. When child victims protect the perpetrator, they may be doing more than identifying with the aggressor. They may be acting within a paranoid belief system in which continuing the incest is seen as the only option.[21,22] Those families in which incest continues well into the adulthood of the child partner, in which the mother actively participates in the sexual abuse, or in which incest progeny are sought and welcomed by the family, are likely to show elements of shared paranoid disorder[23] (see chapter 14).

9. How close is the father to a paranoid, substance abuse, or violent decompensation?

Fathers faced with the humiliation of disclosure and left in unsupported isolation may strain their paranoid defenses beyond their limits. The case

of Kallinger is instructive. Here the paranoid father was told by a judge, after the embarrassment and public exposure of the child abuse case, that he had to go back home and support his family. The only way he could manage this task was by embarking on the massacre of mankind. Fathers in an incest situation need treatment in an authoritative reality-oriented system with goals, rules, and a conscience, with safe, supportive relationships, with predictable consequences and prescribed protective maneuvers, if they are to build a substitute for the previous magical system.

REFERENCES

1. Montag BA, Montag TW: Infanticide: A historical perspective. *Minn Med* 62:368, 1978.
2. Tarachow S: Judas, the beloved executioner, in Colterera J (ed): *Lives, Events and Other Players: Directions in Psychobiography.* New York, Jason Aronson, 1979.
3. Muslin H: On the resistances to parenthood. Read before the Michael Reese Hospital Department of Psychiatry Conference on Parenting as an Adult Experience, Chicago, March 7–8, 1980.
4. Goodwin J, Harris D: Suicide in pregnancy: The Hedda Gabler syndrome. *Suicide Life Threat Behav* 9:105, 1979.
5. Goodwin J; The meaning and the madness in the method of suicide in pregnancy, in Kleiner GJ, Greston WM (eds): *Suicide in Pregnancy.* Litteton, Mass, PSG Publishing Co, 1984, pp 9–13.
6. Nabokov V: *Lolita.* New York, Crest Books, 1959.
7. Cooper I, Cormier BM: Intergenerational transmission of incest. *Can J Psychiatry* 27:231, 1982.
8. Ross JM; Oedipus revisited: Laius and the "Laius complex." *Psychoanal Study Child* 37:169, 1982.
9. Schreiber F, Arieti S; Multiple murders of a schizophrenic patient: A psychodynamic interpretation. *J Am Acad Psychoanal* 9:501, 1981.
10. Simonds JF, Glenn T: Folie a deux in a child. *J Autism Childhood Schiz* 6:61, 1976.
11. Ginsberg EL, Hebeler J; Counter-violence counseling in incest. Read before the Third International Congress on Child Abuse and Neglect. Amsterdam, April 21–25, 1981.
12. Weiner IB; Father-daughter incest: A clinical report. *Psychol Q* 36:607, 1962.
13. Cavallin H; Incestuous fathers: A clinical report. *Am J Psychiatry* 122:1132, 1966.
14. Goodwin J: Helping the child who reports incest: A case review, in Goodwin J (ed): *Sexual Abuse: Incest Victims and Their Families.* Littleton, Mass, PSG Publishing Co, 1982, pp 1–16.
15. *Diagnostic and Statistical Manual of Mental Disorders*, ed 3, revised. Washington, DC, American Psychiatric Association, 1987.
16. Saltman V, Solomon RS: Incest and the multiple personality. *Psychol Rep* 50:1127, 1982.
17. Goodwin J, Cormier L, Owen J: Grandfather-grandaughter incest: A trigenerational view. *Child Abuse Neglect* 7:163–170, 1983.
18. Sahd D: Psychological assessment of sexually abusing families and treatment implications, in Holder W (ed): *Sexual Abuse in Children,* Englewood Colo, American Humane Association, 1980, pp 71–86.
19. Kirkland KD, Bauer CA: MMPI traits of incestuous fathers. *J Clin Psychol* 38:645, 1982.

20. Lord Raglan: "*Jocasta's Crime: An Anthropological Study.*" London, Methuen, 1933.
21. Greenberg H: Crime and folie a deux: A review and case history. *J Ment Sci* 102:772, 1956.
22. Gralnick A: Folie a deux: The psychosis of association. *Psychiat Q* 16:230, 1942.
23. Goodwin J, DiVasto P: Mother-daughter incest. *Child Abuse Neglect* 3:953–1979.

8

Incest from Infancy to Adulthood: A Developmental Approach to Victims and Families

Jean Goodwin
John Owen

Part of the difficulty in developing a unified approach to the treatment of incest is the wide variation in the needs of the victimized child and her family depending on her developmental age. This chapter reviews for each developmental stage—infancy, preschool, latency, adolescence, and adulthood—the type of sexual abuse seen most commonly; the physical, emotional, and family symptoms seen most often; and the kinds of interventions which tend to be most helpful.

In our experience the developmental approach is important in the treatment of the parents and of the entire family, as well as in the individual treatment of the child victim. Development itself produces specific crises in parents, in the marriage, and in the family. In any family a daughter's entry into the oedipal stage will tax the father's ability to develop a warm relationship with his daughter and the mother's ability to cope with triangles, and with competition. However, if the mother feels that she lost her own mother irretrievably during her own oedipal conflict, her child's entry into the oedipal stage may become a more serious crisis.[1] Sensitive help to such parents can offer them the opportunity to rectify their own developmental failures as they allow the child to progress.[2]

When, as in the incest situation, family crisis is added to the child's and the parents' current developmental crises, there is potential for great disorganization, but also for significant growth in the family.

THE INCEST VICTIM FROM INFANCY TO AGE FOUR YEARS

In infants who have no language as yet, the substantiation of sexual abuse can be difficult indeed. It is an important diagnosis to make, however, because one death has been reported in an infant who was suffocated when the perpetrator attempted fellatio.[3] The following is a case example.

Case 1 A paranoid schizophrenic and alcoholic man and his passive-dependent wife had had ten of their 12 children removed from the home because of sexual and physical abuse. Protective services were asked to investigate what was happening to the couple's new infant daughter. The parents responded angrily to requests for a family interview and for physical examination of the infant. On interview the father hugged and kissed the infant passionately while displaying an obvious erection. On physical examination there was redness around the infant's vulva and anal area. The family's overwhelming concern was to protect the parents, and especially the father, from interference and harassment by "agencies." Neither the mother nor the two adult cousins living in the home had a commitment to protect this infant. An older daughter who had been adopted into another home because of sexual abuse said that her sexual experience with her father had begun before she could remember, and that she had observed her father sexually abusing younger siblings when they were infants and toddlers.

Although this kind of evidence would not have been adequate to substantiate sexual abuse in an older victim, it was felt that in a 6-month-old infant no more conclusive evidence could be expected.

Incest victims between 1 and 4 years of age often present with loss of toilet training, sleep disturbances, fear of men, or with excessive clinging to the mother. They have usually made a communication about having been "bothered" sexually; vulvar reddening may be the only physical evidence of what happened.

Brant and Herzog[4] have described several cases in which toddlers from ages 1 to 3 have been able to communicate a sexual abuse incident. In one case the older sisters of a 2½-year-old boy described how he had been sexually abused by their mother's boyfriends. This boy was usually withdrawn, frightened, and watchful, but displayed outbursts of inappropriate sexual behavior such as jumping into the psychiatrist's lap and fondling his genitals. At one point, this 2-year-old startled a nurse on the pediatrics ward by asking her if she "wanted some cock." This child was able to return to superior functioning after living in a foster home for 6 months. A second 2-year-old was able to complain to her mother about sexual abuse, pointing to her perineal area and saying, "Joe stick bum-bum." When the mother examined the child, she found vulvar redness and irritation. For several weeks after her report, the child became anxious around male strangers. She also became more clinging than usual with her mother, slept restlessly, and had a poor appetite. Play with dolls in a therapeutic setting clarified the identity of Joe who turned out to be a male day-care worker.

Brant and Herzog concluded that toddlers are able to complain about sexual abuse, that their complaints should be taken seriously, and that techniques of physical examination and of play therapy can be helpful in this age group.[4] Our own experience confirms that children aged 2 and 3 can be fairly effective in complaining about sexual abuse. One 2-year-old on a routine visit to her pediatrician pointed to her genital area and then to her mouth, and said the words, "Ya-ya ... Daddy." The pediatrician took this cryptic statement seriously enough to examine the child, and found a severe perianal bruise consistent with attempted penetration. Another 2-year-old said, "Daddy hurts my pee-pee." Three-year-olds are able to make complex and even poetic statements about what has happened. A 3-year-old boy said, "A man crawled on top of me and he had a big potato." A 3-year-old girl said, "Daddy gets on top of me and pulls my panties down."

Decisions about where the infant or toddler will be placed must be made swiftly. Institutional or temporary environments are not appropriate for the care of these young children. If the young child returns home, it must be in the context of intensive work with the parents. Gebhard's work also indicates that incest offenders who molest children under 12 are more likely to have alcoholism, sociopathy, and other psychiatric diagnoses.[5] If the mother cannot sever her relationship with the disturbed perpetrator, it may be necessary to place the child in preadoptive foster care with a view to termination of paternal rights.[6] Mothers of victims in this age group, despite showing some signs of the passivity characteristic of many mothers in incest families, have been uncharacteristically willing to separate from the abusive male and to actively participate in the treatment plan for their daughters.

Very brief (two to eight sessions) play therapy is often entirely successful in removing emotional symptoms in toddlers who have been sexually abused. Play therapy can take place at a therapeutic preschool which both mother and child attend. A typical set of goals for play therapy with a 3-year-old would be: (1) to help the child express her anger toward the perpetrator, (2) to help her say goodbye to him (he has usually left precipitously and dramatically), and (3) to resolve the child's anxiety enough so that symptoms resolve, for example, she can return to sleeping in her own bed. If problems recur in the family, the very young child is likely to signal this by developing a recurrence of symptoms or a developmental delay.[6]

THE PRESCHOOL OR OEDIPAL-AGE CHILD

Not surprisingly to those who have read Freud, some of the most difficult clinical situations arise when incest is revealed in a child aged 4, 5, or 6 years. Often, it is a physical complaint such as a pharyngeal gonorrheal infection or a vaginal discharge secondary to finger penetration that brings

the family into treatment, not a spoken complaint from the child. Children in this age group may require surgical repair if vaginal intercourse has been attempted.

When incest presents at this age, the child's warm attachment to the perpetrator, the child's alienation from her mother, and the serious marital difficulties between the parents are clear. The child feels terribly guilty and utterly cut off from her mother. She may act the wild child because she has given up hope of making anyone love her. Individual therapy for the child may give her a first opportunity to feel that she is important in her own right, not only as a pawn in the ongoing battles between her parents. Compulsive cleaning and repetitive symbolic destruction of both parents are important play sequences, as shown in the following case.

Case 2 Five-year-old Sandy was diagnosed by her pediatrician as having pharyngeal gonorrhea. Despite repeated telephone contacts from the physician and the public health department her parents failed to bring her back for follow-up medical care. The case was referred to child protective services because of medical neglect, and Sandy was placed temporarily with grandparents. On psychological evaluation, she drew pictures that showed her sucking on her father's penis. Sandy had been overactive in preschool, unable to concentrate well, or to share or cooperate with the other children. These problems cleared after she was placed with her grandparents. Both parents vehemently denied that sexual contact had occurred and were outraged and indignant about the placement, but neither took any action to comply with the legal and medical appointments that were required. Sandy's placement with her grandparents became permanent. In therapy Sandy constantly repeated play sequences in which fathers and children undressed and, after that, the father was somehow killed.

Characteristically, the mothers in these families are terribly angry. They may be in a literal rage at the husband for having betrayed them, and divorce is a frequent outcome. The mothers may be openly rageful with the daughter as well. The mother will often react to the daughter's eager attachment to a woman therapist or to a foster mother with jealousy and increased withdrawal of affection, as if this were yet a further betrayal. The mother's rage at the child's attachments is defensive against her own guilty conviction that it is her own sexual sins that have precipitated the disastrous losses she is experiencing.

Marital therapy is important, even though this will often end as divorce therapy. In either case marital therapy should focus on the parents' responsibility to settle their battles without involving the child and to spare some of their energies for the care of the child. The child must often be removed from the home until this work can be completed.

The following cases illustrate some of the difficulties involved in working with these angry and rejecting mothers and with the more nurturing, but often destructive, fathers.

Case 3 Sherry, aged 5 years, had been in a sexual relationship with her natural father which included vulvar fondling and finger penetration of the vagina. Her father was genuinely attached to Sherry, upset by what had hap-

pened, and was very eager for treatment. However, Sherry's mother was absolutely unforgiving of the father and was determined "to put it all behind me." Marital therapy ended in divorce counseling, and Sherry's mother took the child to live in another state, refusing a recommendation that the child's play therapy continue.

Case 4 Six-year-old Maria was referred to child protective services because of physical neglect. Maria's mother had become depressed after the death of her father and had ceased to care for the child. Further investigation showed that Maria's mother had been living in an incestuous relationship with her father for many years and that Maria was the child of this incestuous relationship. Maria described mutual oral-genital stimulation with her father/grandfather. Maria was having violent tantrums which her mother could not control. These cleared after the child was placed in a foster home, except when they occurred immediately after visits from her mother. Maria's mother was hostile to caseworkers and therapists and finally ceased visiting her daughter.

In both of these cases the daughter's attachment to her father was her major source of nurturance. Unfortunately, in our experience incest in the oedipal stage effectively ruptures this father-daughter relationship. As with the victims under 4, we have had difficulty trying to reunite families in which the victim is between 4 and 7 years old. The mothers feel they must choose either the daughter or the father. In other jurisdictions where fathers are routinely prosecuted, the prognosis for family reunion may be better if the legal process provides more barriers to the parents' attempting to flee treatment and to flee their guilt about what has happened.

THE LATENCY-AGE VICTIM

The majority of children who complain of sexual abuse are of latency age.[7] In our program the modal age of the reporting child is 10. Most are in late latency, the period from age 9 to 12, when the defense mechanisms of latency are fully elaborated.[8] The suppression of sexuality that is characteristic of latency accounts for much of the difficulty these girls have in talking about the sexual abuse. Cognitively, they have a good grasp of the reality and sequencing of events, but their embarrassment about sexual topics may lead them to describe events in a forcedly brazen way, in a dissociated or silly way, or to refuse to talk about them at all. Because of the importance of fantasy as a defense, the therapist must as soon as possible allow children of this age to speak metaphorically rather than directly about what happened. Dreams are important, as are drawings and play sequences. Successful therapy is characterized by the rapid transformation of the sexual trauma into fantasy play which can be translated into reality by the child when necessary. Well-defended children of this age will persistently and appropriately refuse therapeutic attempts to "let it all out." However, some of these children demonstrate a determined preoccupation with bringing the perpetrator to justice. They will tell their story patiently and repeatedly in the interests of "making things right" and of ensuring that the perpetrator is fairly punished.

Latency is the age of industry, and a detailed history of school activities

and hobbies is critical in the evaluation. A recent decline in grades is a common finding, as is school refusal, or the abandonment of a sport or musical activity. One of the first priorities of therapy should be the restoration of normal performance at school. Therapy, whether group or individual, will be most successful when it can be described as "learning something" or "doing something." For example, sexuality can be broached by a physician as part of "sex education" with children who otherwise refuse to speak about the sexual abuse. Even if the family refuses treatment, much can be accomplished with the latency-age girl through school-related activities and relationships. The school counselor, the Girl Scout leader, the special education teacher, can do much of the therapeutic work.

The latency-age child, regardless of how bleak the reality of family life, will idealize her home and family, and will be terrified of losing her place there. There often will be recurrent nightmares about death and separation, or phobias about either leaving the house or being trapped inside the house. She will inevitably see her parents as more powerful than they are, and putting the parents into realistic perspective will be one of the continuing tasks of therapy. The issue of confidentiality must always be clarified with the late-latency child who is trying to differentiate herself from her family without losing her secure place there. The therapist should explain to the child that the details of the child's play sessions are confidential, but that the therapist will be available to answer parents' questions, and that the therapist will let the child know before speaking with the parents.

Children in late latency seek out role models of the same sex, and it usually makes sense for therapy to follow this line of least resistance. For example, older sisters, especially if they were victimized too, can be helpfully involved in the therapy. Volunteers who were incest victims in childhood can also be helpful. Groups of late-latency incest victims have worked well under male-female coleaders. This system allows the girls to explore, and to relate to a healthy reality, their fantasies about how a grown-up man and woman relate to each other.[9]

On physical examination, many of the children over 9 years old will have the absent hymen and widened vaginal canal characteristic of repeated intercourse. Somatic symptoms are common in this age group, and are often the first sign of a serious depression secondary to the separation from home that is sometimes necessary after incest is reported.

The following case illustrates the pattern:

Case 5 Jamie, aged 11 years, was removed from her large, chaotic family because she had been having sexual intercourse with her father since age 8. Her family left the state after she reported incest. Physical examination was consistent with regular and repeated intercourse. Jamie did not talk about the sexual abuse, and said she could not talk about it with anyone except the police. She thinks a lot about testifying against her father. She daydreams that she and her siblings will be reunited someday in a foster home in the country. She has a recurring nightmare that her parents' car goes over the edge of a

cliff. Her youngest sister is killed, and Jamie is crying, but her father says, "There's no need to cry. We never loved her anyway." Jamie often complains of pain in her stomach, chest, and head. She has been enuretic at night and has refused school saying, "I'll go back to school when everything is settled." She had straight As in school until the previous semester when she got a D in physical education because she refused to dress out. After that, she became afraid that she would fail and began to be truant. Play therapy was begun; Jamie was given practice in testifying, and she was sent back to school with special tutoring in those subjects she was afraid of failing.

The next case shows how a less symptomatic latency-age child still manifests preoccupations with school and with loss, fantasizes extensively as a defense, and may develop somatic symptoms when stressed.

Case 6 Connie is a 9-year-old referred by her pediatrician because of pharyngeal and anal gonorrhea. She described a 3-year relationship with her natural father which began after her parents divorced; she visited her father on school holidays. Physical examination showed small tears around the anal sphincter characteristic of anal intercourse; the hymen was intact. Her father is an alcoholic who had been jailed for incest at the time of the interview. In the playroom Connie played with soldiers who kept getting eaten by a crocodile. She said she has dreams about green slimy animals who sneak up and try to eat her. She commented about the dollhouse, "There are not enough rooms," and put all the child dolls outside of the house. She daydreams about camping trips.

A year before she had told a 7-year-old school classmate about the forced sexual activity with her father. She and her friend had made plans to run away. They collected a tent, cooking pans, and other camping equipment in a vacant lot near the school. The teacher found them doing homework in the tent, about 2 hours after school dismissal, when the mothers reported that they had not returned home. The children were planning to attend school during the day and do yard work in the afternoons to pay for food. Her mother scolded Connie for running away saying, "You might have been raped." She has frequent sore throats, and is afraid she will never have children "because of the things that have happened." Connie said she did not want to talk about the sexual things her father did because "I don't like to talk about things; I like to do things."

THE ADOLESCENT VICTIM

The adolescent incest victim typically presents with runaways, promiscuity, or suicide attempts.[10] The mood swings of adolescence make great demands on the therapist who may find the adolescent "fine" and uninterested in discussing anything during the treatment hour, but attempting suicide later that evening. Some adolescents will have decided to leave the home but may still be struggling with guilt about leaving. This conflict may become manifest in multiple unsuccessful placements. One 15-year-old victim went through 13 different placements in the first year after she reported sexual abuse. Group therapy is helpful for victims who have weathered the acting-out phase of their reaction. Unlike the latency-age victims, the adolescent victim will want to explore the sexual details of the incest and her feelings about the perpetrator.

An understanding general practitioner can be invaluable in helping such adolescents deal with dating, birth control, rape prevention, drug use and abuse, and somatic symptoms (see chapter 1). The incest pregnancy is a particularly tragic complication in this age group (see chapter 12).

When one sees two victims of different ages in the same family, the developmental differencs become apparent. The following case was a clear example.

Case 7 Dorothy, aged 11 years, has had poor school attendance since her mother was diagnosed as having a potentially fatal collagen disease. "I wouldn't mind the school work if I could do it at home. One reason I ditch school is to take care of my mother. Is there any way to treat that disease she has?" Her school performance has improved since she revealed the ongoing sexual abuse with her stepfather. "In court I'll say he's mean, a drunk, and powerful with hits. He thought I was asleep the whole time he had his finger in me. My mom doesn't want me to testify, but he didn't do anything to her. I want everyone there when I testify." Dorothy fantasizes that a ghost lives in her room and watches over her. She is having nightmares which she described and about which she drew detailed pictures. She is extensively involved in church activities.

Dorothy's sister Joan is 14. She is on probation for curfew violation and is sexually active with many boyfriends. "My mom really does try to be a mother. She doesn't have close friends, and her temper gets out of hand. She's overworried by this court thing." About the sexual abuse: "He said, 'Lie down on the couch' and, like a fool, I did. I guess he was just horny. My mom wasn't enough for him. He was cruel to mom. I could hear her scream in bed. I don't want to marry or have children. Married people fight. I don't really like sex but I do it anyway. It's confusing. I'm really a shy person and I get embarrassed easily." Joan complains of insomnia. She has a best friend.

Wheras the preadolescent sister was oriented toward school, church, and the idealized relationship with her mother, the adolescent sister is oriented toward peers and sees her parents in a deflatingly realistic light. The preadolescent is symptomatic at school; the adolescent violates rules and sexually misbehaves. The preadolescent communicates through fantasy and dreams. The adolescent talks directly about feelings and about sexuality.

The teenage victim has usually found some strategies for resisting the sexual abuse, and parents can often be overwhelmed even by a token resistance. The parent's distress can make it easier for the therapist to empathize with the abusive father of an adolescent. The father, who for years has been quietly getting away with the sexual relationship and who has not had to contribute much to the actual parenting of the child, now finds many chickens coming home to roost. The following are quotes from a 14-year-old who had been sexually abused since age 9 but who had only recently begun to resist.

A couple of months ago is when I started turning him down all the time. I was used to it when I was young. It didn't bother me. Then lately I thought maybe I was going crazy. I would get mad and cuss and hit the pillows and cry. I told him I hated him for what he's been doing to me. I feel like he owes me everything to make it up. After I told my grandmother, he promised me

he would never do it again. Then he did it again, so I called the police. My father said, "It was her fault, too." That was when I told everyone in the family that I had called the police because I couldn't trust him. My dad can't keep his word. He's an alcoholic; he is not successful at working and he's not successful as a father.

This adolescent described her mother in similarly unflattering terms, "Mother has to get her way, so she makes up fake headaches. I have learned not to be like her." In this case the parents could not tolerate the strengths emerging in their child and asked the grandmother to take custody.

The following case illustrates how one family was able to adapt to sexual abuse when it occurred in late latency but how that adjustment crumbled as the children became adolescents. This family also illustrates the chaos that can result when two adolescent incest victims attempt to live in the same household. The two victimized daughters can seem almost to be competing to see which one can exact the worst punishment and extract the most attention from the no longer idealized parents; in another such family this competition culminated when one of the daughters burned down the family home.

Case 8 Mrs Connor has been married 4 times and her two daughters are now 15 and 14. The 14-year-old, Linda, reported a 6-year sexual relationship with her stepfather when Mrs Connor returned to him after a marital separation. Three years earlier the older girl, Carol, then 12, had reported sexual abuse. Carol had said that her stepfather told her to take off her clothes, and that he then made her lie on top of him while he sang *Rock-a-Bye Baby* and put his finger into her vagina. On that occasion the younger sister, then 11, denied that anything sexual had happened to her. Mrs Connor said that Carol was lying and should be put into a foster home to teach her a lesson. Mr Connor said that perhaps his hand had slipped and he had touched Carol "where I shouldn't" but that everything was innocent. Carol retracted her accusation at that time.

Three years later, at the time of Linda's adolescent accusation, both girls had been expelled from school because of truancy. Carol experienced episodes when she spoke only in baby talk and hit herself compulsively. Linda had run away from home several times and had attempted suicide. Fighting had become constant between Linda, Carol, and their mother. Mrs Connor's denial of the incest broke down when she joined a group of other mothers from sexual abuse families. After an episode of amnesia in the group, she revealed a system of five different personalities that she had used since adolescence "to keep myself together." She also revealed that she had herself been an incest victim. Mr Connor gained enough support from a fathers' group to admit what he had done sexually with his stepdaughters. Physical and psychological examination showed that frontal lobe problems and impaired liver function had developed secondary to his chronic alcoholism. Both adolescents had to be placed in separate therapeutic group homes; the parents decided to divorce. It seemed that even with support this family no longer had the energy to resolve the many problems that had developed.

It is possible that, had this family come into treatment at the time of the first referral when the girls were still preadolescent, the mutual investment in family that characterizes the latency stage would have made it possible to work toward keeping the family together. Three years later the additional

years of trauma, disillusion, and symptom formation, and the development of an adolescent focus on identity had acted to transform the feasible treatment goal into helping family members to terminate their relationships with one another in order to seek individual fulfillment.

THE ADULT VICTIM

Most therapists have treated women who report prior incest experiences; such women comprise 5% to 20% of psychiatric outpatients.[11] However, many therapists forget to ask if the sexual relationship is continuing. If asked, some adult patients will describe being fondled by the father, being undressed by the father, or even continuing to have intercourse with the father during family visits. We have even seen one case where it was the adult daughter who had become the tyrant of the relationship, threatening her father with exposure or with physical abuse if he tried to avoid her sexual advances.

Like adolescent victims, adult victims will present with suicidal depression or with sexual problems, usually at a time when these symptoms are threatening an important relationship such as the marital bond. About one third of women who have been raped multiple times are prior incest victims.[12] The realization that they are not able to protect themselves sexually may bring some women to treatment. Parenting is the major additional stress in the developmental lives of these adults. New presenting complaints are fears that they might harm their own child, fears that the father might sexually abuse his grandchild, fears that the extended family will never be a normal one because of all the secrets still present. The therapist needs to recognize the validity of these fears and to help the victim to take responsible self-protective action. It is therapeutic as well as legally sound for the therapist to insist on making a protective service referral if the perpetrator is living with minor children. The therapist may be found liable for damages if a child is sexually abused by the identified perpetrator after the therapist decides not to report.[13]

Group therapy is helpful and should focus on (1) abreacting aspects of the traumatic experience, (2) dispelling guilt by reviewing the experience from a shared adult point of view, and (3) clarifying moments in current situations when the woman responds as she did in the incest situation. Many women use these groups to design action plans to resolve their incest experience: confronting the perpetrator, confronting the mother, telling a spouse or a sibling about what happened.[14] Women seem relieved when they can bring to bear on the childhood trauma the tools of their maturity—autonomous rational thinking, decision making, and responsibility taking.

The following case illustrates some of the developmental issues that are important in adulthood.

Case 9 Roxanne is a 23-year-old housewife, 3 months pregnant with her second child. She was referred to a psychiatrist by her obstetrician because "things from my past are bothering me to the point where I don't want the baby."

Roxanne's father began fondling her when she was 3 years old. Intercourse began when she was 7. When she was 15, she and her older sister went to the police with their complaint of sexual abuse. Their mother, who has a chronic physical problem, refused to believe them and testified in court against them. Roxanne's father was acquitted. The father reacted with anger when Roxanne married at 17. One year later he and his wife divorced. At that point, the father began visiting Roxanne while her husband was at work. "He helped me with my first baby a lot. My father puts me on a pedestal in a way." Intercourse resumed. Roxanne says she is certain that it is her husband who fathered this pregnancy, but she is deeply ambivalent about having the baby. She has now told her husband about the incest. Although she now finds sex with her father intolerable, she is not certain she can stop it.

In the history of this adult victim one finds echoes of all the earlier developmental problems: (1) toddler—"I was a mean baby. I wet my bed, walked in my sleep, and had temper tantrums;" (2) preschool—"Now mother blames me for what happened with my dad. I resented her not being there for us, but I wanted to protect her from being hurt too. Maybe the divorce was my fault;" (3) latency—"I was not a good student; I was only interested in arts and crafts;" (4) adolescence—"I didn't have too many female friends. I had boyfriends my dad didn't know about. I slept around a lot until finally I got gonorrhea." Coming after all these unresolved conflicts, the possibly incestuous pregnancy presented conflicts around generativity that could not be untangled without psychotherapy.

CONCLUSIONS

Depending on her developmental stage, the incest victim will present with different constellations of medical and psychological symptoms, and the physician's concerns and interventions will be different. The child under 4 will present with clinging and fears, and a communicated complaint about the assailant. The physician should examine the perineal area for redness and irritation due to penile rubbing. The assailant will often be absent, severely disturbed, or otherwise unavailable for treatment. However, the mothers are usually very willing to become involved in a therapeutic play school or in play therapy with the child.

The oedipal-age child may present with severe medical complications of incest such as gonorrhea or perineal injury, with tantrums, or with parental neglect. The physician needs to focus on decreasing the child's guilt and on helping the parents to sort out their marital difficulties so they can respond to their child's needs for care. The fathers feel so guilty they often literally flee the situation, and the mothers may flee the child by rejecting her. Long-term play therapy and long-term placement of the child with a nonhostile relative should be considered.

The latency-age child presents with school problems, somatic complaints, phobias, and fears of losing her comfortable place in the family. These children have the cognitive skills necessary to describe the sexual abuse, but are resistant to doing so except in fantasy play. With the exception of very disturbed

families, parents and children are committed to each other and are willing to do therapeutic work to stay together.

Adolescent incest victims present with runaways, suicide attempts, sexual acting out, and other behavioral problems. They use therapy to talk in a very direct way about sexuality and feelings. They are actively involved in the process of leaving home, and parents may need to work on their own individuation skills in order to allow the adolescent to become strong enough to leave them. The physician needs to ask about fears of incest pregnancy and to provide sex education and sex counseling in many areas. The therapist should be prepared for crises, especially if there are two or more adolescent incest victims in a single family. In family therapy it is often helpful to break the family into subunits or to ask individual family members to work in separate therapy groups in order to sharpen the focus on individuation and differentiation.

In the adult incest victims, problems around parenting and other aspects of generativity are important. The therapist should take seriously a victim's concern that the former perpetrator will find new victims in a new generation of granddaughters or nieces. It is prudent to ask if an adult complaining of prior incest continues to be unable to say no to the incestuous partner.

Arguments continue about whether victims under 12 are more or less harmed by incest than are older victims.[15, 16] Bender and Blau[15] felt that the younger victim was less likely to be harmed by the experience. Recent studies have supported this view, but link it to the longer duration of incest in children who report later.[17] From a developmental point of view, this question may be so complex that it has no helpful answer. "Children under 12" include the oedipal child who is rejected by her mother, loses a loving fahter, and suffers a frightening medical complication; this category also includes the late-latency victim who is able to stop the relationship early and to repress memories of the experience. Although both children are under 12, they may have very different outcomes to incest situations that have developmental impacts and meanings which are quite different.

In a group of incest victims who later presented as psychiatric outpatients, 33% (two of six) had been victimized between ages 4 and 7.[11] In a group of victims identified on a psychiatric inpatient unit, incest took place between 4 and 7 years in 57% (eight of 14).[18] In a group of incest victims who presented as child-abusive mothers, 21% (four of 24) were age 4 to 7 at the time of their own abuse. Only 6% of incest victims (one of 15) in a "normal" control group described the prior incest as having occurred during the oedipal stage.[17] These data would support the simple hypothesis that the developmental family pressures on the late preschool/early grade school victim increase her risk for later sequelae. It may be that similar analyses of other outcome data will make more precise the developmental pathways that lead to the late sequelae of incest.

REFERENCES

1. Berlin I: Parents' developmental crises: Treatment of the child. Presented at the Annual Meeting of the American Psychiatric Association, Toronto, May, 1978.
2. Berlin I: Opportunities in adolescence to rectify developmental failures, in Feinstein SC, Giovacchini PL, Looney JG, et al (eds): *Adolescent Psychiatry, Developmental and Clinical Studies*. Chicago, University of Chicago Press, 1981, vol 8, pp 225–240.
3. Sgroi S: Molestation of children: The last frontier. *Child Today* 4:18–21, 1975.
4. Brant RST, Herzog JM: Sexual abuse of children under three years of age. Presented at the Annual Meeting of the American Academy of Child Psychiatry, Atlanta, October, 1980.
5. Gebhard PH, Gagnon JH, Pomeroy WB, et al: *Sex Offenders: An Analysis of Types*. New York, Hoeber Medical Books, 1965.
6. Kempe RS: Individual treatment planning for the abused and neglected child. Presented at the Third International Congress on Child Abuse and Neglect, Amsterdam, April 21–25, 1981.
7. Greenberg NH: The epidemiology of childhood sexual abuse. *Pediatr Ann* 8:289–299, 1979.
8. Sarnoff C: *Latency*. New York, Jason Aronson, 1976.
9. Gottlieb B, Dean J: The co-therapy relationship in group treatment of the sexually mistreated adolescent. Presented at the Second International Congress on Child Abuse and Neglect, London, Sept 12–15, 1978.
10. Goodwin J, Zouhar M, Bergman R: Hysterical seizures: A sequel to incest. *Am J Orthopsychiatry* 49:698–703, 1979.
11. Rosenfeld A: Incidence of a history of incest among 18 female psychiatric patients. *Am J Psychiatry* 136:791–795, 1979.
12. Miller J, Moeller D, Kaufman A, et al: Recidivism among sex assault victims. *Am J Psychiatry* 135:1103–1104, 1978.
13. Forward S, Buck C: *Betrayal of Innocence*. Los Angeles, JP Tarcher, 1978.
14. Tsai M, Wagner NN: Therapy groups for women sexually molested as children. *Arch Sex Behav* 7:417–427, 1978.
15. Bender L, Blau A: The reaction of children to sexual relations with adults. *Am J Orthopsychiatry* 7:500–518, 1937.
16. Goodwin J, McCarty T, DiVasto P: Prior incest in abusive mothers. *Child Abuse Neglect* 5:1–9, 1981.
17. Tsai M, Feldman-Summers S, Edgar M: Childhood molestation: Variables related to differential impacts on psychosexual functioning in adult women. *J Abnorm Psychol* 88:407–417, 1979.
18. Goodwin J, Attias R, McCarty T, et al: Effects on psychiatric inpatients of routine questioning about childhood sexual abuse. *Victimology*, in press, 1988.

9

Posttraumatic Symptoms in Incest Victims

Jean Goodwin

In 1896, Sigmund Freud[1] reported 18 cases of hysteria; in each case, he had uncovered a history of sexual abuse in the patient's childhood. Freud found that the sexual abuse experience could be reconstructed from the pattern of the patient's hysterical and obsessive symptoms, even when that experience had been completely repressed. Ultimately, the sexual "scenes" were relived in abreaction during psychoanalytic or hypnotherapeutic treatment, and symptoms disappeared.[2, 3]

Freud[4] eventually renounced these findings saying that he had been naive to mistake for actual memories the oedipal fantasies of patients who had merely longed for sexual adventures with their parents. However, although Freud published many cases, including the famous case of "Dora,"[5–7] in which the patient's complaint about a sexually seductive adult was corroborated by other family members, he never published a case in which sexual allegations could be translated, entirely, as remembered fantasies.[8] In the absence of clinical material one is not even certain what Freud meant by "fantasies"—screen memories, delusions, opportunistic lies, imaginary experiences of alter-personalities? Nevertheless, this concept, that accounts of childhood sexual events might represent fantasies, helped delay for nearly 80 years the elaboration and replication of his original work.

The present chapter reviews recent attempts to build on Freud's early ideas by tracing symptom development to childhood efforts to defend against the physical and psychosocial trauma of sexual abuse. Two basic questions have remained in dispute since Freud's first paper. First, can sexual encounters

in childhood be considered as traumatic events? Second, are the victims of such experiences symptomatic, and can their symptoms be related to the sexual abuse?

Case material in this chapter describes victims of incest, that is, individuals who were sexually exploited as children by an adult in a parental role.[9]. Freud[1] noted that this was the most common type of sexual abuse in his series and that this kind of abuse often led to further sexual abuse by unrelated or peer perpetrators. Several case histories of incest victims are reviewed, in which the observed symptom pattern was similar to that described for posttraumatic disorders in combat veterans and in rape victims. Most incest victims who request treatment meet criteria for posttraumatic disorder, although this can be difficult to recognize, either due to the victim's young age, the severity of symptoms, or the victim's tendency to conceal both symptoms and the extent of the prior sexual abuse.

IS INCEST TRAUMATIC?

In the 1890s, Freud did not have difficulty convincing his readers that incest was a traumatic, overwhelming experience for a child. This was assumed, just as readily as it was assumed that incest occurred only rarely, one case per million population,[10] too rarely for Freud's data to be correct. Today, as more surveys tell us that 1% to 4% of women in the general population have experienced incest with a father or stepfather,[11] it is no longer self-evident that all such episodes must be automatically traumatizing.

In this era of social and sexual permissiveness, there is even a proincest lobby to champion the right of children to engage in sexual activities with adults of their choice.[12] Some investigators describe the gradual induction of "cooperative victims" into sexual relationships which provide "attention" and "nurturance."[13, 14] Some of these clinicians seem to assume that if trauma is present, it must be an inherent property of the sexual act itself.[15, 16] In some cases this is, in fact, the child's view. However, Freud,[1] and later Ferenczi,[17] looked beyond the specifics of the sexual encounter to assess the quality of the victim's overall interpersonal environment. Freud spoke of children's powerlessness in the face of adult demands and their discomfort at having to shift roles from lover to obedient child without explanation.[1] Ferenczi described the "confusion of tongues between adult and child," with the adult's needs, feelings, and perceptions determining the course of the sexual relationship, while the child must suppress his or her true responses.[17]

Psychotherapists regularly encounter patients who describe an incest experience matter-of-factly, sometimes as an aside to a more "important" memory or problem. Such patients may deny that there was any frightening or painful quality in the experience.[18] Of course, this is not an uncommon finding in posttraumatic disorders as well, especially in those cases where

dissociation, repression, and other defenses have been exceptionally strong.[19, 20]

However, the intensity of the traumatic impact of such events must also vary. Freud,[1] and later Rollo May,[21] suspected that psychic pain might actually be less in those cases where the consistent brutality of the perpetrator made the sexual incidents more congruent and expectable for the victim and thus less disappointing.

Few psychiatrists would argue about the damaging potential for children who grow up in the most extremely disturbed incest families where a psychotic parent sadistically abuses the children physically and sexually. The hallmarks of this kind of incest include the use of bondage, or burial; the insertion of objects into orifices; the recruitment of other family members as witnesses or coperpetrators; the involvement of multiple victims, including nonfamily members, infants, and adults; and the active pursuit of incest pregnancies[22] (see chapter 14). This is the type of incest most commonly found in the childhood histories of patients with Multiple Personality Disorder,[23] 70% of whom are incest victims.[24]

However, the circumstances of even the most damaged families may not meet the strict criteria for childhood trauma that are being developed as posttraumatic disorders begin to be defined in young children.[25] Incest victims cannot be said to be free of symptoms due to deprivation and pathologic family interaction. They have been exposed not to a single, discrete, overwhelming incident, but to hundreds of assaults, spanning years and developmental phases, and to the concealment, lack of empathy or protection, and hypocrisy that fill the interstices between assaults.[26]

Nevertheless, contaminated as this system may be with confounding variables, it is no more confounded than the World War I trenches that gave us the patients whose symptoms were first called posttraumatic.[27] Here, too, one found multiple assaults on the self, some more disorganizing than others. Here, too, the shape of the ultimate disorganization was profoundly influenced by the deprivations and distortions learned in the "combat family" (and by those experienced carlier in the patient's own family).

One of the most interesting definitions of trauma is the pragmatic one developed by Richard Kluft,[28] based on his treatment of over 70 patients with Multiple Personality Disorder. As mentioned above, this disorder is particularly relevant to the problem of incest. Multiple Personality Disorder is also relevant to the problem of posttraumatic syndromes since fugue, amnesia, and other dissociative symptoms sometimes occur in posttraumatic states.[29] The question Kluft asked was, "What kinds of events trigger the creation of new personalities in children who later present with multiple personality disorder?" By analyzing the characteristics of those experiences that triggered dissociative escapes, he generated the following criteria for a traumatic incident: (a) The child fears for his or her own life; (b) the child

fears that an important attachment figure will die; (c) the child's physical intactness and/or clarity of consciousness is breached or impaired; (d) the child is isolated with these fears; and (e) the child is systematically misinformed, or "brainwashed," about his or her situation. Again, these criteria are not so distant from data collected from Vietnam veterans, which indicate that symptom severity is influenced by: (a) exposure to life-threatening combat; (b) loss of comrades; (c) wounds, illness, and drug use; (d) absence of permission to discuss the trauma; and (e) participation in atrocities or other activities that require concealment or lead to moral dilemmas.[20]

Using this pragmatic definition of trauma, one finds that it predicts many of the factors that have been associated with poor prognosis in incest victims. The perpetrator's use of physical force, death threats to the child or to other family members, the child's fears about his or her own physical sensations, the absence of any mirroring or comforting parent figure, the confusing quality of the rationalizations or paranoid thinking used by some families—all of these increase the traumatic potential of the incest experience.

ARE INCEST VICTIMS SYMPTOMATIC?

In 1980, Mrazek and Mrazek[30] reviewed all published reports describing child and adolescent incest victims. Twenty-four publications reported significant symptoms in victims; three publications found no negative effects, and two found both symptomatic and asymptomatic victims. Symptoms recorded included fears, anxiety, sleep disturbances, depression, low self-esteem, guilt, psychosomatic problems, sexual disorders of all types, and behavioral problems.

Adams-Tucker[31] found symptoms in 100% of 28 child incest victims. Maisch[32] made at least one psychiatric diagnosis in two thirds (49) of 70 child victims. Becker et al[33] reported more frequent and severe orgasmic problems in adolescent incest victims as compared to adolescent rape victims. Meiselman[34] found that of adult incest victims in psychiatric treatment, three fourths complained of sexual dysfunction.

Studies that report a high frequency of symptoms in incest victims can be criticized because populations are selected on the basis of a request for psychiatric help, or because a criminal conviction was obtained in the case (opening the question of traumatization by the criminal justice system). Studies that report no symptoms in incest victims also have methodologic problems. These studies often fail to differentiate victims of peer and stranger contacts from victims of classic incest.[35] Some of these studies also fail to include measures that would register posttraumatic symptoms.[36]

Overall, the symptoms found in incest victims resemble those found acutely in rape victims. Fear, sleep and eating disturbances, guilt, decreased functioning, sexual problems, and irritability—all are found in the rape-

trauma syndrome as described by Burgess and Holmstrom.[37] Symptoms in incest victims may be more numerous, more severe, and longer-lasting, but this parallels the observation that incest victims have undergone more numerous sexual assaults over a more prolonged period. These rape-trauma symptoms, so frequently described for incest victims, have been incorporated into check lists for pediatricians who provide forensic pelvic examinations for child victims.[38] In some jurisdictions the presence of these behavioral symptoms can be used as evidence that the child was sexually abused.[39] Thus the legal system appears ready to acknowledge that some child incest victims suffer symptoms of the type found in acute posttraumatic disorders.

IMPLICATIONS OF PERCEIVING INCEST SYNDROMES AS POSTTRAUMATIC

If incestuously abused children are experiencing a posttraumatic syndrome, this implies that certain animal models may have applications as well as the extensive psychiatric research with combat veterans and rape victims.

One animal model for posttraumatic syndrome is "learned helplessness" secondary to inescapable shock.[40] In this experimentally induced state, animals that have previously learned to avoid electric shock by initiating certain required behaviors are placed in a situation where they receive the shock regardless of how they behave. Such animals show: (1) anxious immobility which can progress to death as catecholamines are depleted and cholinergic tone predominates; (2) an actual decrease in sympathetic tension when the painful shock arrives; (this is related to endorphin release)[20, 41]; (3) decreased feeding and sexual behaviors; (4) a reduced ability to learn in later trials that the animal's own responses once again produce effects; and (5) an increase in disturbed behaviors with a decrease in survival-related aggression. The animal data raise many questions: Do abused children seek out new traumatic experiences because, in their end-stage anxiety the pain-produced endorphin release is their closest approximation to pleasure? Is the developmental deficiency in these children related to a disturbance in a basic precursor for learning—that is, the lack of a sense that one's own actions make a difference? The syndrome of learned helplessness can be treated by providing the animal with situations where his actions do make a difference; this is most effective if done prior to the experience of inescapable shock. (One wonders if pancultural initiation ceremonies are designed to provide precisely this kind of experimental immunization against abuse and torture. Such rituals often involve genital assault as well as elements of brainwashing, isolation, disturbance of consciousness, and death fears.) Monoamine oxidase inhibitors, minor tranquilizers, and alpha- and beta-receptor blockers can improve later learning in animals. These drugs also benefit adult human beings in posttraumatic states.

RECOGNIZING POSTTRAUMATIC DISORDERS IN INCEST VICTIMS

In the following case examples, victims were found to be symptomatic in the five areas described by Kardiner in his original descriptions of shell-shocked combat veterans.[27] These patients presented with symptoms of (a) fear, startle reactions, and anxiety; (b) repetition, reenactment, or flashback to the trauma; (c) sleep disturbance and other depressive phenomena, including excessive guilt; (d) ego constriction or regression; and (e) explosive and maladaptive expressions of anger. This symptom list, adapted from Kardiner, overlaps the diagnostic criteria for Post-Traumatic Stress Disorder in the *Diagnostic and Statistical Manual of Mental Disorders.*[42]

The first case describes a very young child. However, the classic nature of her symptoms becomes apparent despite her young age. As treatment has become more available, the average age of incest victims has declined (see chapter 18). If victims of one-time-only sexual abuses are ever to be studied, those subjects will probably come from this preschool-age group, as latency-age victims are likely to have undergone protracted and repeated abuses before they are identified.

Case 1 Karen, an only child, aged 2½ years, was brought to a pediatrician by her parents after a week-long visit from her maternal grandparents. Karen had brought a knitting needle to her mother, saying, "That belongs to granny and grandpa; they stuck it in my bottom." She also said that her granny had slapped her across the face. Physical findings were consistent with her complaints. In the first 2½ weeks after the examination, Karen refused to sleep in her own bed, complaining of ghosts in her room. She appeared fearful around men and would plead, "Please don't stick your fingers in my bottom." She had two or three awakenings each night and complained of nightmares in which she was forced to shake hands with a witch. She lost toilet training completely for the first few days and afterward continued nighttime wetting. In the playroom, Karen held tightly to her mother and begged her to put all the animal and human toys in the trash "so they won't stick me." Later, she was able to throw the grandparent puppets onto the floor repeatedly. In subsequent sessions she made a "jar full of fire" and jailed the grandparent puppets there. In the second session, Karen described an imaginary playmate named *Married* (sic) who was not afraid of the animals or the grandparents. Karen explained that Married was older and liked to play with snakes. A chair had to be provided for Married at most family functions and whenever the grandparents were spoken of in the play sessions. When we discussed the possible need for Karen to talk to a judge about the "strange things" her grandparents did, Karen said that Married would not be afraid to do that. By the third session all initial symptoms had disappeared. Karen was able to explore the playroom alone with great freedom, although she still kept the grandparent puppets "in jail." We talked about how Married was like a part of her that was still brave even when Karen was most afraid. Married had disappeared by the fifth session. After 18 months, Karen is asymptomatic. Her mother, who recalled her own sexual abuse for the first time during Karen's evaluation, remains in treatment.

Karen's use of an imaginary playmate to deal with the sexual abuse may be a model for the process that leads, in more severe and protracted cases, to the development of multiple personality disorder.[43] The child's rapid improvement seems characteristic of the response of such children to adequate protection and the direct interpretation of their dissociative defenses.[44]

The next case illustrates how Kardiner's five symptom clusters are manifested in a victim of late-latency age, and later in the same child during midadolescence. On follow-up the now adolescent victim might be misdiagnosed as having a conduct disorder. Only the interviewer's awareness of the history of family violence makes visible the fear that underlies the adolescent's symptoms.

Case 2 Jessie was a 12-year-old whose mother had watched while her adoptive father engaged Jessie in finger-penetration and mutual oral sex. The sexual contact had lasted 3 years. Several of Jessie's friends had been genitally fondled by the father. What Jessie had hated most about the abuse were her preorgasmic feelings during cunnilingus. The marriage was violent and the mother had entered battered-women's shelters several times. The family had last been reunited after the father had kidnapped Jessie's 1-year-old brother from a cousin's home in another state. Jessie believed that her brother, too, had been sexually abused. On first interview, Jessie was afraid either to enter the office or to take a walk. She was convinced that her father, because of his criminal connections, would find her and have her killed before his trial, no matter where she was. Jessie's fears were based on her adoptive father's actual threats and on family lore. One of the father's siblings had been executed in a car bombing; Jessie had heard that her father had murdered a colleague several years before. She was adamant that agencies would be unable to protect her, and the history bore this out. Jessie slept restlessly with many awakenings. She usually cried out in her sleep, but recalled no dreams. In waking hours, she often found herself weeping "for no reason." She kept constantly on the alert for vehicles belonging to her father or any of his numerous family. When she believed she saw one of these, she fled to her room and might not leave it for days. Schoolwork suffered because she was often too fearful to attend classes. Her father had kidnapped her from school in the past. She felt hopeless about learning history and science because she "could not think" about those subjects. She lost her temper frequently, and felt "crazy" when she found herself engrossed in complex fantasies about killing her father.

Largely because of family chaos, follow-up was intermittent until 2 years later, when Jessie was 14. Her mother had contracted a new alliance, with a man who battered her and emotionally abused the children. Jessie had run away from home 5 times, never succeeding in finding a safer place. She was on probation for stealing blankets and clothes during a runaway on a winter night. She continued to feel it was only a matter of time before her adoptive father found her and killed her. She doubted she would live to adulthood. She was in the process of repeating her eighth-grade year at school; truancy had become an insuperable problem. She had resolved never to let a man touch her, and felt most comfortable with a lesbian friend. Jessie had male

friends, however, including a distributor of pornographic films, who had promised to make her a star. She currently had several broken ribs from "a fight with some girls." She said she was better at fighting than she had been; "my soul just leaves my body; I don't even remember what happened."

In contrast to the first case, this history illustrates what happens to a victim's symptoms in the absence of adequate protection. Despite developmental transformations, symptoms persist. As seen in this patient's use of dissociation, a particular symptom may become identified as a helpful and necessary ally, thus further complicating the task of treatment.

Delayed and chronic posttraumatic symptoms have been best described in adult incest victims.[45] The symptom complex is usually present when the adult seeks treatment during a crisis. Also, symptoms can sometimes be traced back to manifestations during childhood when the pattern may have been quite similar to that already described for child and adolescent victims (see chapter 8). Like child victims, adult victims may have concerns about parents, and about other victims within the family, and may need referral to a child-protection agency to halt the abuse of child relatives[46, 47]

Case 3 Mary, a 28-year-old married secretary with one child, came to a crisis clinic with concerns about her sanity. She had just come home from the grocery store and thrown all the groceries on the kitchen floor. She had been reading a book of reminiscences by incest survivors for the past two days and had been unable to sleep. Mary could not recall any time in her life when she had felt relaxed, but the tension of the past 48 hours had been unbearable. The book had reawakened feelings of rage, guilt, and grief about her incest experiences with her father from ages 4 to 12. A few weeks previously, her father had been diagnosed as having dementia. Mary felt trapped and unable to respect herself. She was unsure if she had successfully protected her son from her father's sexual advances. Mary forced herself to participate in marital sexuality, although flashbacks to the incest blocked both arousal and orgasm. Her childhood had been complicated by her mother's psychosis, as well as by her father's sexual abuse of all siblings. Of Mary's five siblings, one had been convicted for pedophilia, one had been diagnosed as schizophrenic, one was alcoholic, one had numerous suicide attempts, and one was a psychotherapist. Mary had been taken to psychiatrists twice in childhood. At age 6, her teacher reported that Mary looked frightened, cried often, was afraid to go to the bathroom, and did not socialize with other children. Tranquilizers were prescribed. At 15, Mary was brought to a guidance clinic by her mother because of runaways, drug use, promiscuity, and chronic rule breaking. She was diagnosed as having a conduct disorder and no further treatment was recommended. Prior incest was not uncovered at either evaluation, even though it was Mary's complaint to her mother about her father's sexual abuse that precipitated the second evaluation.

It should be noted that the diagnoses made when Mary presented as an adult were: dependent personality disorder and marital problems. Her tension, her sleep difficulties, her flashbacks, her inability to cope with sexuality, her unintegrated feelings of rage were still not recognized as the primary symptom complex. However, when brief treatment that focused on re-experiencing the incest trauma was provided, these problems resolved.

CONCLUSION

Most incest experiences can be defined as potentially traumatic. The persistence of professional debate on this issue probably stems from the reluctance of both therapists and victims to explore in detail the day-to-day childhood realities of the incest predicament.[48] Fears and threats of death, fears for loved ones, fears about bodily damage, isolation, and misinformation enhance the traumatogenic potential of incest experiences. Most studies report that incest victims develop symptoms. These symptoms are similar to those described in the rape-trauma syndrome, but may be longer-lasting and more severe.

Posttraumatic syndromes can be recognized in incest victims, from preschool age to adulthood. They are easily overlooked, however, especially if the interviewer has failed to ask about child abuse and family violence. Therapists may be best advised to refrain from diagnosing personality disorders until posttraumatic symptoms have cleared. Dissociative disorders are the most likely secondary diagnoses. Monitoring the intensity of posttraumatic symptoms is a sensitive way to identify failures in environmental protection, since fear, often unconsciously perceived, is a common trigger for the recurrence of this syndrome.

REFERENCES

1. Freud S: The aetiology of hysteria [1896], in *Standard Edition*, translated and edited by Strachey J. London, Hogarth, 1962, vol 3, pp 189–221.
2. Masson JM: *The Assault on Truth: Freud's Suppression of the Seduction Theory*. New York, Farrar, Straus & Giroux, 1984.
3. Miller A: *Thou Shalt Not Be Aware: Society's Betrayal of the Child*. New York, Farrar, Straus Giroux, 1984.
4. Freud S: *The Origins of Psychoanalysis: Letters to Wilhelm Fliess, Drafts and Notes, 1887-1902*. Bonaparte M, Freud A, Kris E (eds). New York, Basic Books, 1954.
5. Freud S: Fragment of an analysis of a case of hysteria [1901, 1905], in *Standard Edition*, Strachey J (trans-ed). London, Hogarth, 1953, vol 7, pp 3–124.
6. Erikson E: Reality and actuality: an address. *J Am Psychoanal Assoc* 10:451–474, 1962.
7. Balmary M: *Psychoanalyzing Psychoanalysis: Freud and the Hidden Fault of the Father*. Baltimore, Johns Hopkins University Press, 1982.
8. Goodwin J, Sahd D, Rada R: Incest hoax: false accusations, false denials. *Bull Am Acad Psychiatry Law* 6:269–276, 1979.
9. Goodwin J: Helping the child who reports incest: a case review, in Goodwin J (ed): *Sexual Abuse: Incest Victims and Their Families*. Littleton, Mass, PSG Publishing Co, 1982, pp 1–16.
10. Henderson DJ: Incest, in Freedman AM, Kaplan HI, Sadock BJ (eds): *Comprehensive Textbook of Psychiatry*. Baltimore, Williams & Wilkins, 1975.
11. Goodwin J, McCarty T, DiVasto P: Prior incest in abusive mothers. *Child Abuse Neglect* 5:1–9, 1981.
12. DeMott B: The pro-incest lobby. *Psychology Today* 3:11–16, 1980.
13. Henderson J: Is incest harmful? *Can J Psychiatry* 28:34–40, 1983.

14. Krieger MJ, Rosenfeld AA, Gordon A, et al: Problems in the psychotherapy of children with histories of incest. *Am J Psychother* 34:81–88, 1980.
15. Bender L, Blau A: The reaction of children to sexual relations with adults. *Am J Orthopsychiatry* 7:500–518, 1937.
16. Yorokoglu A, Kemph JP: Children not severely damaged by incest with a parent. *J Am Acad Child Psychiatry* 5:111–124, 1966.
17. Ferenczi S: Confusion of tongues between adults and the child. *Int J Psychoanal* 30:225–230, 1949.
18. Barry MJ, Johnson A: The incest barrier. *Psychoanal Q* 27:485–500, 1985.
19. Horowitz MJ: *Stress-Response Syndromes*. New York, Jason Aronson, 1976.
20. Van der Kolk BA: *Post-Traumatic Stress Disorder: Psychological and Biological Sequelae*. Washington, DC, American Psychiatric Association, 1984.
21. May R: *The Courage to Create*. New York, WW Norton, 1975.
22. Goodwin J: Persecution and grandiosity in incest fathers, in Pichot P, Berner P, Wolf R, Thaw K (eds): *Psychiatry: The State of the Art*. New York, Plenum, 1985, Vol 6, pp 309–332.
23. Wilbur C: Multiple personality and child abuse. *Psychiatr Clin North Am* 7:3–8, 1984.
24. Putnam, F: The psychophysiologic investigation of multiple personality disorder. *Psychiatr Clin North Am* 7:31–40, 1984.
25. Terr L: Chowchilla revisited: the effects of psychic trauma four years after a school-bus kidnapping. *Am J Psychiatry* 140:1543–1550, 1983.
26. Summit R: The child sexual abuse accomodation syndrome. *Child Abuse Neglect* 7:177–193, 1983.
27. Kardiner A: The traumatic neuroses of war, in Arieti S (ed): *American Handbook of Psychiatry*. New York, Basic Books, 1959, vol 1, pp 245–257.
28. Kluft R: Treatment of multiple personality disorder: a study of 33 cases. *Psychiatr Clin North Am* 7:9–30, 1984.
29. Spiegel D: Multiple personality as a post-traumatic stress disorder. *Psychiatr Clin North Am* 7:101–110, 1984.
30. Mrazek PB, Kempe CH (eds): *Sexually Abused Children and Their Families*. New York, Pergamon Press, 1980.
31. Adams-Tucker C: Proximate effects of sexual abuse in childhood: a report on 28 children. *Am J Psychiatry* 139:1251–1256, 1982.
32. Maisch H: *Incest*. London, Andre Deutsch, 1973.
33. Becker J, Skinner L, Abel G, et al: Incidence and types of sexual dysfunctions in rape and incest victims. *J Sex Marital Ther* 8:65–74, 1982.
34. Meiselman K: *Incest*. San Francisco, Jossey-Bass, 1978.
35. Renshaw D: *Incest: Understanding and Treatment*. Boston, Little, Brown, 1982.
36. Burton L: *Vulnerable Children*. London, Routledge & Kegan Paul, 1968.
37. Burgess AW, Holmstrom LL: *Rape, Crisis, and Recovery*. Bowie, Md, Robert J Brady Co, 1979.
38. National Center on Child Abuse and Neglect: *Sexual Absue of Children: Selected Readings*. Washington, DC, US Dept of Health and Human Services, Publication No. (OHDS) 78–30161, 1980.
39. National Legal Resource Center for Child Advocacy and Protection: *Recommendations for Improving Legal Intervention in Sexual-Abuse Cases*. Washington, DC, American Bar Association, 1982.
40. Seligman MEP: *Helplessness*. San Francisco, WH Freeman, 1975.
41. Van der Kolk BA: *Psychological Trauma*. Washington, DC, American Psychiatric Association, 1987.
42. American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, 3rd ed. Washington, DC, American Psychiatric Association, 1980.

43. Fagan J, MacMahon PP: Incipient multiple personality in children: four cases. *J Nerv Ment Dis* 172:26–36, 1984.
44. Kluft R: Multiple personality in childhood. *Psychiatr Clin North Am* 7:121–134, 1984.
45. Gelinas D: The persisting negative effects of incest. *Psychiatry* 46:312–332, 1983.
46. McFarlane K, Korbin J: Confronting the incest secret long after the fact: a family study of multiple victimization with strategies for intervention. *Child Abuse Neglect* 7:225–240, 1983.
47. Goodwin J, Cormier L, Owen J: Grandfather-granddaughter incest: a trigenerational view. *Child Abuse Neglect* 7:163–170, 1983.
48. Benedek E: The silent scream: countertransference reactions to victims. *Am J Social Psychiatry* 4:49–52, 1984.

10

Simulated Neglect as a Sequel to Physical and Sexual Abuse: The Cinderella Syndrome

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In this chapter we describe three adopted girls, aged 9 and 10 years, who falsely alleged that their adoptive mothers dressed them in rags, made them do all the chores, and favored their stepsiblings. Underlying these false accusations of abuse was a history that included: (1) actual abuse of the child in a previous placement–two of the three had been sexually abused; (2) early loss of a mothering figure; and (3) emotional abuse in the adoptive home. Professionals involved in child protection need to recognize this syndrome because intensive family therapy and temporary placement of the child outside the home are required in all cases. The child's false accusation of abuse is a cry for help and should not be dismissed as a manipulative fabrication.

When professionals responsible for child protection discover that a child has exaggerated, fabricated, or simulated abuse, they tend to respond by simply closing the case. However, we have previously shown that false accusations of sexual abuse are often a child's way of calling for help in a family situation that has become desperate for other reasons.[1] This chapter describes a similar pattern in false accusations of child neglect. In the three cases we report, the child's false accusation of neglect called attention to underlying family dysfuncion that did require the intervention of a child protection agency.

The adopted girls in these three cases of simulated neglect had complaints remarkably like those of the fairy-tale heroine Cinderella. Each falsely alleged that her stepmother dressed her in rags, made her do all the

chores, and showed preference for her stepsiblings. All three girls had been adopted by relatives after suffering the traumatic death of an early mothering figure.

The children's Cinderella-like accusations functioned at several levels as a cry for help: (1) They were being emotionally abused and probably would have been physically abused had their false accusations not led to the involvement of a child-protection agency and their temporary removal from the home; (2) they had never resolved experiences of abuse and abandonment which occurred before adoption; and (3) all three stepmothers had been abused as children and needed to integrate those past experiences before they could fully accept their stepdaughters. In addition, the Cinderella tale mapped inner conflicts which these children needed to explore in treatment. All of the families were hostile to psychotherapy. It was only under pressure of the legally mandated investigation triggered by the child's false accusation of neglect that these families allowed the troubled child to receive needed treatment.

Case Reports

Case 1 Adele, a 9-year-old girl, was referred to a child protection agency when a policeman found her wandering outside school clad only in an undershirt and panties. She explained that because she had been unable to finish her chores at home, her adoptive mother had locked her out of the house. She said her adoptive parents often took her stepsiblings on outings, leaving her at home to do all the chores. A family interview established that Adele had taken off her own clothes and hidden them.

Adele's biological mother died when Adele was 1 year old. Adele was then placed with another relative, an alcoholic woman who neglected and physically and sexually abused her. This woman died when Adele was 6; she was then adopted by her current parents. Her adoptive father was also her uncle.

Adele's adoptive father, who held two jobs, tended to be distant and aloof. His wife, herself sexually abused and brutally beaten as a child, was an anxious woman with many compulsive rituals who bitterly resented Adele's uncontrollable behavior. The stepsiblings became angry with Adele for upsetting their mother. Adele said she wanted to be a member of the family and to get all her chores done.

The adoptive parents decided to place Adele voluntarily in foster care while she received therapy. They refused family therapy, but the mother agreed to participate in joint sessions with Adele's therapist. After 4 months, Adele was reintegrated into the adoptive family.

Case 2 Betty, a 9-year-old girl, was referred by the school because she came to class in shabby clothes and without shoes. Betty said her adoptive mother had thrown away her shoes as punishment for not cleaning under the bed. A family interview established that Betty had changed into shabby clothes on her way to school.

Betty had been adopted into this family at age 6. Her adoptive mother was her biological mother. Because Betty's mother was an unmarried schoolgirl when Betty was born, Betty was raised from birth by a friend of her mother

who was killed in an auto accident when Betty was 6. This foster mother had been overprotective and indulgent, keeping Betty on a bottle until age 4. After the foster mother's death, the girl's biological mother forcibly removed her from the foster home, not telling the child until a year later that she was her biological mother. Betty had many questions about her biological father, but her mother refused to speak of him.

The mother's present husband was a volatile man who refused to become involved with Betty. The mother felt frustrated about disciplining Betty, saying that the child responded to reprimands by tearing up clothes and toys. Betty's adoptive/natural mother had been the victim of sadistic abuse as a child. The stepsiblings resented Betty and physically abused her by locking her in the doghouse and feeding her dog food. Betty had frequent stomach aches, had one episode of hysterical paralysis, and daydreamed that a race car driver would come and rescue her. After a year of play therapy, Betty was able to be in the home only on weekends. Her adoptive parents still refused to become involved in her treatment and finally agreed to place Betty permanently with other relatives.

Case 3 Carol, a 10-year-old girl, was referred to a child protection agency by a passerby. Carol had run up to this man and told him that her adoptive mother had kicked her and was keeping her home from school to do all the household chores. Carol used terms such as "child sexual abuse" in describing her problems. A family interview revealed that the bruise Carol offered as evidence of being kicked had been sustained in a baseball accident and that she had refused to go to school because she had not been given the part of the princess in a school play. At age 9, Carol had claimed that her adoptive mother was trying to drown her in the bathtub. That complaint had been dismissed as fiction, and therapy was not offered.

Before her adoption, Carol had been an abused child raised in a psychotic family situation. Carol's psychotic mother had abused her by tying her hands and forcing her head into the toilet. Carol first lived with her adoptive parents at ages 5 and 6 while her mother, a relative of the adoptive father, was psychiatrically hospitalized. At age 7, Carol returned to live with her mother who had remarried. The new stepfather began a sexual relationship with Carol. Within a year, Carol's mother committed suicide.

When Carol was 9, her current parents adopted her; their only biological child, a blind and severely retarded son, had been institutionalized shortly before. Soon after her adoption, Carol had one episode of hysterical blindness. The adoptive father held two jobs. He was ashamed of the mental illness of his relative, Carol's natural mother, and refused to allow Carol to speak of her. The adoptive mother had been sadistically beaten as a child by her mother and had been sexually abused by her father, but never complained about these incidents because she feared that she would not be believed. She felt defeated by Carol, something she denied having felt with her severely handlicapped son, and she spanked Carol hard enough at times to leave bruises. Carol was not certain that her natural mother was dead and daydreamed about returning to her.

Carol was placed in a foster home. The foster mother complained that Carol refused to go to school or to do chores and that she made false accusations against her foster siblings. After 3 months of family therapy, Carol was able to be with her adoptive parents on weekends. However, the family ultimately decided that Carol should be placed permanently with other relatives.

DISCUSSION

These three cases were the only documented instances of simulated neglect seen over a 3-year period in a child-protection agency that screens 150 complaints of neglect each month. Since the children were treated by different therapists, their remarkable similarities were not recognized until a systematic review of the agency's cases.

Child-protection workers are understandably reluctant to make the judgment that a child is lying about parental abuse. One case report[2] described a 3-year-old whose allegation that his mother beat and burned him was dismissed as a false accusation planted by his father who was estranged from the mother. Four months later this child was beaten to death by his mother. The cases reported here make the additional point that even if the worker is correct in judging a child's accusation to be a lie, other kinds of abuse may still be occurring in the home.

These three cases are remarkably similar and appear to represent a specific syndrome. All three children were 9- or 10-year-old girls who had entered their adoptive homes at about age 6. Each had experienced the traumatic death of an earlier mothering figure before adoption. Two of the girls had been sexually abused in their earlier homes; two had developed hysterical symptoms after adoption (one paralysis and the other blindness). The adoptive fathers were emotionally distant and unavailable to the children. The adoptive mothers had been severely abused as children and were appalled at being regarded as "bad" mothers, in part because that was how they viewed their own mothers. There was intense rivalry with stepsiblings in all cases. Betty was physically abused by her stepsiblings, and Carol developed the symptom of blindness, which mimicked the handicap of her stepbrother.[3]

The false accusations made by these girls closely resemble the complaints of the fairy-tale heroine Cinderella. There is one report[4] of a 5-year-old girl who briefly took on the role of Cinderella, complaining that her mother made her do the hardest chores, made her sleep in the ashes, and favored her younger sister. The three girls reported here had similar complaints, but they were unable to deal with their grievances in fantasy play; instead, they presented them as realities. Girls of this age often experience disillusion with the mother who comes to be seen as a taskmaster, a rival, and a person with many loves, rather than the always indulgent child-centered mother of infancy. For the girls described here, that disillusion was made unworkable by the circumstances that forced them to actually switch to a new mother just as this developmental change in their perception of the mothering figure was emerging.

In the original fairy tale, Cinderella's grief for her dead mother is a central issue. *Cinderella* is one of a series of fairy tales which includes *Cap o' Rushes* (the source for Shakespeare's *King Lear*), and several tales like

Thousandfurs and *Manekine* in which the father's incestuous desire for his daughter is explicitly described as the cause of the child's wandering and loss of her brithright (see chapter 20). The normal rivalry of the oedipal-age girl with her mother is intensified by actual incest with the father, and should the mother die at the height of this intense competitive conflict, the child may experience the unconscious fear that she caused the mother's death.[5] The girl must blot out all negative feelings about the mother in order to avoid intolerable guilt about her mother's death. In the Cinderella story these negative feelings were displaced and projected onto the stepmother, and the dead mother was idealized.

Sibling rivalry is particularly intense for the Cinderella child, partly because she feels that her parents prefer her siblings to someone guilty of incest and murder, and partly because she may provoke victimization by her siblings to punish herself and assuage her guilt. The therapeutic solution prescribed in the fairy tale was for Cinderella to complete the grief work for her mother — in the story she watered a tree on her mother's grave with her tears daily — and to accept the tasks requested both by the "bad" stepmother and the "good" fairy godmother. This acceptance of chores is a nucleus for the identification with the mother that must supplant rivalry.

Treatment of these cases is complex. Strategies include family therapy, individual therapy for the adoptive parents, and play therapy for the children. Family therapy defines the situation as a family problem and resists the family's effort to find a scapegoat. In our cases individual play therapy focused on helping the child to mourn the idealized dead mother and to give up fantasies of reunion with her. It was critical for the therapist to visit the child in her home — as did the prince in the fairy tale. These children tended to shamefully conceal from the therapist the rejecting and lacerating family battles that constituted the actual abuse; the false accusation was a face-saving version of the actual situation revealed in the home visit.

The therapist had to monitor the family situation carefully throughout treatment because premature therapeutic interventions tended to trigger new cycles of simulated abuse. When the child felt rejected or blamed because of a therapeutic confrontation, she would provoke or invent a situation in which she felt unfairly abused by the family. This process assuaged the child's guilt and renewed her hopes that she might be rescued by a perfect, fantasized family, perhaps with the therapist. However, this acting out also provoked actual rejection and abuse by the outraged adoptive family. Ultimately, the "wicked stepmother" had to be brought into the child's treatment in order to break this cycle.

The reenactments of earlier abuse found in these children may illuminate other reenactments described in adolescents and adults abused as children. Severely sexually abused children seem to be at risk later for rape in adulthood (chapter 1), and for other forms of family violence (chapters 17 and 18). Like the Cinderella syndrome children, these victims

may be continuing to complain through reenactments of prior events which they can no longer speak about, or perhaps even recall.

Therapy with the adoptive parents focused on their unresolved feelings about the child's lost parent and about their own parents. Two of the adoptive fathers — Carol's and Adele's — felt intense rage and shame about their psychotic female relatives who had abused these girls and thus would not allow the girls to speak of these mother-figures. Similarly, the adoptive mothers needed help in resolving their anger and guilt about their own abusive mothers and childhood experiences of sexual abuse. The adoptive mothers' guilt about childhood incest fostered their identification with the girl's guilt-ridden attempts to degrade themselves as well as their mothers. They seemed unconsciously gratified that the adoptive daughters were voicing complaints that they themselves had never dared to make; at the same time, the false accusations freed these mothers from the dangers of surpassing their own mothers by being "good," nonabusing mothers.[6] As the adoptive mothers' fear and rage lessened, they were better able to consistently enforce the performance of chores and to allow the girls to identify with them in more positive ways.

Although they are rare, cases involving simulated child abuse should be actively evaluated by professionals. In each of these three cases of simulated abuse, actual physical abuse or neglect was subsequently uncovered.[7] It is possible that more severe abuse would have occurred had the child's simulated abuse not brought her family to professional attention.

REFERENCES

1. Goodwin J, Sahd D, Rada R: Incest hoax: False accusations, false denials. *Bull Am Acad Psychiatry Law* 6:269–276, 1978.
2. Kaplun D, Reich R: The murdered child and his killers. *Am J Psychiatry* 133:809-813, 1976.
3. Rada RT, Meyer GG, Kellner R: Visual conversion reaction in children and adults. *J Nerv Ment Dis* 166:580-587, 1978.
4. Rubenstein B: The meaning of the Cinderella story in the development of a little girl. *Am Imago* 12:197–205, 1955.
5. Bettelheim B: *The Uses of Enchantment*. New York, Alfred A. Knopf, 1976, pp 236–277.
6. Shainess N: The structure of the mother encounter. *J Nerv Ment Dis* 126:146-161, 1963.
7. Goodwin J, Cauthorne C, Rada R: Cinderella syndrome: Children who simulate neglect. *Am J Psychiatry* 137:1223–1225, 1980.

11

Hysterical Seizures in Adolescent Incest Victims

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This chapter describes six cases of hysterical or conversion seizures occurring in adolescents who had previously experienced incest. Eight similar cases have been reported in the psychiatric literature. The simultaneous occurrence of these two relatively uncommon conditions suggests a causal connection. In addition, the cases described have other characteristics in common and appear to define a specific syndrome.

Galen, the second-century Greek physician, believed that seizures were the result of premature intercourse in childhood.[1] This is not too distant from Freud's perception that the hysterical seizure repeats a traumatic event.[2] The Navajo Indians have recognized for centuries a syndrome that includes incest, seizures, suicide attempts, and witchcraft. When a Navajo has a seizure, it is often assumed that she has experienced incest and may be a witch.[3] The Navajo phrase for epilepsy includes the word for incest. It is said also that the act of incest plants a moth embryo in the brain. As this moth matures, it will draw the incest offender into the fire. A case has been reported of a Navajo incest victim who fell into a fire during a seizure and was seriously burned.[4]

Our first two cases were drawn from the experience of two of the authors. After noting the similarities between these two cases, we reviewed the records of 12 psychiatric admissions for hysterical epilepsy. Four of these 12 patients had reported prior incest. This finding and data from 25 previously reported cases of hysterical seizures[5] suggest that at least 10% of such seizures are associated with prior incest. Better recognition of this syndrome would be of diagnostic and therapeutic importance.

Case Reports

Case 1 A was an Anglo (English-speaking white) teenager hospitalized at age 14 following convulsions in the detention center in which she was placed after running away from home for the second time. Two weeks previously, her natural father had had intercourse with her. He was an alcoholic who had been separated from the family since this child was 4. She said that her father had been seductive with her before this episode, as had a maternal uncle. The father admitted having had intercourse with her. A was sexually active with peers and had threatened suicide. She said that she was conscious during the seizures and that they usually occurred when she was alone. She said that she had had them as a child but no one had ever seen them before. Seizure activity included fine, rapid trembling of all extremities, and mouth movements that resembled a silent scream. She recalled having "shaken all over" whenever her mother whipped her. EEG was normal. Conversion disorder with hysterical seizures was diagnosed. Psychotherapy was begun and the seizures disappeared, but promiscuity and runaways continued as problems.

Case 2 B was an Anglo girl who was first seen psychiatrically in midadolescence because of runaways and self-mutilating behavior. Psychomotor epilepsy had been diagnosed when she was 5, despite repeatedly negative EEGs. Seizures consisted of "automatic behavior"—usually lying down and taking off her panties—followed by violent thrashing movements that left her severely bruised. Despite the violence of her seizures, she experienced a feeling of control during convulsions. Phenytoin and phenobarbital were begun and continued until she entered intensive psychotherapy in her mid-20s. In therapy she disclosed a history of genital fondling by her mother, which extended from infancy to age 6. At that time, she refused further contract from her mother but entered a relationship with a cleric, which included undressing and mutual masturbation. She became promiscuous as a teenager, but seizures were often triggered by sexual contact. Seizures decreased in psychotherapy and her antiepileptics were discontinued. It was determined that her 20-year history of seizures had been hysterical rather than organic in origin.

Case 3 C was an Anglo who presented at age 17 with seizures characterized by dizziness, stiffness, and jerking. She said she had had seizures as a child but had not complained of them. These episodes were precipitated by anger, and C could be roused from seizures. EEG and brain scan were normal. In hospital she disclosed a brief incestuous relationship with her stepfather at age 10. This was explored in conjoint sessions with C and her mother, and the seizures disappeared. C had attempted suicide and had run away from home earlier in adolescence. She had been a practicing homosexual since a 2-week marriage, which she left because she found the experience of intercourse "horrible." The marriage immediately preceded the onset of seizures. She was diagnosed as having hysterical seizures and an intermittent depressive disorder.

Case 4 D was an Anglo woman who presented at age 18 with seizures that she said had started at age 5 "but nobody ever noticed them." The seizures began with an aura of flashing colored lights; D would then fall to the ground and thrash from side to side while groaning. She described being raped by a teenage neighbor at age 5; she remembered having been left by him lying on the ground crying and rocking from side to side. After this, she began

a sexual relationship with her brother, which ended a few months prior to her complaining about seizures. EEG was negative and seizures disappeared in hospital. The seizures were diagnosed as hysterical. D said she had never had orgasm and had been "on the road" for 2 years since running away from her home and from the incestuous relationship. She had attempted suicide twice. Psychological testing showed a schizotypal personality.

Case 5 E was a 17-year-old Spanish-American woman whose left temporal lobe epilepsy had been diagnosed at the age of 8. The diagnosis had been confirmed by EEG. She was psychiatrically hospitalized after overdosing with her seizure medication. In hospital she disclosed incestuous relationships with a younger brother, a paternal uncle, and a first cousin, which had taken place between ages 8 and 12. Her mother confirmed this. Over the 2 years preceding hospitalization, E had developed a new type of seizure in which she would scream and strike out at people; her usual seizures were brief absence attacks with urinary incontinence. The violent seizures cleared in hospital. She had run away from out-of-home placements as well as from her own home. She was promiscuous, but very naive about menstruation and pregnancy. She was diagnosed as having a mixed personality disorder with hysterical seizures, in addition to temporal lobe epilepsy.

Case 6 F was a Navajo girl evaluated at age 15 because of promiscuity, multiple runaways, and suicide attempts. She had been diagnosed as having temporal lobe epilepsy at age 5. At 10, she entered an incestuous relationship with her stepfather which ended when she became pregnant by him. After this, her seizures became uncontrolled on medication. The seizures changed in character, becoming longer, and involving more violent limb movements. She felt she could partially control these seizures. EEG showed abnormalities in the right temporal lobe, but the seizures were not accompanied by EEG change. These violent seizures disappeared after psychotherapy was initiated. Psychological testing showed a mixed character disorder with depression. This girl was probably uniquely at risk for incest because of the cultural belief that her epilepsy was a sign of incest. It was felt that hysterical seizures had been superimposed on the temporal lobe attacks after her incestuous experience.

DISCUSSION

These six cases share characteristics in addition to the history of prior incest. All six patients experienced relief from their hysterical seizures when psychotherapy began to explore the incest experience. All six had histories of running away from home; all had either threatened or attempted suicide. Four were promiscuous, one was nonorgasmic, and the sixth was homosexual. All presented psychiatrically in their teenage years. Prior incest should be suspected in cases of hysterical epilepsy which present in this way, since psychotherapy is rapidly effective in such cases.

Review of the psychiatric literature revealed four additional cases. Schechter and Roberge[6] described a 14-year-old American Indian boy who convulsed on his way home from church after hearing a sermon about incest. He was involved in incest with his sister. This boy was not Navajo but had been influenced by other American Indian folk beliefs that associate incest

with epilepsy and witchcraft. McAnarney[7] reported the case of a 15-year-old Anglo girl who presented with hysterical seizures and subsequently revealed ongoing incest with both father and brother.

Standage[5] collected 25 cases of hysterical seizures. No systematic effort had been made to obtain complete sexual histories of these patients, and many were interviewed by neurologists rather than by psychiatrists. Despite this, two (9%) of the 21 women in the sample reported prior incest experiences. One of these patients had been diagnosed as having petit mal epilepsy at age 3 years. However, in adolescence she developed more violent attacks in which she would fall to the ground and injure herself. During an amobarbital interview, she revealed a long history of incest with her father. The other patient experienced her first seizure at age 15, shortly after her alcoholic father attempted intercourse with her. Seizures consisted of her spitting; screaming, "Don't touch me"; throwing her limbs about widely; and assuming the position of arc de cercle. Seizures stopped when she was allowed to live apart from her father. In another case report[8] an adolescent girl with hysterical seizures described, under amobarbital, a sexual attack. However, because there was no physical evidence of intercourse, her account was assumed to be fantasy.

Recently, Gross[9] reported four cases of incest victims aged 13 to 15 who presented with hysterical absence attacks or convulsions. All four had either threatened or attempted suicide. All four perpetrators were alcoholic fathers and the girls' "ictal" amnesias seemed to mimic their fathers' "alcoholic blackouts" as a defense against taking responsibility for the sexual involvement.

Early in his career, Freud postulated that many hysterical symptoms resulted from early sexual traumata. However, he did not publish any cases of hysterical seizures resulting from incest. Freud later modified this trauma theory, taking the position that most hysterical symptoms result not from actual incest, but from anxiety caused by incestuous wishes and fantasies.

We obtained independent confirmation of prior incest in all six cases reported here. Four of the six women reported sexual assaults by more than one perpetrator, and one of the four cases in the literature involved multiple incestuous relationships. In our cases this multiplicity results not from the child's tendency to fantasize such relationships, but from a powerful compulsion to repeat an early overwhelming experience. We had expected that some Navajo epileptics would present with fantasized accounts of childhood incest because of the cultural belief that this must have occurred. Temporal lobe seizures that include an orgasmic aura might also produce such fantasies.[10] However, we have not been able to confirm any such case of incest fantasy in a Navajo epileptic. It did seem, however, that in case 6 the Navajo child was uniquely at risk for incestuous acting out because she was epileptic. Neutra et al[3] have found that among female Navajos with grand mal epilepsy 30% have experienced incest. In true epileptics the

incest experience usually develops after the onset of seizures as relatives realize that this child is not protected by the incest taboo. These epileptic children are at risk for rape, illegitimate pregnancies, and murder, as a result of the family and community scapegoating engendered by the disease. Psychoses, hysterical reactions, and suicide attempts are also frequent in these epileptic Navajo women. In Navajos with hysterical epilepsy the incest precedes the seizure.

It is possible that epileptic children other than Navajos (as case 5) are also at higher risk for incest. A "special" or "different" epileptic child may be less clearly protected by the incest taboo.[6] A similar and familiar situation is the incest victimization of retarded children in Anglo-American culture. There is often a feeling that such children are "fair game." One pediatrician belatedly and reluctantly reported to authorities a family in which all three sons were having intercourse with their retarded sister. The pediatrician asked, "Isn't it better to save three normal boys rather than one retarded girl?"

As more data are collected the connections become more complex. Davies[11] found abnormal EEG patterns in 17 of 22 (77%) adult psychiatric inpatients with prior incest; only 20% to 30% of psychiatric inpatients in general have such abnormalities. Similarly, high percentages of EEG abnormalities have been reported in adults with sexual deviation. This could be interpreted as supporting the hypothesis that neurologic dysfunction is associated with a vulnerability to sexual abuse, perhaps because of some idiosyncrasy of childhood sexual expression or psychosexual development. Epileptic foci in the limbic system may lead to hyposexuality; unusually varied sexual outlets might be sought to overcome this. Another hypothesis would be that overwhelming trauma in childhood can lead to seizures through direct effects on neurophysiologic circuitry. We know that patients with Multiple Personality Disorder (MPD), 97% of whom were traumatized in childhood, show an unusual degree of EEG plasticity, with different alters showing different auditory and visual-evoked responses.[12] Do these patients have a basic neurophysiologic lesion that causes both the EEG abnormality and dissociation? Patients with temporal lobe epilepsy can develop dissociative states.[13–15] Does the tendency to dissociate then produce a tendency toward traumatic victimization? One rape victim experienced her first and only dissociative episode during a rape; she recovered consciousness to find her jaw broken. The rapist had not been able to tolerate her dissociative response to physical and emotional pain and had escalated until the defense broke down. Could similar interactions punctuate the life histories of patients with MPD?

We could not document suggestion or contagion as explanations for the concurrence of childhood incest and hysterical seizures. Navajo beliefs about epilepsy and incest are known only to a few anthropologists and physicians; the Navajo are so reluctant to talk about epilepsy that the

condition is not even mentioned in most Navajo ethnographies. It is very unlikely that any of the Anglo patients reported on here knew of these Navajo beliefs. None of the patients was hospitalized simultaneously or treated by the same therapist.

The similarities among these cases led us to question whether hysteroepilepsy might be a particularly natural symptom choice in incest victims. The incest victim experiences guilt, conflict between pleasure and shame, and fears of being controlled or of being damaged or punished.[16] The hysterical seizure repeats movements related to sexual stimulation, as well as those related to resisting sexual assault. Weiss[17] pointed out that the position of arc de cercle is highly unsuitable for intercourse; however, this position is also an exaggeration of the backarching that occurs in orgasm and childbirth. The sense of control described by many victims may refer to the power of the convulsions to control their own tensions, as well as the power to influence and frighten observers. Instead of being terrified herself as she was in the sexual attack, the patient who repeats the attack in a pseudoepileptic mode is able to terrify others. Through her unconscious control of the hysterical attack, the victim identifies with the aggressor in the original sexual attack. The seizure disorder often helps the child attain realistic control, acting to reconcile the girl's mother and to reinvolve her in a parental relationship with the child.

Hysterical seizures serve other defensive functions. The victim magically substitutes the conversion symptoms for the more fearful punishment that might come from an outside source. In three of these six cases, seizures were described as "violent." Freud observed that bodily damage during convulsions was not necessarily diagnostic of "true" seizures in patients who have unconscious needs for self-mutilation. The amnesia that the victim experiences during her hysterical "attack" strengthens the defenses of repression, denial, and dissociation, which are often used to forget the original sexual attack. Also, by having "epileptic attacks" in public, the child can release some of the tension associated with keeping the sexual attack secret. A symbolic identification of the epileptic attack with the prior sexual attack is seen not only in the sexual characteristics of the observed seizures, but also in the child's description of the present illness. Three of the four women without coexisting "true" epilepsy dated the onset of their seizures to the time of the first seduction, but said that "seizures" had occurred secretly at that time. For girls who have dealt with the incestuous activity by pretending to be asleep during the act, the questions from physicians about whether they are "really" unconscious during or after seizures mirror their own questions about how conscious they are allowed to be. They may violently resist the suggestion that they were "really" awake during the seizure because this would mean they were "really" awake during the incest and must therefore assume the blame for what happened.

It is often assumed that folk beliefs act as self-fulfilling prophesies

to create hysterical symptoms. Observation of the six cases reported here has led us to an alternative hypothesis. Navajo and European beliefs that incest and epilepsy are connected may be based on valid psychological connections between the experience of childhood incest and the symptom of hysterical seizures. These folk beliefs may result from observation of these symptoms in incest victims in the community.

These psychodynamic underpinnings of Navajo and Greek beliefs about incest and epilepsy led us to question whether other folk beliefs about incest may rest on similar observations of a fairly uniform pattern of traumatic neurosis in incest victims. Weinberg[18] described beliefs about incest in 11 cultures. Banishment was the most common punishment for incest, occurring in seven of the 11 cultures. Suicide was enforced on incest participants in five cultures. Two of the cultures predicted sterility for incest participants and two believed that incest led to magical power.

This tetrad of banishment, forced suicide, sterility, and magical power is similar to the clinical picture of runaways, suicide attempts, sexual dysfunction, and narcissistic difficulties that were present in the six patients discussed in this paper. Devereaux,[4] in his description of shamanism as a sequel to incest among the Mojave Indians, demonstrated how this particular cultural prescription channels the isolation and guilt of incest participants, allowing them a special role in which their dissociative symptoms can be used as a way to help others. Banishment may have functioned to resolve the deep ambivalence about separation that occurs in incest situations. Many of the founders in creation myths are incest participants. This may parallel the clinical observation that creativity and complete ego functioning can occur only after the incest participant has achieved a meaningful separation from his family (see also chapter 20).

The Navajo belief that epilepsy results from incest is based on underlying psychological realities valid in many cultures. It may be better understood as a valid psychological insight than as a culturally determined pathogenic influence.[19]

CONCLUSION

The physician should always take a complete sexual history when pseudoseizures are in the differential diagnosis. Sexual trauma may predate the onset of hysterical seizures and, once established, they may be triggered even by sexual interactions.[20] In a teenager with atypical seizures and a history of incest, suicide attempts, and runaways, it may be possible to diagnose hysterical seizures by history alone. If the seizures recapitulate movements and vocalizations that occurred during the sexual event, if the onset of seizures coincides with a major change in the incest ritual, if seizures disapear once the incest is discussed with the family, the seizures are probably psychogenic. However, since two of our six patients with pseuodseizures

had organically based seizures as well,[21] a complete neurologic examination including EEG is also important.

REFERENCES

1. Temkin O: *The Falling Sickness.* Baltimore, Johns Hopkins, 1971.
2. Freud S: Some general remarks on hysterical attacks (1909), in *Standard Edition*, Strachey J (trans-ed). London, Hogarth, 1963, vol 9, pp 229–254.
3. Neutra R, Levy J, Parker D: Cultural expectations versus reality in Navajo seizure patterns and sick roles. *Cult Med Psychiatry* 1:225–275, 1977.
4. Devereauzx G: The social and cultural implications of incest among the Mojave Indians. *Psychoanal Rev* 8:510–533, 1939.
5. Standage K: The etiology of hysterical seizures. *Can Psychiatr Assoc J* 20:67–73, 1975.
6. Schechter M, Roberge L: Sexual exploitation, in Helfer R, Kempe CH (eds): *Child Abuse and Neglect: The Family and the Community.* Philadelphia, Balinger, 1976, pp 127–142.
7. McAnarney E: The older abused child. *Pediatrics* 55:298–299, 1975.
8. Glenn T, Simonds J: Hypnotherapy of a psychogenic seizure disorder in an adolescent. *Am J Clin Hypn* 19:245–249, 1977.
9. Gross M: Incestuous rape: A cause for hysterical seizures in four adolescent girls. *Am J Orthopsychiatry* 49:704–708, 1979.
10. Warneke L: A case of temporal lobe epilepsy with an orgasmic component. *Can Psychiatr Assoc J* 21:319–324, 1976.
11. Davies R: Incest: Some neuropsychiatric findings. *Int J Psychiatry Med* 9:117–119, 1978–1979.
12. Putnam F: The psychophysiologic investigation of Multiple Personality Disorder. *Psychiatr Clin North Am* 7:31–39, 1984.
13. Schenk L, Bear D: Multiple personality and related dissociative phenomena in patients with temporal lobe epilepsy. *Am J Psychiatry* 138:1311–1316, 1981.
14. Mesulam M: Dissociative states with abnormal temporal lobe EEG. *Arch Neurol* 38:176–181, 1981.
15. Van der Kolk BA: *Psychological Trauma.* Washington, DC, American Psychiatric Association, 1987.
16. Lewis M, Sarrel P: Some psychological aspects of seduction, incest and rape in childhood. *J Am Acad Child Psychiatry* 8:606–619, 1969.
17. Weiss E: A contribution to the psychological explanation of the arc de cercle. *Int J Psychoanal* 6:323, 1925.
18. Weinberg S: *Incest Behavior.* New York, Citadel, 1955.
19. Goodwin J, Simms M, Bergmann R: Hysterical seizures in adolescent incest victims. *Am J Orthopsychiatry* 49:704–708, 1979.
20. LaBarbera JD, Dozier E: Hysterical seizures: The role of sexual exploitation. *Psychosomatics* 21:897–903, 1980.
21. Liske E, Forster F: Pseudoseizures: A problem in the diagnosis and management of epileptic patients. *Neurology* 14:41–49, 1964.

12

Suicide Attempts: A Preventable Complication of Incest

Jean Goodwin

Suicides and suicide attempts are among the many complications that accrue in the wake of an incest event. In *Oedipus Rex*, that foremost of incest stories, the "victim" mutilates himself by plucking out his eyes, the "perpetrator" Jocasta commits suicide, and a nonparticipant in the incest, their child Antigone, ultimately hangs herself. In a series of German cases where fathers were convicted of incest in court, Maisch[1] reported that two of the 63 fathers (3%) committed suicide after conviction. Roberts and Hawton report that in 20% of 114 families where physical abuse had occurred, a parent made a suicide attempt after the report.[2] Wild[3] and Morrison[4] reported that risk factors for suicide were present in most incest perpetrators who attempted suicide, but were missed in the evaluation. We have previously described a triad of runaways, suicide attempts, and sexual misbehavior in teenagers whose seizures are determined to be conversion responses to prior incest.[5] It is not known what percentage of all suicide attempters belong to incestuous families. It has been estimated that 3% to 5% of suicide attempters abuse their children.[2]

This chapter presents a study which reports on the frequency of suicide attempts in families where sexual abuse had been substantiated. The aim is to define how often and under what circumstances suicide attempts occur in incestuous families so that involved professionals can be better prepared to cope with this complication.

METHODS

In a busy protective service agency that provides treatment to families where intrafamilial sexual abuse has been substantiated, records were reviewed for suicide attempts that occurred during a 2.5-year study period. Intrafamilial sexual abuse was defined as exploitative sexual behavior toward a child by a socially defined family member (this includes stepfathers and stepbrothers). Two hundred and one cases were substantiated during the study period; fathers, stepfathers, or common-law fathers were the perpetrators in over 80% of cases. The 201 study families were followed from 3 months to 33 months after the substantiation of sexual abuse, and all suicide attempts recorded in the casework charts were tabulated. Suicide attempts were defined as self-destructive behaviors taking place in the context of a suicidal plan. Suicidal threats were excluded.

RESULTS

Thirteen suicide attempts occurred in 11 families; that is, attempts occurred in 5.4% of the 201 treated families. Five suicide attempts occurred in mothers and eight attempts occurred in daughter-victims during the 2.5 years. Six attempters were Anglo (English-speaking whites), five were Spanish-American, one was black, and one was an American Indian. None of the suicide attempts was life-threatening, and no completed suicides occurred. No attempts occurred in perpetrators or in uninvolved fathers or siblings. It may be relevant for understanding this absence of suicidal behaviors in perpetrators that only five perpetrators were prosecuted during this time.

Suicide Attempts in Mothers

Three of the five suicidal mothers were diagnosed as having borderline personalities and drug abuse problems, and had made prior suicide attempts. All three took overdoses in the first week after the revelation of an atypical sexual abuse situation; for example, in one case a teenage stepson forced oral sex on the mother, and he was sexually abusing his 6-year-old brother as well. As might be expected given the poor reality testing of these mothers, a prolonged period of confusion about what was actually happening sexually in the family characterized the investigations in all three cases. These three mothers had themselves been incest victims in childhood, and were so panicked by the repetition of the sexual trauma that they were unable to cope with the immediate realities of their children's needs. Two mothers had to be psychiatrically hospitalized. Professionals who interviewed these mothers at

the time of the suicide attempts were amazed at how rapidly the mothers reintegrated their lives and their maternal functioning. These mothers readily misinterpreted agency decisions as harsh criticism. One suicide attempt was aborted when the mother telephoned her therapist while taking pills and dicovered that there was no plan to remove her child from her custody. Another mother interpreted the placement of her child with her mother (the grandmother) as a rejection and condemnation of her mothering abilities as she became more suicidal.

The two mothers who made suicide attempts later than the first week of accusation and crisis came from families where more usual patterns of father- or stepfather-daughter incest had occurred. One mother overdosed a month after the incest disclosure, on the night before a legal decision had to be made about whether her daughter would be placed. The mother had decided to leave her husband and keep her daughter, but after the overdose, she reversed her decision, and placement of the daughter was arranged. The second mother overdosed 5 months after the incest disclosure when she learned, on the same day, that her daughter could not be psychiatrically hospitalized and that her husband was leaving her. Both these mothers felt torn between the husband and the daughter. The suicide attempt communicated a protest at feeling forced to choose the daughter. Both these women were depressed with dependent personalities. One of the two responded well to tricyclic antidepressants; the other did not respond. However, neither was able to reestablish a mothering relationship with her daughter despite extensive treatment. Both daughters went on to attempt suicide themselves as they struggled with their side of the guilt about losing the mother-daughter relationship.

All five mothers were young women (aged 24 to 32) involved in ambivalent struggles with their own mothers as well as with their daughters. All described feeling unable to forgive their mothers for prior abandonments, and feeling that their mothers in turn would never forgive them if they abandoned their daughters. One woman had been abandoned at age 2 by her mother; another had been scapegoated by the family since "turning mother in for child abuse" at age 14; another had never forgiven her mother for keeping her from her father's deathbed. Another said, "I hate my mother. She made me marry at 14. If I kill myself, my daughter will have a good home." Still another said, "My mother will never forgive me now." It was impossible for these mothers to imagine mobilizing the resources necessary to adequately mother their children, but it was equally impossible for them to face the blame from their mothers and the self-blame for failing at that task. In addition, four had been surgically sterilized and the fifth had been told she was sterile secondary to multiple bouts of gonorrhea. The knowledge that they could not bear substitute children must have increased their panic at the possibility of losing the victimized daughter.

Suicide Attempts in Victim-Daughters

In this retrospective review, all eight suicide attempts in daughters occurred in victims aged 14 to 16. This is the peak age for adolescent suicides[6]; however, the median age for sexual abuse victims referred to this agency is 10 years. Three attempts occurred more than 1 year after the child disclosed incest. It is almost as though the 14 to 16 age range developmentally produces a vulnerability to suicide regardless of the age at which the incest occurred or was revealed. It may be that the combination of adolescent sexual experimentation and adolescent exploration of values rekindles feelings of moral repugnance about the incest, which may be directed toward the self as well as toward parents. Three of the suicide attempts occurred immediately after a sexual crisis with a boyfriend, such as the first experience with breast petting. Similar precipitants have been described in other series.[7]

None of the eight had been diagnosed as depressed; however, the behavior problems seen in seven of the girls may have been signs of masked depression. Five had been runaways, four were truant, three were promiscuous, and two abusing drugs. These kinds of behavior can mask depression in teenagers.[8] None of the teenagers was treated with antidepressants.

The suicide attempt was only one of many severe complications in these cases. None of the eight families managed to remain intact after the reporting of the incest. Either the father or the victimized daughter had moved out of the home. Such an outcome will occur in less than one half of the families treated by our agency, which has, as a priority, keeping families together. In all cases the mothers actively blamed the daughters for the breakup of the family and, at times, refused to believe that incest had occurred. One mother physically abused the daughter for disclosing the incest; another voluntarily relinquished custody of her daughter "for telling." Two of the mothers had previously attempted suicide in response to the incest accusation.

Like the mothers who attempted suicide, these suicidal victims directed most of their anger at their mothers. Their comments about their mothers were bitter: "Mother will want my sister back, but not me." "If I have to go back to my mother, I'll just give up."

In three cases the victim's suicide attempt occurred at a point when the victim interpreted the agency's actions as siding with the mother in condemning the girl for having made the accusation. In one instance the daughter had left therapy and returned to live with her incestuous stepfather; despite this, the therapist had neither remonstrated with the family nor reported the situation to the authorities. In a second case the agency had threatened to drop custody of the child because of the victim's misbehavior. And in a third situation the agency had just placed the youngest and only unmolested daughter with the abusing father. (He was in treatment and

was the most stable family member, but the sister experienced the decision as one more occasion when her complaints were minimized and her father was the one chosen to be trusted.)

In six cases precipitants of the suicide attempts were incidents which intensified the daughter's grief and guilt about having made the family disintegrate: a visit from an accused and now accusing father, a visit from a depressed and lonely sister, assaultive behavior by the now estranged father, and in three cases the dissolution of a foster placement.

The two attempts that occurred about 1 year after disclosure of the incest may have signaled anniversary reactions. In both cases the teenagers were able, after the suicide attempt, to cease ruminating about the incest situation and to become more productively involved with work and peers.

Seven of the eight daughters overdosed, using a variety of drugs ranging in lethality from antibiotics to heroin. The other attempter pushed her hand through a window. Only one of these children was hospitalized after the attempt, and three were able to keep the attempt secret from their families and their therapists, and did not discuss what they had done until months afterward.

SUMMARY

Suicide attempts occurred in 5.4% of 201 families where sexual abuse was substantiated and families were followed from 3 to 33 months. It is likely that this percentage will rise as the duration of follow-up lengthens. No attempts were seen in perpetrators or in uninvolved siblings. The absence of suicide in perpetrators may be secondary to the rarity of prosecution in our jurisdiction. Mothers who made attempts within the first week after disclosure of the incest had severe personality disorders with histories of prior incest in childhood and of prior suicide attempts. They swiftly returned to successful mothering. Mothers who made suicide attempts later in treatment were depressed and did not reestablish a mothering relationship with the victim. Victims who made suicide attempts were between 14 and 16 years of age, and tended to have behavior problems. Their families were not able to remain intact through the incest crisis and their mothers blamed the victims for this. Attempts were triggered by incidents which made the victim feel that mother was right to blame them, or by incidents which rekindled their grief at the dismantling of their families.

IMPLICATIONS

Despite the retrospective nature of the study, the data suggest several preventive interventions which are simple and consistent with good case management.[9]

1. Mothers who become panicked and lose touch with reality when sexual abuse is revealed deserve a thorough psychiatric evaluation and reassurance that they will not lose their children if hospitalization is necessary.

2. All mothers facing a sexual abuse accusation should be asked about prior sexual abuse in their own childhoods and about prior suicidal thoughts and behaviors.

3. Mothers and victims over 14 should be screened for depression, and depressions should be actively treated. Two studies, which have screened consecutively identified incest mothers for depression, report that over one half are found to be significantly depressed.[10]

In surveying consecutive psychiatric evaluations in my own practice, I found that 7 (35%) to 20 incest mothers were prescribed psychotropic medication as compared to only 1 (5%) in 20 physically abusive mothers. Four women (20%) in each group had made prior suicide attempts. Tricyclic antidepressants were the drugs most commonly prescribed to incest mothers. In prescribing such potentially lethal drugs for these women, one must be concerned not only about their own potential to use medication suicidally, but also about suicidal misuse by their husbands or daughters.

4. Incest victims with behavior problems and disintegrating families who are between 14 and 16 should be asked about suicidal thoughts and plans. Such children should be followed at least until the first anniversary of the incest accusation. Increased suicidal risk may be a lifelong hazard for some extremely abused victims. Carmen et al[11] found repetitive suicidal behaviors in 30% of patients with histories of both physical and sexual abuse (see chapters 1,15,16, and 20).

5. Case management decisions in cases where suicidal behavior is a risk should be examined from the point of view of the suicidal family member. Is this decision saying, "You are a bad mother"? Is it saying to the victim, "Your mother is right, you did this on purpose"? Such decisions should be discussed at length with the family in a way that leaves the door open for further clarification and for calling the therapist rather than taking an overdose. When a mother or daughter becomes suicidal, her relationship with her own mother should be explored. It may be necessary to bring the maternal grandmother or another grandmother-figure into the family's treatment to provide support and to dispel shame and guilt.

REFERENCES

1. Maisch H: *Incest*. New York, Stein & Day, 1972.
2. Roberts JC, Hawton K: Child abuse and attempted suicide. *Br J Psychiatry* 137:319–323,1980.
3. Wild NJ: Suicide of perpetrators after disclosure of child sexual abuse. *Child Abuse Neglect* 12:119–121, 1988.

4. Morrison JL: Incest reporting precipitating perpetrator suicide. *Child Abuse Neglect* 12:115–117, 1988.
5. Goodwin J, Simms M, Bergman R: Hysterical seizures: A sequel to incest. *Am J Orthopsychiatry* 49:698–703,1979.
6. Teicher JD: Suicide and suicide attempts, in Noshpitz JD (ed): *Basic Handbook of Child Psychiatry*, Vol II. New York, Basic Books, 1979, pp 685–696.
7. Anderson LS: Notes on the linkage between the sexually abused child and the suicidal adolescent. *J Adolesc* 10:157–162,1981.
8. Anthony EJ: Two contrasting types of adolescent depression and their treatment. *J Am Psychoanal Assoc* 18:841–859,1970.
9. Goodwin J: Suicide attempts in sexual abuse victims and their mothers. *Child Abuse Neglect* 5:217–221,1981.
10. Browning DH, Boatman B: Incest: Children at risk. *Am J Psychiatry* 134:69–72,1977.
11. Carmen E, Reeker PP, Mills T: Victims of violence and psychiatric illness. *Am J Psychiatry* 141:378–383,1984.

13

Female Homosexuality: A Sequel to Mother-Daughter Incest

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With increasing attention to the problem of incest, better understanding of the complexity and variability of such relationships has emerged. Reports describing homosexual incest between males[1] have appeared only in the past 20 years. Awad, in his review,[2] found only five reported cases of father-son incest and one reported case of mother-daughter incest. However, data from retrospective surveys indicate that the incidence of homosexual incest may be higher than suggested by these few case reports. A retrospective review of the histories of 1500 male child psychiatric patients showed that six (0.4%) had experienced father-son incest.[3] A German survey found that 4 (5%) of 78 incest cases involved father-son relationships and that one (1%) involved mother-daughter incest.[4]

McCarty[5] found 4% of incest offenders were mothers and that 16 (60%) of the 26 mothers studied abused female children. Those who abused female children were more likely to be seriously disturbed. Half the maternal offenders had substance abuse diagnoses and half had histories of indiscriminate sexuality including bisexuality, prostitution, or promiscuity. Overall, 95% of the sexually abusing mothers had been physically or sexually abused in childhood. Of the mothers who sexually abused children together with a male co-offender 100% had experienced childhood incest with a caretaker. Those who pursued incestuous relationships independently tended to have been sexually abused by brothers.

This chapter reviews five cases of mother-daughter incest and elaborates on one further case. Two cases of grandmother-granddaughter incest will

be reviewed and some patterns seen in homosexual incest between females will be described.

PREVIOUS REPORTS

Two previously reported cases of grandmother-granddaughter incest are similar in that both grandmothers were ill when they initiated the children into sexual relationships. Barry and Johnson[6] describe a nurse who came into psychotherapy because of anxiety about her dislike of elderly female patients. As a teenager, this woman had engaged in mutual masturbation with a terminally ill grandmother. The child was simultaneously involved in an incestuous relationship with her father. The latter she experienced as guilt-free, but she felt ashamed about the relationship with the grandmother and ended the sexual activity at age 15.[7] I have recently treated a very similar case where a nurse recalled childhood sexual abuse by her grandmother only after she sought psychotherapy because she was physically abusing elderly female patients. A case report from Germany describes a 74-year-old woman who made her 8-year-old granddaughter manipulate the grandmother's genitals "to strengthen the abdomen." The grandmother was found to be abusing barbiturates and to have hypochondria with depression and dementia.

Five reported cases of sexual contact between mother and daughter deviate in some ways from the usual definition of sexual abuse as the sexual exploitation of a child by a caretaking adult.

Weiner[8] describes a sexual relationship between a mother and her 26-year-old daughter. The daughter had been in foster homes since infancy and first met the natural mother at the onset of their 4-month-long sexual relationship. The daughter subsequently married and had five children before being hospitalized with depression at age 39, at which time she disclosed the relationship. Since this case involves consenting adults and a natural mother who was not her caretaking figure, it does not qualify as sexual abuse even though the relationship was biologically incestuous.

Two cases reported from Germany involve multiple familial perversions and are also dissimilar from most cases of incest. In one case[7] the mother physically abused her 6-year-old son and 5-year-old daughter while smearing them with excrement. While beating the daughter, the mother would masturbate the girl with her hand or with a shoehorn. The father was involved as a spectator. Both parents were alcoholic. Maisch[4] describes a case in which the stepfather's perverse sexual needs led to mother-daughter as well as father-daughter incest. This man came to depend, for sexual arousal, on watching his wife masturbate while she described fictitious lesbian experiences. When he began a clandestine relationship with his pubertal stepdaughter, he insisted on the same preintercourse performance. Eventually, he persuaded his wife and daughter to stage lesbian dramas for him. After watching them

engaged in mutual masturbation, he became sexually excited and had intercourse with both mother and daughter.

The reported mother-daughter relationships which most resemble the more common father-daughter patterns of sexual abuse are those reported by schizophrenic women who describe childhood sexual relationships with mothers.[9] In one case a woman who became psychotic in college described a ritual which began at puberty. Her mother would frequently have the child strip while the mother commented on the ugliness of the child's body and made the child do special exercises to correct these defects. A few years later when the mother became terminally ill, she frequently had the child massage her. Sexual aspects of this idiosyncratic relationship are so mixed with other material, it is unclear whether it can be defined as incest. A more clear-cut case involves a 30-year-old married woman who came into treatment after a psychotic episode. Early in treatment she complained of her father's seductiveness. Later, she revealed that she had always slept with her mother and that at night the mother would lie behind her and fondle her breasts. This woman was unable, even as an adult, to refuse her mother this favor until she had been in treatment for many months.

The following case describes a mother-daughter relationship which shares many characteristics with father-daughter incest. The sexual contact began in early puberty and was ended by the daughter several years later. The mother initiated the sexual contact in the context of a deteriorating marital relationship. The secret remained shrouded in amnesia, confusion, and shame, and was not revealed by the daughter until her second year of psychotherapy. This is a unique case of mother-daughter sexual contact in that the mother was a practicing homosexual outside the home and the daughter later engaged in overt homosexuality.

Case history J was a 28-year-old Anglo (English-speaking white) graduate student, who entered psychotherapy on the recommendation of her physician. Her presenting problem was migraine headaches of several years duration. J presented herself as a bright, verbal, somewhat hostile woman. She related a 5-year history of severe migrainelike headaches which began when she returned to her parents' home after an unsuccessful attempt to emancipate herself by attending a distant university.

J was the only child of a highly religious, energetic woman and her quiet, withdrawn husband. The family lived in a small town where her father was employed as an engineer. The family interactions were controlled by the mother who made excessive demands upon both her daughter and her husband. The father would respond by withdrawing emotionally and taking as many business trips as possible. When J was approximately 6 years old she began sleeping in her mother's bed. The parents had had separate bedrooms for approximately a year prior to this. The mother's explanation for the new sleeping arrangement was that she "got lonely." They continued to sleep in the same room for 8 years. At the same time J had a room of her own, which her mother fanatically insisted she keep neat; she even refused to let the child play in this room.

When J was prepubertal, she awoke on several occasions to find her

mother leaning over her after having kissed her. After she reached puberty, there were two incidents in which she awoke to find her mother fondling her breasts. At age 14, J awoke after feeling a hand on her genitalia. Like the previous experiences, this had a dreamlike, unreal quality. Soon after this, J demanded that she return to sleeping in a bed of her own. Her mother reluctantly agreed. Her mother then occasionally shared her bed with a female friend. J was convinced this was a sexual relationship and wished her father would demand that the relationship cease.

When J was 18, her father died and she attempted to leave home to attend college. Her mother soon fell ill and demanded that J return home to care for her. J did this and soon found a job. She then entered into a series of homosexual relationships, which characteristically ended with J rejecting her partner. J eventually convinced her mother to move to a town with a university and there she completed school.

J entered psychotherapy to gain relief from her headaches. She was hesitant to discuss her family history and was guarded in general. The process of psychotherapy focused on her ambivalent strivings to emancipate herself from her mother. Early in treatment she slashed herself in a mutilating suicidal gesture after a disagreement with her mother. After a year of therapy, which included chemotherapy for depression, she was able to move out of her mother's home.

She embarked on a short courtship which ended in marriage to a young man with whom she shared many mutual interests. She had hopes that mother would no longer intrude into her life after the marriage, but these have proved untrue. She remains in therapy, although at less frequent intervals.

DISCUSSION

This case of mother-daughter incest more closely fits the definition of sexual abuse than do five previously reported cases. Nevertheless, both therapist and patient were uncertain at times as to whether these incidents were indeed sexual abuse or simply part of the normal closeness that exists between mothers and daughters. Had these same incidents occurred with the father rather than the mother, it would have been clearer that these incidents were sexual and exploitative in nature.

Examination of the anthropologic and psychiatric literature reveals that physical closeness between mothers and daughters is much less subject to taboo than are father and daughter contacts. In some cultures mothers commonly fondle the genitals of their nursing infants. This occurs among the Hopi in North America, the Siriono in South America, and the Alorese in Indonesia.[10] In Western culture mothers tend to show more emotional and physical closeness toward their daughters than toward their sons.[11] This closeness has been shown to have positive effects[12] and may be biologically necessary in preparing girls to nurture their own children.

This greater toleration of physical intimacy between mothers and daughters makes it more difficult for the child, the parent, and eventually the therapist to recognize when these contacts become incestuous. The ambiguity of the taboo makes it more difficult for the child to set limits

on the mother. Children in other cultures may face similar ambiguity. Among Anatolian peasants, genital stimulation of nursing infants is prescribed; however, some individuals, as adults, recall the experience as disturbing, and wonder if the mother crossed some undefined line (Michael Meeker, personal communication, 1981). We have found that a useful guideline in defining mother-daughter incest is to ask oneself, "Would I consider this to be incest if the father were the initiator?"

Since the reports of mother-daughter incest are both few and brief, we can only make tentative statements in regard to this form of incest. These mothers seem to be similar in some ways to those mothers who initiate mother-son incest.[13,14] Most notably, they are aggressive women who have abandoned their maternal role for an exploitative relationship with their children. The mother's need for nurturance, especially while she is physically ill, often precipitates a sexual relationship with the child. In both of the grandmother-granddaughter cases and in one of the mother-daughter cases, illness in the perpetrator precipitated the sexual contacts. In J's case the mother used her own illnesses to maintain her long-time hold on her daughter.

The sexual contact in the reported cases varies greatly. It ranges from voyeurism through kissing and fondling to mutual masturbation. In both cases of grandmother-granddaughter contact and in two of the cases of mother-daughter incest, sleeping in the same bed was the precursor to more explicit sexual contact. Kaplan and Poznanski[15] found that daughters who sleep with mothers constitute a distinctive subgroup of child psychiatric patients. The five mothers they studied were involved in deteriorating marriages. The fathers were passive but very angry with their wives because of the sleeping arrangements. The mothers were seen as using the sleeping arrangement as a means of avoiding sex with the husband.

The victims of mother-daughter incest presented with a variety of serious symptoms. These included encopresis, depression, psychosis, and migraine headache with homosexual acting out. One of the granddaughter victims presented with mixed phobic and neurotic complaints. This picture of varying psychotic, depressive, and psychosomatic complaints is similar to the sequelae of father-son incest. The presenting symptoms in the child victims of father-son incest have included: (1) sex play with sister,[16] (2) effeminate behavior and suicidal gestures,[17] (3) drug-induced psychosis and homosexual fears,[18] (4) acute psychosis and homosexual encounters,[19] and (5) eczema and delinquent behavior.[2]

In one of the mother-daughter cases and in one of the grandmother-granddaughter cases, the victim's presenting complaint was sexual abuse by the father. Careful therapeutic work was required before the victim could reveal the homosexual incest as well. In two of the other cases, the father was an active participant in sexual activity between mother and daughter. These observations lead to a concern that mothers may be more actively

involved in cases of father-daughter incest than previously thought. There may be a continuum of maternal involvement with active participation at one end and active effective protection at the other.

The case of J described homosexual behavior in the daughter as a sequel to mother-daughter incest. It also involved a mother who was a practicing homosexual outside of the family. This pattern has been described in father-son incest. In two of the five reported father-son cases, the father had been a victim of homosexual incest as a child.[18, 19] One had been a practicing homosexual for years. Two of the victims of father-son incest developed homosexual interests. However, there is no evidence that the children of homosexuals are at any special risk for incest in general.[20]

Previous studies have discussed female homosexuality as a consequence of heterosexual incest. A survey that compared homosexual and heterosexual women in a nonpatient population found a significantly higher incidence of prior incest among homosexual women (7% *vs* $<1\%$).[21] In this case of mother-daughter incest the homosexual experimentation seemed to be part of the girl's attempt to find a resolution to the incest by repeating it. This may be similar to the heterosexual promiscuity that is a symptomatic solution chosen by some victims of heterosexual incest. Recently, two additional cases have been published,[22] in both of which the victim of mother-daughter incest subsequently developed homosexual fantasies or relationships. One of these women identified with the mother to the extent of sexually abusing her younger sister in an even more brutal way than her mother, who was abusing both daughters, had done. Victims of heterosexual incest may resort to homosexuality as a way out of the anxiety and the sexual dysfunction that heterosexual contact would precipitate.

CONCLUSION

Mother-daughter incest is probably more common than the rare case reports would indicate. To facilitate the identification of such cases, the following is suggested[23]:

1. Examine reports of mother-daughter physical contacts with the question in mind, "Would this contact be judged incestuous if the initiator had been father rather than mother?"
2. Explore in detail those family situations in which mother and daughter share a bed.
3. Consider the possibility of active involvement by mother in father-daughter incest cases.

"Softer" clues which should also prompt the therapist to consider homosexual incest include: (a) the reliance of a physically ill mother on a particular daughter for nurturance; (b) the presence of overt homosexuality in both mother and daughter.

REFERENCES

1. Cory W: Homosexual incest, in Masters REL (ed): *Patterns of Incest*. New York, Basic Books, 1963, pp 265–273.
2. Awad GA: Father-son incest: A case report. *J Nerv Ment Dis* 162:135–139, 1976.
3. Dixon KN, Arnold LE, Calestro K: Father-son incest: Underreported psychiatric problem? *Am J Psychiatry* 135:835–838,1978.
4. Maisch HS: *Incest*. New York, Stein & Day, 1973.
5. McCarty LM: Mother-child incest: Characteristics of the offender. *Child Welfare* 65:447–458,1985.
6. Barry MJ, Johnson A: The incest barrier. *Psychoanal Q* 27:485–500,1958.
7. Cabanis D, Phillip E: The paedophile homosexual incest in court. *Dtsch Z Gesamte Gerichtl Med* 66:46–74,1969.
8. Weiner IB: On incest: A survey. *Excerpt Criminol* 4:135–155,1964.
9. Lidz RW, Lidz T: Homosexual tendencies in mothers of schizophrenic women. *J Nerv Ment Dis* 149:229–235,1969.
10. Ford CS, Beach FA: *Patterns of Sexual Behavior*. New York, Harper & Row, 1951.
11. Diamond M: Biological foundations for social development, in Beach FA (ed): *Human Sexuality in Four Perspectives*. Baltimore, Johns Hopkins, 1977, pp 22–61.
12. Miller TW: The effects of core facilitative conditions in mother on adolescent self-esteem. *J Soc Psychol* 100:147–148,1976.
13. Weinberg SK: *Incest Behavior*. New York, Citadel, 1955.
14. Wahl CW: The psychodynamics of consummated maternal incest. *Arch Gen Psychiatry* 3:188–193,1960.
15. Kaplan SL, Poznanski E: Child psychiatric patients who share a bed with a parent. *J Am Acad Child Psychiatry* 13:344–356,1974.
16. Bender L: *A Dynamic Psychopathology of Childhood*. Springfield, Ill, Charles C Thomas, 1954.
17. Rhinehart JW: Genesis of overt incest. *Compr Psychiatry* 2:338–349,1961.
18. Langsley DG, Schwartz MN, Fairbairn RH: Father-son incest. *Compr Psychiatry* 9:218–226,1968.
19. Raybin JB: Homosexual incest: Report of a case involving three generations of a family. *J Nerv Ment Dis* 148:105–110,1969.
20. Green R: Sexual identity of 37 children raised by homosexual or transsexual parents. *Am J Psychiatry* 135:692–697,1978.
21. Gundlach RH: Sexual molestation and rape reported by homosexual and heterosexual women. *J Homosexuality* 2:367–384,1977.
22. Forward S, Buck C: *Betrayal of Innocence*. Los Angeles, JP Tarcher, 1978.
23. Goodwin J, DiVasto P: Mother-daughter incest. *Child Abuse Neglect* 3:953–957,1979.

14

The Incest Pregnancy

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This chapter reviews the theoretical importance of the incest pregnancy and the studies which have documented the genetic hazards of incest. It also describes the clinical problems that develop when the accident of pregnancy intervenes in a family already enmeshed in an incest situation.

THE INCEST TABOO AND THE INCEST PREGNANCY

The incest taboo appears in all times and cultures. In some of the most widely accepted theoretical explanations for this universal taboo, it is the incest pregnancy which is singled out as the intolerable eventuality against which the taboo was erected. The sexual relationship itself threatens social and familial priorities, but it is the potential for progeny that creates a disequilibrium serious enough to warrant proscription.

The biological explanation for the origin of the incest taboo hinges on the increased risk of damaged offspring when close relatives mate. Long before modern genetics had precisely defined these risks, there was a folk perception that incestuous offspring were somehow degenerate, both mentally and morally.[1] Such genetic fears led to laws forbidding sexual intercourse among consanguineous relations; these are the "incest" laws which survive in many states. The genetic hazards of incest are now understood to include both (1) an increased risk of homozygosity which may lead to mortality, malformation, or decreased ability to adapt and to

procreate, and (2) other genetic and extragenetic effects which decrease fertility in the offspring.[2]

Anthropologic explanations of the incest taboo[3, 4] focus on its efficacy in extending social contacts and promoting interdependency among human groups. In some cultures the belief is stated quite matter-of-factly that human beings would never leave the security of the family home unless driven by the desire to mate and by the taboo against mating within the family unit. The incest taboo, together with the biological drives toward mating and procreation, forces families to create the network of cooperative and economic bonds that is necessary for human survival.

Explanations which depend more on intrapsychic realities point out how disruptive is the incest situation to family functioning. Incest violates generational boundaries, and superimposes rules for behavior between lovers on the contradictory rules about how father and child interrelate. Jealous rivalry between mother and daughter is dissonant with the behaviors prescribed in their parent-child roles. The incongruity between behaving as a daughter to the father and behaving as mother to the father's child strains even our culture's streamlined kinship terminology. The incestuous father would be both father and grandfather to such a child; the incest victim's brothers are uncles to the child and also half-brothers; the infant's mother is also its half-sibling. Anthropologists argue that the incest taboo is designed to prevent such conflicting and incongruous situations which are psychologically intolerable.

THE "TYPICAL" INCEST SITUATION

In 70% to 80% of incest cases, it is a father or father-figure who is involved with a daughter in the sexual relationship.[5, 6] There are probably many reasons for this. The taboo on mother-son incest is so powerful as to prevent the occurrence or at least the confession of this type of incest, except in very disturbed families. In most cultures not only the mother, but all maternal relatives are more stringently interdicted as sexual partners than are paternal relatives.[7] Sexual relations between siblings seem often to be experienced as sexual play rather than as incest; the current Anglo-American focus on the nuclear family provides few opportunities for incest to occur between extended family members. In about one half of the cases of father-daughter incest, it is the natural father who is involved. The balance of cases involves stepfathers.[2]

The incestuous father is often a man who was emotionally deprived as a child. He seeks the nurturance denied him as a child through overinvesting in his family. Also, being a social introvert, he is unable to develop outlets outside the family. Weinberg[8] has called these fathers "endogamic." This type of father is usually of average intelligence and without diagnosed psychiatric disorder or criminal record. He limits his social and sexual contacts

to his family. He is usually the dominant figure in the family; this dominance may become paranoid in nature if any family member (especially his sexual partner) begins to form social relations outside the home.

Mothers may be as needy and dependent as the fathers.[9] The mother's own mother was often unavailable and hostile. The mother may relinquish her duties as mother and wife to her daughter, and may withdraw sexually from her husband. The mother's desperate dependence emotionally and economically on the father perpetuates the incest situation. She cannot assert herself against her husband to protect the daughter.

Daughters are often eldest daughters (64%, according to Weinberg) and role reversal tends to dominate interaction with the mother. She may seek out affection from the father, for she is often socially isolated and in need of human contact. Special presents and privileges are used to maintain the secret relationship. Daughters may also see themselves as the only person who can hold the family together through pacifying the father.

PREGNANCY AS AN EXIT FROM THE INCEST SITUATION

As can be seen, incest is a triangular situation perpetuated by many emotional and social factors. Incestuous relationships last several years[2] and terminate in a number of ways. Some possible exits are: (1) the daughter refuses to continue the relationship; (2) the daughter leaves home; (3) the mother, the daughter, or another family member argues with the father and reports the incest; or (4) the daughter becomes pregnant (venereal disease rarely provides a similar exit into medical discovery of the incest).

The frequency of incest pregnancy has been quoted in several studies. It ranges from 1.7% in Meiselman's study[2] in California in the 1970s, to 50% in Kubo's study[10] in Japan in the 1950s. Weinberg[8] found a 20% frequency of pregnancy; Maisch[11] found the same frequency when studying a similar group of forensically identified cases in Germany. Merland et al from France[12] reported that 14% of incest victims were pregnant. De Francis,[5] in a 1965 study of 269 incest victims in New York City, found that 29 (11%) were pregnant. Meiselman's low figure for pregnancy frequency fits into a pattern of declining frequencies in this country since the 1960s; Gligor,[9] in 1966, found that only 7% of victims were pregnant. In New Mexico in 1977, a survey showed that 10% of victims were pregnant.[13] In 1980 in a New Mexico county with an active treatment program for incest, less than 1% of victims were pregnant. The increases in use of the birth control pill and in sex education in the schools have probably influenced this observed decline in frequency. Forensic series of cases always seem to include more pregnancies than do series identified by therapists, perhaps because cases involving pregnancy are more likely to be prosecuted.

The figures would also support a hypothesis that exit from the incest

situation via pregnancy occurs less often when other exits become more available, such as reporting and treatment (see chapter 19).

GENETIC RISKS IN INCEST

The child of a biologically incestuous union is at higher risk for malformation, both because of the increased risk of autosomal recessive disease and because of an increase in the risk of polygenic malformation. For mates who are unrelated, the probability of their having a child with an autosomal recessive malformation depends on the carrier frequency of the deleterious gene in the general population. For mates who are genetically related, the probability of recessive disorder in the offspring varies with the percentage of shared genes in the parents. The following hypothetical case is an expanded version of an example used by Sarah Bundey[14]:

> The carrier frequency of Hurler's disease in the general population is 1/150. The probability that a carrier for Hurler's will mate with another carrier in the general population and have an affected child is 1/600 (1/150 × 1/4). On the other hand, if that carrier were to marry her first cousin the probability increases to 1/32: the proportion of their shared genes (1/8) times the risk that both recessive genes of the carriers would sort into a homozygous affected child (1/4). If the carrier for Hurler's mates with her father, the probability of having an affected child goes even higher: 1/2 (the proportion of shared genes in father and daughter) × 1/4 = 1/8; that is, there is one chance in eight that the child will be affected, as opposed to the one in 600 risk that would have prevailed had the woman chosen an unrelated mate.

As can be seen, the probability of having a homozygous child with a major single-gene defect increases with increasing shared genes. It is estimated that every individual carries three to eight detrimental genes.[15]

In addition, children of an incestuous mating also have an increased possibility of having a polygenic malformation. These abnormalities are caused by many genes in combination. Since related parents have more shared genes, their risk of having offspring with polygenic malformations is also increased.

The translation of theory into actual data has been studied by several authors. Most studies of consanguinity have been evaluations of third-degree relatives, (matings between first cousins). Unfortunately, very few studies have looked at offspring of the first-degree relatives usually involved in clinical cases of incest. The following is a review of existing studies on children of consanguineous matings.

Third-Degree Relatives: Matings Between First Cousins

Spontaneous abortion Fraser and Biddle[16] measured the percentage of spontaneous abortion in first-cousin marriages. They found that 15.5% of pregnancies in the first-cousin matings ended in fetal loss, compared

with 13% for the control group. They concluded: "There is no appreciable increase of recognizable fetal loss attributable to rare recessive genes." These percentages are in concordance with those found in Chicago by Slatis et al.[15] They reported a rate of spontaneous abortion of 14.5% in first-cousin matings versus 13% in the control group. A study of consanguinity in Japan showed that inbreeding had no significant effect on the rate of fetal loss.[17] However, one study done in Iran[18] does report that the rate of spontaneous abortion as well as later mortality and morbidity are significantly higher in first-cousin matings. In the Iranian study, the rate of spontaneous abortions in controls was 9.5%, and the rate in related offspring was 14.5%. However, this finding could be due to other differences between the groups, such as differential diet or care.

Mortality Many studies report a higher mortality rate for offspring of consanguineous matings. In these genetic studies, mortality is usually defined as neonatal or infant mortality plus later deaths resulting from congenital conditions. Naderi[18] found a 3.9% mortality in offspring of first-cousin matings versus a 2.6% mortality in controls. Fraser and Biddle[16] reported an 8.8% mortality in the consanguineous offspring versus 4.1% in controls. In their Chicago study, Slatis et al[15] found mortality figures of 8% in related couples and 2% in control couples. In the consanguineous group two children died of cystic fibrosis, one of von Gierke's disease, and one of muscular dystrophy. All these disorders are thought to be transmitted by autosomal recessive genes, creating a "nonrandomness" in the increased mortality among the consanguineous offspring. All 17 deaths in the study by Slatis et al[15] occurred in 12 of their 209 families.

Malformations As with mortality, anomalies in offspring of related partners are higher than in controls. Slatis et al[15] examined abnormalities which "seriously interfered with the processes of a normal life." Disabilities secondary to infection were included, since resistance to infections is genetically mediated. Using those criteria, major disabilities were found in 15% of consanguineous offspring and 10% of the control offspring. Naderi[18] found that the frequency of congenital abnormalities was 4% in consanguineous matings versus 1.6% in nonconsanguineous matings.

Second-Degree Relatives: Uncle-Niece Matings

Mortality In a study of Moroccan Jews by Fried and Davies,[19] the mortality rate in the consanguineous offspring (N = 131) was 16.8%. The control group's mortality rate was 6.7%.

Malformations Congenital abnormalities were found in 7.6% of incest offspring but in only 2.2% of the control children. In three of the consanguineous sibships a particular anomaly was manifested in more than one child.

First-Degree Relatives: Father-Daughter and Brother-Sister Matings

The more closely related two partners are, the more genes they share. This increases the probability that autosomal recessive disease and polygenic malformations will be expressed. Since first-degree relatives share one half of their genes, they run the highest risk for expression of deleterious genes.

Mortality Carter[20] reviewed the outcome for 13 offspring resulting from incestuous matings between first-degree relatives. Their mortality rate was three in 13, or 23%. All children who died had genetic diseases. The diseases and deaths were directly attributed to the incest. Seemanova's study[21] of 161 incest offspring also reported a higher mortality rate than has been reported for offspring of second- or third-degree relatives. Of the incest cases, 13% died (21 of 161) compared with 5.3% in the control group (five of 95). Death again could be attributed to genetic problems resulting from the first-degree mating. Examples of abnormalities causing death in this study were cystic fibrosis, tetralogy of Fallot, cerebral degeneration, and lymphosarcoma in a child with cerebral palsy. None of the control children who died had congenital abnormalities. Adams and Neel[22] found a mortality rate of 16.7% in their study of 18 incest offspring. one of the deaths was attributed to glycogen storage disease, one to prematurity, and the third to respiratory distress syndrome. None of the control children in this study died.

Prematurity Prematurity was also more prevalent among the incest group in Seemanova's study.[21] Twelve percent of the incest pregnancies ended in premature deliveries versus 6% in the controls. On the other hand, Adams and Neel[22] found no difference in prematurity rates.

Malformations In the offspring of first-degree relatives, the frequency of congenital abnormalities is higher and the malformations are more detrimental. In Carter's study,[20] only five of the 13 children (38.5%) were normal at age 4 to 6 years. Of the ten surviving children, four had IQs in the range of 59 to 76, and one child was more severely mentally retarded.

Seemanova's study[21] confirms the above findings. Among the 130 living incest offspring whose mothers had no apparent defect, 53, or 41%, had congenital abnormalities, compared with four of 86, or 4.7% of the control group. These differences are highly significant. Multiple congenital anomalies were found only in the incest group. Congenital abnormalities also tended to be severe (meningocele, heart malformations, cystic kidney disease, homocystinuria). In contrast, the polydactyly and luxation of the hip found in the control group were not as severely limiting to healthy functioning. Only 78 of the 161 children (48.4%) were normal at follow-up. In the incest offspring studied by Adams and Neel,[22] three of the 15 children who survived (20%) had major congenital abnormalities, two with

severe cerebral palsy, and one with bilateral cleft lip. Of the control children, three had minor abnormalities and only one had a major abnormality. Two of the incest children had minor abnormalities (acetabular dysplasia). Three others (20%) had mental retardation without other abnormalities. Only seven of the 18 children of first-degree unions (38.9%) were normal at 6 months of age.

Summary of the Genetic Risks

The detrimental genetic effects of incest increase with the increasing genetic relatedness of the parents. Early death can be expected in 4% to 8% of the offspring of third-degree matings, in 17% of the offspring of second-degree matings and in 13% to 23% of offspring of first-degree matings. Among surviving offspring, serious malformations will occur in 4% of the products of third-degree matings, 8% of the products of second-degree matings, and in 21% to 41% of the products of first-degree matings. Bundey[14] estimates that 14% of these children will have autosomal recessive diseases, 12% will have polygenic malformations, and the balance of the affected children will have retardation only. When biological father and daughter mate, the likelihood that they will produce a healthy, surviving child is less than 50%. These data powerfully support the biological theory of the origin of the incest taboo.

Clinically, these genetic data suggest: (1) that the incest victim, pregnant by a first- or second-degree relative, deserves every opportunity to choose abortion, and (2) that when the children of such matings are relinquished for adoption, they need a thorough preadoptive medical evaluation. It has been suggested that children born as the result of incest have a strict program of audiometric, developmental, and ophthalmologic tests during the first year of life so that adoptive parents can prepare for any handicap.[14]

EXTRAGENETIC RISKS OF INCEST PREGNANCY

In addition to the genetic effects, there may be extragenetic sequelae of father-daughter incest that would ultimately decrease the likelihood that the father's (and mother's) genes remain in the gene pool. The victimized daughter cannot reproduce if she dies, either from perineal damage secondary to premature intercourse, from complications of premature pregnancy, or from suicide. Her fertility might be decreased less drastically because of an increased risk of venereal disease secondary to promiscuity, or because frigidity, homosexuality, or psychosomatic disorder secondary to the incest decreases the likelihood of successful mating. If the victim has a child, and then batters it or cannot nurture it because of psychological sequelae of the incest, this is another type of reproductive failure. However,

other forces may counterbalance such effects. For example, several studies have shown that incestuous fathers have more children than do control fathers of girls raped by non–family members.[23] Other data indicate that incest victims who reach a therapist actually have more children than do controls,[2] perhaps because they have been challenging their own fears of sterility.

The decreased fertility associated with incestuous matings may be advantageous in certain situations, as in royal families.[11] Social stability may actually increase if the monarch's fertility declines, producing fewer heirs to contend for the throne. This may explain the frequent exceptions to the incest taboo granted to royalty. In other royal incest situations, as in the Ganda and the Nyoro tribes of West Africa, the polygamous king's sister-wives are forbidden to have children, and abortifacients are used to maintain their sterility. It is believed that any children would be born deformed or dead.[7]

CLINICAL REALITIES OF INCEST PREGNANCY

The incest pregnancy constitutes a clinical crisis even in situations where consanguinity is not a problem. In our small sample of eight cases, we find that incest pregnancies occur in families which are (1) intensely patriarchal, (2) extremely chaotic, or (3) unlucky.

In the intensely patriarchal family the father is a tyrannical and sometimes grandiose despot. The mission of the whole family is to obey him. Tormes[23] has described some of the bizarre demands that such fathers make. He may lock the mother in a closet while having intercourse with the children, brand the children, or lock family members out of the house. Paternity of the pregnancy is a well-guarded but proud secret. The father's desire is to keep and to raise the offspring within his family unit. Members of the family obey these wishes. The following case describes such a family:

Case 1 Mathilde is the eldest of four children. She had been in an incestuous relationship with her stepfather for 3 years (from age 12 to 15) before becoming pregnant. Her stepfather was also sexually involved with another sister and a brother. Mathilde concealed the pregnancy for the first 5 months. The stepfather accompanied Mathilde to all her prenatal visits and was present at the child's birth. Mathilde's mother knew of the paternity and was chided by the father for not joyfully accepting the pregnancy. When Mathilde's mother decided to file for divorce, Mathilde became hysterical and said she could not live without her stepfather. He returned to the home, tied the wife and children to chairs, and held them at gunpoint. He wanted the family to go away with him, saying that all would return to normal if they did. After this episode, he was hospitalized and diagnosed as a schizophrenic. Mathilde felt this "explained things" when she learned that her father was "crazy." The baby was a healthy premature female. She thrived and developed normally under the care of her grandmother, while Mathilde returned to high school.

The patriarchal system in these families diminishes the victim's chances to exit from the incest situation. The victim may feel "in love" with the father, feel "hypnotized" by him, or be diagnosable as suffering from a folie à deux.[24]

Incest pregnancy also occurs in the totally chaotic family where incest pregnancy is just one more in a series of problems. In such families the chaos can preclude other exits from the incest situation and can prolong the incest until pregnancy supervenes.

Case 2 Elena was a Navajo woman, the eldest of seven children. Her natural father was killed shortly after Elena was conceived. The mother never accepted Elena and sent her to live with missionaries. The mother remarried and, after her second husband died, she reclaimed Elena from the mission. When her mother married for the third time, Elena ran back to the mission but she was returned to her mother. When Elena was 15, her mother had a nervous breakdown. During her mother's illness, Elena and her stepfather began an incestuous relationship. Both the mother and the stepfather were alcoholics. At age 17, Elena gave birth to a daughter, Mary. Elena told doctors that her stepfather was the father, but her parents denied this and said she often lied. Elena's life continued to be filled with chaos; she became an alcoholic and began a series of involvements with men who abused her. After a younger child was killed by one of her boyfriends, Elena decided to relinquish her daughter, Mary, for adoption "and start a new life."

Elena's life had been riddled with chaos (loss of parents, foster care, alcoholic parents, psychotic mother, incest, and violence). The incest pregnancy was one element in a full spectrum of disorganization.

The following family combines elements of the excessively patriarchal and the chaotic families, and gives an example of the additional problems that consanguinity creates.

Case 3 Betty was the eldest of nine children living at home, and had been in an incestuous relationship with her natural father since age 9. The father had also had incest with two other daughters. In addition, two sons in the family were being physically abused. At 15, Betty became pregnant. She and the rest of the family failed to notice the pregnancy throughout the 9 months. Betty delivered the baby into the toilet bowl at home. Betty's mother had wondered if Betty was pregnant but had not wanted to discuss it. Betty did not admit the paternity until she told her mother during a family argument, and the mother, on learning the truth, beat Betty so severely that hospitalization was required. The child suffered recurrent pneumonias secondary to an esophageal malformation. The infant was removed from the family at 7 months of age because of failure to thrive, and Betty agreed to relinquish the child for adoption. She continued to live with her parents and to comply with their demands, including the patriarchal father's sexual demands.

In this case Betty used dissociative defenses to block recognition of the pregnancy.[25] Several previous reports describe incest victims who denied pregnancy until delivery and carried family and friends along with them in their extreme denial.[25, 26] Chapter 15 describes two victims who

submerged in amnesia the entire incest experience, including the pregnancy, until both the dissociative disorder and the extreme child abuse were diagnosed in adulthood.

In all three described cases, victims were placed in unbearable conflict by the incest pregnancy. Mathilde defended against what happened by adaptively disassociating herself from her incestuous past ("that was crazy"); Elena and Betty ultimately separated themselves from their incestuous offspring. Elena fled into alcohol and Betty had to deny the very fact of her pregnancy. All of these victims were inhibited by the incest and by the pregnancy in making the normal adolescent transition from loyalty to parents to peer affiliation.

In our experience the prognosis for the family is somewhat better when the pregnancy happens more literally as an "accident" and not as a part of the family's patriarchal or chaotic coping system.

Case 4 Fifteen-year-old Natalia was raped by her alcoholic stepfather while her mother was in the hospital. This was the only sexual advance he had ever made toward her. She realized almost at once that she was pregnant, but was ashamed to tell her mother. After 4 months, Natalia's mother filed for divorce because of other problems, and Natalia told her mother about the rape and about her pregnancy. With the support of their priest, Natalia obtained an abortion. She returned to superior school performance and an active social life.

Abortion is almost never sought when incest pregnancy occurs in a partriarchal family (the pregnancy is wanted) or in a chaotic family (the pregnancy is unlikely to be noticed or to generate any adaptive response). It is in the better-integrated family that abortion can be helpful in resolving the crisis and in minimizing interference with the child's development.[27]

PSEUDOPREGNANCY IN INCEST VICTIMS

Teenagers who have grown up in skewed and chaotic families where sex education is done via incest have difficulty in recognizing with confidence either the presence or absence of pregnancy. Some children confess the sexual experience because they fear they are pregnant. Such fears may not be banished by a simple negative physical examination.

Case 5 Cynthia is a bright 13-year-old who had not yet menstruated when her mother remarried for the fourth time. Cynthia's natural father had been physically abusive. A stepfather had sexually abused her older sister. Cynthia had lived with relatives and in foster care. The new stepfather was an alcoholic who teased Cynthia by telling her he would make her pregnant since her mother had been surgically sterilized and could no longer have his babies. Cynthia was terrified to be around him, and when he came into her bedroom and fondled her one night, she was certain he had made her pregnant. She did not confess this fear until after 2 months of foster care, when constant abdominal complaints, and a 10-pound weight gain drove her to consult a woman physician, who won her confidence. Arrangements were made for

Cynthia to see the physician weekly for 2 months for counseling and sex education. The pseudopregnancy resolved.

In another case, where treatment was not so thorough, the incestuous pseudopregnancy was not resolved completely, and left as its residue a phantom child.

Case 6 Phyllis, a mildly retarded 13-year-old, told her mother that she thought she was having a miscarriage. She confessed that 5 months previously her alcoholic stepfather had raped her. When confronted, the stepfather fled the country. The physical examination was consistent with prior intercourse, and a general practitioner concurred with Phyllis's diagnosis of pregnancy. A gynecologist, however, said that Phyllis had not been pregnant, and diagnosed dysfunctional uterine bleeding of adolescence. Three years later, when Phyllis was hospitalized for multiple drug abuse, she told her counselor that she had a 3-year-old child in another country.

MALADAPTATION TO LATER PREGNANCY

Extreme denial or rejection of pregnancy can occur in incest victims who have not worked through an actual or feared incest pregnancy.[28]

Case 7 Mrs B was a 33-year-old divorced unemployed Hispanic woman, whose three older children were in custody of her ex-husband. She became pregnant by a casual boyfriend, and never told him about the pregnancy. She sought prenatal care in the second trimester. Early in the third trimester, she asked for information about having the baby adopted. On psychiatric evaluation, she was depressed and tearful. She had told no one about the pregnancy and had made no preparation for the baby. She was afraid that her parents and ex-husband would interpret the pregnancy as proof that she was an immoral person, and that she would lose visiting privileges with her older children. She had worried about being immoral because of a sexual intercourse relationship with her stepfather that began at age 8. When she was 14, she began menstruating, and told her mother about the sex with her stepfather, because she was afraid of becoming pregnant. Mrs B was not believed by her mother and was chastised for slandering the stepfather, who was a deacon in the church; however, the sexual relations did stop at that time. Mrs B felt that her husband had many affairs during their marriage, but that it was always she who was accused, falsely, of infidelity. She was supported in gaining more information about having the baby adopted and in brief psychotherapy (four sessions) she focused on the prior incest and its influence on her self-image as a woman and a mother. She was able to tell her mother and her ex-husband about the pregnancy, and was surprised to find them supportive. She decided to keep the baby, and shortly after delivering she moved near her ex-husband and older children, and was lost to follow-up.

SUMMARY OF THE CLINICAL EXPERIENCE

Adolescents who become pregnant by a father or stepfather tend to conceal or deny the pregnancy itself and also the fact that it is an incestuous pregnancy. Abortion is rarely sought, especially not if the family is intensely

patriarchal or excessively chaotic. In the majority of cases, someone other than the incest victim ultimately provides mothering to the baby. The incest pregnancy creates conflicts that seem even more destructive to family and individual stability than the incestuous relationship itself. Children who experience or even fantasize an incest pregnancy need support in understanding what has happened and in returning to age-appropriate development tasks.

In summary, the incest pregnancy is an untenable situation both genetically and psychologically. These extreme difficulties must have been noticeable throughout human history and may account for the universality of the taboo against first-degree matings. Treatment programs for incest families should aim at reducing the 10% to 20% incidence of pregnancy found in earlier studies of victims by encouraging early reporting, so that victims can exit from the situation before they become pregnant. Once pregnancy has occurred, the therapeutic interventions needed may include: abortion counseling; careful examination of the child for congenital defects, sensory deficits, and retardation; and arrangements for care of the baby so that the young mother can return to normal adolescent activities.

REFERENCES

1. Morgan LH: *Ancient Society*. Chicago, Kerr, 1877.
2. Meiselman K: *Incest*. San Francisco, Jossey-Bass, 1978.
3. White LA: Definition and prohibition of incest. *Am Anthropol* 40:416–435, 1948.
4. Reimer S: A research note on incest. *Am J Sociology* 45:566–575,1940.
5. DeFrancis V: *Protecting the Child Sex Victim*. Denver, American Humane Association, 1965.
6. Brant RST, Tisza VB: Sexually misused child. *Am J Orthopsychiatry* 47:80–90,1977.
7. Heusch L: *Essai sur le symbolisme de l'inceste royal en Afrique*. Brussels, Institut de Sociologie Solvay, 1958.
8. Weinberg SK: *Incest Behavior*. New York, Citadel, 1955.
9. Gligor AM: *Incest and Sexual Delinquency: A Comparative Analysis of Two Forms of Sexual Behavior in Minor Females*. Unpublished doctoral dissertation, Case Western Reserve University, 1966.
10. Kubo S: Researches and studies on incest in Japan. *Hiroshima J Med Sci* 8:99–159,1959.
11. Maisch H: *Incest*. New York, Stein & Day, 1972.
12. Merland A, Fiorentini H, Orsini J: Concerning 34 psychiatric cases in which acts of father-daughter were reported. *Ann Med Legale* 42:353–359,1962.
13. Goodwin J, Fried JM: Rape. *N Engl J Med* 298:167,1978.
14. Bundey S: The child of an incestuous union, in Wolkind S (ed): *Clinics in Developmental Medicine No. 74*. London, Spastics International Medical Publications, 1979, pp 36–41.
15. Slatis HM, Reis RH, Hoene RE: Consanguineous marriages in the Chicago region. *Am J Hum Genet* 10:446–464,1958.
16. Fraser FC, Biddle CJ: Estimating the risks for offspring of first-cousin matings. *Am J Hum Genet* 28:522–526,1976.

17. Schull MJ, Nagano H, Yamamoto M, et al: The effects of parental consanguinity and inbreeding in Hirado, Japan: I. Still-birth and pre-reproductive mortality. *Am J Hum Genet* 22:239–262,1970.
18. Naderi S: Congenital abnormalities in newborns of consanguineous parents. *Obstet Gynecol* 53:195–199,1979.
19. Fried K, Davies AM: Some effects on the offspring of uncle-niece marriage in the Moroccan Jewish community in Jerusalem. *Am J Hum Genet* 26:65–72, 1974.
20. Carter CO: Risk to offspring of incest. *Lancet* 1:436,1967.
21. Seemanova E: A study of children of incestuous matings. *Hum Hered* 21:108–128,1971.
22. Adams MS, Neel JV: Children of incest. *Pediatrics* 40:1:55–62,1967.
23. Tormes Y: *Child Victims of Incest*. Englewood, Colo, American Humane Association,1968.
24. Simonds JF, Glenn T: Folie à deux in a child. *J Autism Childhood Schiz* 6:61–73,1976.
25. Silverblatt H, Goodwin J: The denial of pregnancy. *Birth Psychol Bull.* 4:13–25,1983.
26. Lage G, Marohn R: Adolescent pregnancy as a threat to the organization of the self. Read before the Michael Reese Hospital Conference on Parenthood as an Adult Experience, Chicago, September 1980.
27. Sholevar G: A family therapist looks at incest. *Bull Am Acad Psychiatry Law* 2:25–31,1975.
28. Romanik RL, Goodwin J: Prior childhood sexual abuse: A risk factor for maladaptation to pregnancy. *Birth Psychol Bull.* 3:2–9,1982.

15

Recognizing Multiple Personality Disorder in Adult Incest Victims

Jean Goodwin

Since the 1970s it has been recognized that as many as 5% to 30% of women seen in psychiatric outpatient or inpatient facilities have experienced intrafamilial sexual abuse, usually by a father or father-figure.[1–3] A characteristic symptom pattern has been described,[1, 3–5] and specific treatment strategies have been devised with group treatment for adult victims becoming a widely accepted modality.[6] Meanwhile, recent reports have pointed out that the overwhelming majority of patients with Multiple Personality Disorder (MPD) were sexually abused in childhood.[7–9] Evidence is accumulating that multiplicity-like phenomena may be more common than was once believed,[10] and dissociative symptoms are now being observed in children who are experiencing abuse.[11]

This chapter describes an occurrence which in retrospect should have been predicted, that is, the appearance in groups for adult incest victims of women with MPD or multiplicity-like phenomena. Six such cases are described. One of the women was screened out of the group, but the other five completed the highly structured ten- to 12-hour group experience. The diagnosis of multiple personality was confirmed by the individual therapist in four cases and suspected, but not yet confirmed, in two others.

These observations raise several questions. First, are other therapists who treat adult incest victims encountering similar cases and with what frequency? Cole found MPD in two (7%) of 30 women in a similar group.[12] Second, can women with this syndrome still benefit from an adult victims' group? There is some evidence that MPD is a relative contraindication to

group treatment.[13] Third, this observation raises the question of whether groups for incest survivors should routinely screen participants for severe dissociative syndromes and, if so, how this can best be done.

THE STRUCTURE OF THE GROUP

From 1979 to 1984, the author co-led eight groups for adult incest victims. Fifty women were interviewed for and/or participated in these groups. All participants were required to be in concurrent individual therapy. The group is sponsored by a rape crisis center which is part of a community mental health center and has strong ties with the local child-protective agency. There is no fee. No formal records are kept and only first names are used. A written format for the group experience is distributed in advance. This specifies three 1.5-hour afternoon sessions on successive weeks followed by a six- to eight-hour marathon and dinner held on a weekend day. The first-session topic is "What happened?" The second session deals with feelings about men and perpetrators and the third with feelings about women and mothers. Husbands or other partners are invited by group members to the marathon session which includes specific planning by each to end her patterns of victimization. Follow-up takes place when group alumnae are invited to a therapeutic weekend wilderness group 1 to 6 months after completion of the inital group. Since only one of the six women with multiplicity volunteered for this additional experience, I will not further detail this process.

Case Examples

The first case example describes the patient that I recognized early and screened out of the group. I will then describe the three other identified patients with MPD who successfully completed the victims' group.

Case 1 Leah, a 35-year-old media technician in her third marriage was referred by child protective services where her two daughters were being treated after they revealed sexual abuse by Leah's present husband and one former husband. Leah had said in a mothers' group that she was beginning to recall sexual abuse by her own natural father. She remembered his asking her to undress and stroking her breasts and genitals when she was 11 years old. He was alcoholic and Leah recalled little else of her childhood, except that she was required to care for her eight younger siblings. Leah asked to meet with the group's therapist before entering the adult victims' group. In the first interview Leah described a six-hour episode of "lost time" that took place immediately after she talked about her incest experience in the mothers' group. She had had many previous episodes of fugue and amnesia. She had once told her two young daughters that she was dying of cancer and had disappeared for 3 years. She had attempted suicide several times and had one psychiatric hospitalization. She had interspersed her life as a housewife with a career as a nude dancer, with training for her present technical career, and with an active painting hobby. She said that an Indian named Grey Eagle came to her in dreams and told her what

to paint. She had had a hysterectomy and numerous surgical and diagnostic procedures and met criteria for Briquet's syndrome. She had "given away" her first child and her two other children had spent more time in foster homes, or with other caretakers, than with Leah. At the end of the interview, Leah confided that an individual therapist had diagnosed her, two years previously, as having MPD. Leah described five named alters who had assisted her since she was 18 in various activities—being a wife, sexuality, mothering, aggression, and painting. She said that she thought it best to have an odd number of personalities so that if an issue came to a vote, there could be a clear majority decision. She understood her episodic amnesias as the result of disagreements among the personalities. It was arranged for her to return to her individual therapist and to add the victims' group as recommended by the therapist. She never appeared for treatment, however, and eventually fled both her marriage and her relationship with her daughters.

Case 2 Lisa, a 31-year-old unmarried, undergraduate student, was referred by her individual therapist because she had just recovered a memory of an incest pregnancy with her natural father. This had ended in miscarriage when she was 15 years old. In group she appeared articulate and eager to talk about her experiences. Her descriptions of her father's brutal beatings and her murderous feelings toward him were difficult to integrate with her otherwise compliant, hyperfeminine manner. The sexual and physical abuse had been prolonged and severe, beginning earlier than age 4 and continuing to age 21. Siblings were sexually abused also. She had been locked in closets and tied to the bed, as well as raped and beaten. She had first attempted suicide at age 16. In adulthood, she had one therapeutic abortion after a rape and later a hysterectomy. She had numerous physical complaints, and met criteria for Briquet's syndrome. After the third group session, she was psychiatrically hospitalized and her individual therapist discussed with group leaders some aspects of her condition that Lisa had not revealed. Lisa had been psychiatrically hospitalized more than 10 times, including a 2-year stay in a state hospital. One year previously the diagnosis of MPD had been made and 26 alters had been identified. Lisa continued in the group and attended the last marathon session from the psychiatric hospital. It was later determined that it was one of her alters who had sustained Lisa's participation in group, although with support from the host personality and from other members of Lisa's internal group. Further work revealed a second incest pregnancy and the witnessing of multiple sexual murders. Two years later the personalities have been fused and she continues in follow-up treatment.

Case 3 Leslie, a 31-year-old, married, master's-level student was referred by her individual therapist. She was very anxious in the first group saying, "I feel like a robot," "I feel like an impostor," and "I am out in space somewhere." Leslie and her younger sister had been removed from their natural mother when Leslie was 3 years old. They had been severely neglected, physically abused, and locked for long periods in closets. Both were malnourished at the time of removal. They were placed together in a foster home which later became their adoptive home, and where the foster father began having oral sex with Leslie when she was 5. Leslie has difficulty recalling the sexual incidents, but believes some were bizarre and sadistic. Leslie believes her sister was involved too, as the sister, as well as Leslie, began a series of serious suicide attempts in her teens.

Leslie has been psychiatrically hospitalized more than 10 times and treated with electroconvulsive therapy (ECT), as well as many psychotropic agents.

Her present problems related to news that her adoptive father had a fatal illness. This had triggered suppressed fears of him, revenge fantasies, and desires to see him once again. She responded to these feelings by "blanking out" and would, at times, come to herself, having done a drawing of, for example, herself split in two, or a Rubik's cube with the small squares floating away from it. Additional stress was associated with her difficulties parenting her own child and her husband's children from a previous marriage. Leslie had undergone numerous diagnostic workshops for migraine and had had a hysterectomy. She contained her anxiety well until the last group session when she went into a trancelike state for about 15 minutes. At that time she revealed that 3 years previously her prior therapist (in another state) had diagnosed MPD, uncovering three named alters. Her present therapist had forbidden Leslie to use any of these terms, although Leslie was aware that another prsonality was doing most of her schoolwork. Leslie was hospitalized. The individual therapist maintained control and Leslie remains in sporadic treatment, which includes four psychotropic agents and much crisis intervention. She has divorced, but maintains contact with one child.

Case 4 Vera presented as a pregnant, married 27-year-old, referred by child protective services, which had become involved because of Vera's severe physical abuse of her 6-month-old daughter. In the process of this involvement, Vera had revealed to her individual therapist an intercourse relationship with her stepfather which began when she was 12 and ended when she ran away from home at age 14. Current stresses included a recent rape and rheumatic heart disease which seriously complicated her pregnancy. Two older sons were living with Vera's mother. Vera followed the group's structure well, although the group was somewhat overwhelmed by the relentless profusion of new problems she brought to sessions; these included prior physical abuse by her alcoholic natural father and continued physical problems in her pregnancy, which included fevers and seizures, and which necessitated one hospitalization during the course of the group. It was not until 4 years later that the therapists learned that Vera had been diagnosed as having Munchausen's syndrome and MPD.[14] One similar case has been reported in the literature.[15] Vera's problem list had kept on lengthening, with diabetes and hysterectomy added to the other physical diagnoses, and with the uncovering of prior suicide attempts and psychiatric hospitalizations going back to age 8. There were two more rape accusations, both believed to be simulated, and her two children were worked up for seizures, which only Vera had witnessed. This was ultimately diagnosed as Munchausen's syndrome by proxy.[16] Eventually, all but the youngest child, born of the pregnancy in which treatment was provided, were removed and adopted by other families. A coordinated medical workup revealed no evidence for rheumatic heart disease or epilepsy, and Vera was observed to simulate fevers and abnormal urines while hospitalized. Matters came to a head when she was hospitalized in insulin coma and on recovery accused her husband of having injected her with an insulin overdose while she slept. It was then noted that Vera had asked to be called at different times by three different first names and that she gave interviewers five different ages: 16, 17, 19, 21, and 27. It was one of her alters who had given her the near-fatal injection. She said that the parents she referred to as "natural" had illegally adopted her to replace a toddler they had killed and buried secretly, and that she had been forced to pretend to be older than her real age in order to maintain this fiction. She traced her worries about her body to her parent's refusal to take her to doctors for fear

that their ruse and this child's new bruises and injuries would be documented. She remains in productive treatment.

The following two group participants were much less disrupted by symptoms than the first four. In both, however, they seemed to be giving subtle clues about problems with dissociation.

Case 5 Beth is 57 years old and married. Her adult children are out of the home; she works part-time as a professional and part-time as a volunteer in activist organizations. She was referred by her individual therapist because of emerging memories of sexual abuse by her natural father beginning when she was 3 years old, culminating in a pregnancy and induced abortion at age 16, and continuing into her 20s. What puzzled her was her complete amnesia for this extensive abuse until a few months before joining the group. She became more puzzled when her husband told her that she had discussed the sexual abuse extensively with him early in their marriage. She had no memory of this. Beth was often silent in group meetings and said that she "blanked out" at times. She described a recurrent dream in which there were three of her; she assigned the three selves letters and said that self 'A' was trying to tell self 'B' (who was deaf) that self 'C' had been sexually abused in childhood. Beth described herself as a dreamy child who often found herself chastised, without being able to remember the offense. On completion of the group, plans were made for her to further explore these dissociative phenomena in individual therapy, but after a few sessions she left treatment.

Case 6 Amy was a 32-year-old single administrator who was referred to the group by her individual therapist because of emerging memories of fondling by her natural father when she was about 10 years old. She had entered individual therapy to clarify her decision not to marry her boyfriend and never to have children. She was visibly anxious in the first group meeting and said that her "cheerleader" had forced her to come. Her cheerleader was an outgoing side of herself that developed out of extensive childhood daydreams in which she imagined herself as one of the "Riders of the Purple Sage," socializing and singing with Roy Rogers and Dale Evans in a cheerful, relaxed way. It was only by imagining herself in this role that she was able to interact sexually with her boyfriend without collapsing into sobbing paralysis. Amy had been treated for depression, migraines, hypoglycemia, and hypothyroidism in the past. Her brother had had his first psychiatric hospitalization at age 16 and later died by suicide. He had been diagnosed as schizophrenic and manic-depressive. Her sister had first attempted suicide at age 16 and had subsequently completed suicide after a postpartum psychosis, later diagnosed as schizophrenia. While psychotic, the sister had said that people around her thought she was a whore. She had also worried that someone might take her baby daughters out of their beds at night and "do something to them." One of Amy's concerns in the group was whether she should take action to protect these girls who now spent every weekend with Amy's parents. Although Amy came to feel more relaxed and supported in the group, she was never able to coalesce her fragmentary images of the sexual abuse into concrete sequential memories. She had few memories in any case from before age 16. She suggested the therapist read a novel, *Tour de Force*, by Christianna Brand.[17] This is the story of two sisters—mirror-image doubles—[18] who decide to merge to form one personality; then one kills the other. Plans were made for Amy to pursue individual therapy, but the exact nature of her amnesia and inner defenses remains unclear.

RESULTS

In the course of providing very brief, highly structured groups for adult incest victims, 50 women were interviewed or treated. Three of these had been previously diagnosed as having multiple personality and one was subsequently diagnosed. The syndrome was suspected in two additional women. Of the eight groups conducted in this time period, four included at least one confirmed or suspected multiple personality. Several factors make this particular group atypical of survivors' groups in general: its strong connection with a community mental health center and a child protection agency, the presence of a coleader who is a psychiatrist, and involvement of husbands or other family members. These factors may contribute to increased referrals of more fragile adult victims and also to a greater likelihood of recognition of severe dissociative symptoms. However, other factors may make this 10% figure of multiplicity an underestimate of the true frequency in such groups. For example, it was impossible to obtain complete follow-up information for all participants in this group setting where only first names were used for reasons of confidentiality.

Of the three patients with confirmed multiple personality who completed the group, all three were hospitalized, medically or psychiatrically, during the treatment course. However, this did not interfere with their attendance or subjective sense of satisfaction with the group. All three have maintained positive connections with psychotherapy. The one patient who was screened out has fled treatment all together. It was noted repeatedly that group members were less upset than were group leaders by the multiple problems and dissociative symptoms of these women.

Table 15-1 summarizes symptom patterns in the 6 women in whom MPD was suspect. The four confirmed multiple personalities showed well-described associated complications of MPD. All had prior suicide attempts and psychiatric hospitalizations. As expected, psychophysiologic symptoms were common.[8] All had had hysterectomies in their 20s. Two met criteria for Briquet's syndrome; one had Munchausen's syndrome, and one had chronic headaches. One was childless and the other three had experienced major problems in parenting. Three had undergone severe sadistic physical abuse in addition to sexual abuse. One patient had incest pregnancies. All four complained of problems in remembering their childhood abuse. Each of the four exhibited or described severe dissociative symptoms in group settings: (1) fugue; (2) use of an alter personality; (3) trance states; and (4) pseudoseizures.

Multiple personality was suspected in two other group members who were experiencing extraordinary frustration about their amnesia for the childhood sexual abuse. Both experienced separate parts of the self: one used the letters A, B, and C to designate parts with differing levels of access to the sexual abuse memories, and one referred to a part of her self as the

Table 15-1 Diagnostic Features of Six Cases of Multiple Personality Disorder or Multiplicity-like Phenomena

Patient	Age (years)	Amnesia for Sexual Abuse	Previous Psychiatric Treatment	Suicidal Behavior	Medical Involvement	Interpersonal Relationships
Leah	35	Total for many years	1 hospitalization	Multiple suicide attempts	Somatization disorder; hysterectomy	3 divorces; 1 child given away; 2 children in foster care
Lisa	31	Suppressed 2 pregnancies	10+ hospitalizations	Multiple suicide attempts	Somatization disorder; hysterectomy	No family ties
Leslie	31	Partial	10+ hospitalizations	Multiple suicide attempts	Headaches; hysterectomy	3 divorces
Vera	27	Partial	2 hospitalizations	Multiple suicide attempts	Munchausen's syndrome; hysterectomy	Stormy marriage; has relinquished 3 children
Beth	57	Suppressed an incest pregnancy	Outpatient contacts	None	None	Wife and mother
Amy	32	Total for many years	Outpatient contacts (both siblings hospitalized and both died by suicide)	None	Headaches; hypoglycemia; hypothyroidism; requested hysterectomy	Afraid of marriage

"cheerleader." Both remembered daydreams better than the realities of childhood and one recalled recurrent childhood experiences of being "falsely accused." Neither had attempted suicide, or been psychiatrically hospitalized, and neither showed or described severe dissociative symptoms in group settings. Parenting was not a major problem. Both had experienced severe abuse, with one undergoing an incest pregnancy and submitting to sexual abuse by the father in adulthood and with the other having a dense amnesia for childhood, but being the only survivor in a sibship where both other siblings died by suicide.

It may be that these two women had used multiplicity-like defenses in childhood, but have not elaborated these systems in adulthood, except as necessary to maintain their amnesia for the childhood abuse, and to handle sexual fears.[11] Marmer has described a case which seems somewhat similar.[19]

DISCUSSION

Review of these six cases suggests four areas that may predict serious dissociative symptoms in adult incest victims. The first is the sheer multiplicity of problems brought to group including medical problems and parenting difficulties, as well as suicide attempts and psychiatric treatments. A second characteristic of these women was the severity of the abuse with concurrent sadistic physical abuse, being bound and locked up, incest pregnancy, persistence of the abuse into adulthood, and severe disturbance in abused siblings. A third factor is the intensity of childhood amnesia in these women and their frustration when they try to piece together a coherent picture of the sexual abuse. The fourth factor is a history in childhood or adulthood of dissociative symptoms such as fugue, trance, pseudoseizures, using an alter for certain activities, using an alter to cope with the abuse, or maintaining an alter untouched by the abuse.

It will be apparent that all four of these factors are present to some extent in many incest victims without dissociative disorder.[7] One always uncovers more sequelae of the sexual abuse than the patient was at first able to perceive through the cloak of her denial. Other types of childhood abuse and neglect are almost always uncovered, as are submerged memories of the most painful episodes of sexual abuse. As these memories emerge, most adult victims will recall some strategy for "trancing out" or "leaving the body" which helped them survive. If multiplicity represents the extreme of a spectrum of post-traumatic response to childhood trauma,[20] this may explain the mutual acceptance of women with MPD and other victims in these groups and the generally positive outcome, despite the stress of the group experience.

REFERENCES

1. Gelinas DJ: The persisting negative effects of incest. *Psychiatry* 46:312–332, 1983.

2. Meiselman K: *Incest.* San Francisco, Jossey-Bass, 1978.
3. Rosenthal AA: Incidence of a history of incest among 18 female psychiatric patients. *AM J Psychiatry* 136:791–795, 1979.
4. Goodwin J, Flanagan M: Incest: Treating child and family. *Physician Patient* 2:59–68, 1983.
5. Herman J: *Father-Daughter Incest.* Cambridge, Mass, Harvard University Press, 1981.
6. Tsai M, Wagner NN: Therapy groups for women sexually molested as children. *Arch Sex Behav* 7:417–427, 1978.
7. Putnam F: The psychophysiologic investigation of multiple personality disorder. *Psychiatr Clin North Am* 7:31–40, 1984.
8. Bliss E: Multiple personalities: A report of 14 cases with implications for schizophrenia and hysteria. *Arch Gen Psychiatry* 37:1388–1397, 1980.
9. Saltman V, Solomon RS: Incest and the multiple personality. *Psychol Rep* 50:1127–1141, 1982.
10. Coons PM: The differential diagnosis of multiple personality: A comprehensive review. *Psychiatr Clin North Am* 7:51–67, 1984.
11. Kluft R: Multiple personality in childhood. *Psychiatr Clin North Am* 7:121–134, 1984.
12. Cole CL: A group design for adult female survivors of childhood incest. *Women Ther* 4:71–82, 1985.
13. Caul D: Group and videotape techniques for multiple personality disorder. *Psychiatr Ann* 14:43–50, 1984.
14. Goodwin J: Munchausen's syndrome as a dissociative disorder. *Dissociation* 1:54–60, 1988.
15. Shelley WB: Dermatitis artefacta produced in a patient by one of her multiple personalities. *Br J Dermatol* 105:587–589, 1981.
16. Meadow R: Munchausen syndrome by proxy. *Arch Dis Child* 55:731–732, 1980.
17. Brand C: *Tour de Force.* Harper & Row, New York, 1955.
18. Eder D: The idea of the double. *Psychoanal Rev* 65:579–614, 1978.
19. Marmer S: Psychoanalysis of multiple personality. *Int J Psychoanal Psychother* 61:439–459, 1980.
20. Spiegel D: Multiple personality as a post-traumatic stress disorder. *Psychiatr clin North Am* 7:101–110, 1984.

16

Recognizing Dissociative Symptoms in Abused Children

Jean Goodwin

Since the "rediscovery" of Multiple Personality Disorder (MPD) in the 1970s, it has become apparent that adequate treatment and prevention of this disorder will require early case finding in children and adolescents.[1] Although the majority of cases are diagnosed between ages 20 and 40, patients invariably describe onset in childhood, usually before age 6.[2, 3] Despite this natural history, prior to 1980 only one case of childhood MPD had been reported in the literature—Despine's nineteenth-century case of Estelle.[4] The *Basic Handbook of Child Psychiatry*, published in 1979, lists only one reference to MPD in its index and only four references to dissociative disorders.[5] The cases of childhood MPD published since 1980 shed some light on factors which make these disorders difficult to recognize.[6–9] First, childhood MPD is often a mild disorder expressed as episodic dissociative symptoms resembling forme fruste MPD in adults. Fleeting amnesia, depersonalization, and alteration in ego states can be easily concealed or dissembled by children or rationalized by adults. The positive aspect of this is that MPD can be treated swiftly and effectively in most children, often in only a few months in contrast to the years of intensive treatment required for adults with the disorder.[7,10] Secondly, diagnosis is difficult because affected children are in a poor position to seek assistance, often living in families of violence or with parents who suffer psychiatric disorders.[11]

In a previous paper Sachs et al[12] reviewed the evidence linking the development of MPD to abusive childhood experiences. We recommended

that abused children be screened routinely for dissociative symptoms which could signal a vulnerability to adult dissociative disorders or, more importantly, a need for protection from environmental trauma extensive enough to trigger these emergency defensive operations. This chapter outlines the settings and the personnel that could be trained for this effort and the indicators that could be used.

STRATEGIES FOR SCREENING HIGH-RISK CHILDREN

In the process of cataloguing the presenting symptoms and situations which might trigger screening for dissociative symptoms in abused children, it became apparent that this exercise was also generating an extensive descriptive check list for factors associated with dissociative pathologic findings in children. Thus the following listing becomes not only a list of indicators for screening but is in itself the outline for a structured screening interview. Other screening instruments can be integrated into use of the check list including: (a) tests for hypnotizability,[13] (b) check lists for multiple somatic symptoms,[14] (c) instruments assessing prior physical or sexual abuse in childhood or the presence of other aberrant childhood experiences,[15–17] and (d) checklists for dissociative symptoms[18] and for depression.[19] In outlining the indicators that might prompt more extensive focused history taking or formal screening, I have used four broad categories.

The first category of indicators includes familial and constitutional factors. Operationally, such indicators include diagnostic and descriptive findings made by general and forensic psychiatrists in adult patients that should trigger a request to evaluate any young children being parented by these patients.

The second category reflects medical and physiologic factors most likely to be noted by pediatric or general hospital personnel. Again, these indicators might suggest a need for extensive screening even in the absence of worrying psychological symptoms in the child.

The third category lists elements found in the child's family and social situation. These are the risk factors for dissociation most likely to be observed by child protection workers, family therapists, social workers, and workers in domestic violence shelters and rape crisis centers.

The fourth and final category of indicators includes those psychological symptoms of dissociation described in children with MPD and in other dissociative syndromes. These are the symptoms most likely to be recognized by a child's therapist or teacher or in a child psychiatric hospital or other milieu or group therapy setting. Each set of indicators is outlined and discussed in a separate section. For a structured interview based on the outline, see Appendix I.

I. Familial and constitutional indicators
   A. Presence of MPD in a parent.
   B. Presence of other severe psychopathologic disorders in a parent.
   C. Presence of a diagnosis or other condition in a parent which places the child at risk for the familial patterns listed in section III below. Pertinent psychiatric conditions include paranoia, sexual perversion, substance abuse, antisocial personality, and explosive disorders.

Braun[20] found a positive family history of MPD in 12 of 18 adults with the disorder. Kluft[6] found that 40% of children diagnosed as having MPD had at least one parent with the disorder. Kluft recommends that all children of patients with MPD be routinely screened.[7] This transgenerational pattern of transmission may reflect constitutional factors, such as hypnotizability,[21] and/or may reflect environmental difficulties for the child that may arise when a patient with untreated MPD attempts to parent. Kluft[6] described a patient whose angry alter struck one of her children during a family interview. Neither her host personality nor the child's host personality was aware that anything untoward had occurred, because the child as well as the parent switched to an alter personality during the abusive incident. Other disorders can lead to the disturbed family environment described in section III, and MPD can be misdiagnosed as a major psychosis or behavior disturbance or coexist with these disorders. For example, in a study of 33 convicted sexual offenders, Bliss and Larson[22] found that 13 had definite or probable diagnoses of MPD. Disturbances of sexuality, aggression, and impulse control can be found in association with prior childhood abuse. Parents who have been abused are at risk for transmitting their own childhood trauma to the next generation. This generational repetition of trauma has been best decribed in families of survivors of the Holocaust[23] and is part of the more general phenomenon of trauma contagion described by Terr.[24]

The following case illustrates the kind of situation in which findings in a parent might stimulate reexamination of a child to screen for dissociative symptoms.

> A 6-year-old was referred for protective services because of medical and behavioral indicators of sexual abuse and the child's allegation that her father had hurt her genitals. The father met confrontation with a blank denial, but said he had experienced a precognition that his child might be sexually abused. He suggested that a seance might identify the abuser. He had two prior convictions for pedophilia. His brother had been psychiatrically hospitalized after attacking their mother. Though generally soft-spoken and articulate, his history contained sudden inexplicable acts of violence. On one occasion he strangled the family dog; on another he tried to run down the social worker with his car. The only treatment he would accept was sex change surgery. Further exploration revealed a named female alter who had cross-dressed since childhood.

II. Medical and physiologic indicators
   A. Hospitalization of index child or other family member for non-accidental injuries
   B. Death or suicide of any family member, especially when this occurs in a context of family violence
   C. Presence of severe physical sequelae of sexual abuse including venereal disease, pregnancy, or genital damage; precocious development of sexual dysfunction syndromes
   D. Presence of intrusive or bizarre health care or health habits
   E. Observation of inappropriate absence or presence of pain or other sensation
   F. Evidence of distorted body image, such as found in anorexia nervosa
   G. Identification of a conversion disorder or other unexplained somatic symptom
   H. Presence of pseudoseizures or somnambulism

Several reviews have described the severity of the abuse observed in families of patients with MPD[1, 12] and the fact that medical intervention is often necessary. In reviewing the histories of six women whose dissociative disorders were recognized in a group for adult incest victims (see chapter 15), I found that two had been hospitalized because of abuse, two reported that siblings had been killed because of physical abuse, and two had undergone incest pregnancies. In one case, both the patient's siblings had died by suicide. Five of these six women experienced chronic unexplained physical symptoms dating from adolescence; two had chronic headaches; two carried diagnoses of Briquet's syndrome; and one had Munchausen's syndrome. The patient with Munchausen's syndrome seemed to be engaging in an ongoing epic, but unconscious, struggle to obtain medical attention for her child abuse which had not been diagnosed at the time. Another of these patients had been treated for vaginitis by her family physician 6 times from age 12 to 18; the question of sexual abuse was never raised; by age 30, chronic pelvic pain had led to numerous gynecologic surgeries. Two women in this group had been treated for epilepsy, later appropriately diagnosed as pseudoseizures.[25] Bliss found MPD in over 40% of women with Briquet's syndrome; other studies have also found headaches to be a frequent symptom in women with MPD.[26, 27]

Kluft[7] found somatic complaints infrequent among children with MPD but quite frequent in adults with the disorder. In longitudinal follow-up of severely abused children at risk, somatic manifestations and pseudoseizures tend to appear during late latency and adolescence (see chapter 11). However, conversion disorders in childhood constitute a relatively neglected area of study,[28, 29] and early precursors of the adult manifestations may go unrecognized. When conversion disorders are

recognized in children, they occur in the same multiproblem settings which produce dissociative disorders.[30] Pseudoseizures as well can be differentiated from true epilepsy by the presence of multiproblem factors familiar to specialists in MPD: family history of psychiatric disorder, personal history of psychiatric disorder, history of attempted suicide, history of psychosexual disturbances, and history of major dysphoria.[31]

Bizarre health practices reported in these families include inappropriate uses of enemas, "pelvic examination" of children by a parent, and refusal to allow children to see a doctor.[12, 32] In the famous case narrated in the autobiographical novel, *I Never Promised You a Rose Garden*, the dissociation relates to necessary but traumatic medical treatment, which involved genital manipulation.[33] Distortion of body image may be reflected not only in incomprehensible concerns about body size, as in anorexia nervosa, but also in compulsive requests for plastic surgery or sex change surgery.

The following case exemplifies the kind of presentation in which a pediatrician might initiate an evaluation for dissociative disorder:

> A 10-year-old boy was brought to the emergency room after a family fight. He was calm and required no anesthesia while a facial laceration was sutured. Areas of excoriation were found on his face and hands which he was unable to explain. His mother said he "picked at" himself. Medical history showed numerous visits for accidents and a prior genital examination at age 8 because of substantiated sexual abuse. He had been refusing food and his weight was below the third percentile.

III. Family, social, and environmental indicators

These factors may result from the child's presence in a violent family, from membership in a persecuted minority like the Jews under Hitler, or from involvement in a cult or pornographic ring. Removal of a child by a social agency is an indicator for the presence of the types of abuses listed below.

A. Presence of extreme physical abuse
   1. Extreme punishments are used, as confinement, physical restraints, beatings with an object, burns
   2. Presence of death threats, as explicit or implicit death threats, threatening use of weapons, and witnessing severe injury or deaths of persons or pets

B. Presence of extreme sexual abuse
   1. Sexual abuse is frequent, of long duration, and involves multiple activities and multiple partners
   2. Sexual sadism is present with humiliation of partner or infliction of pain necessary for sexual release

C. Presence of psychological abuse
   1. Presence of excessive controls
      a. Basic bodily functions such as eating, sleeping, and excretion are interfered with

   b. Economic resources, possessions, and capacity to work are exploited
   c. "Indulgences" are used to foster dependence on controlling person(s)
2. Presence of excessive isolation and secrecy
   a. Prohibitions against socializing
   b. Interference with school or other potential sources of independent pleasure and power
   c. Prohibitions against independent thinking
   d. Limitations on incoming information and dissemination of misinformation
   e. Severe limitations on communication based on a need for secrecy
3. Presence of factors resulting in depletion and exhaustion
   a. Setting of impossible or near-impossible tasks
   b. Monopolization of perception
   c. Forced administration of substances or use of other tactics to alter perception
4. Excessive blaming and humiliation
   a. Frightening accusations
   b. Name-calling, often with an extreme antifemale or antichild bias
5. Induction into violence
   a. Obfuscation in framing moral questions
   b. Coerced participation in psychological, sexual, or physical abuse of peers

D. Patterns of "multiplicity" in the history of traumatic experiences
   1. Multiple types of abuse
   2. Multiple abusers and multiple victims
   3. Multiple generations involved
   4. Multiple family problems
   5. Multiple moves or other contextual shifts making it difficult to integrate traumatic experiences
E. Extreme denial of documented physical, sexual, or psychologial abuse
F. Lack of a close, nurturant, protective relationship

Cornelia Wilbur[1] has pointed out that the family environments described by patients with MPD partake more of experiences usually described as "torture" than of those called "abuse." Episodes of physical, sexual, and psychological violence are planned, frequent, and designed to cause pain. One sees use of partial burial as a punishment, genital manipulation with instruments such as ice picks, destruction of favorite toys or pets.[12] Sexual abuse seems to have a particular potency for stimulating dissociation.[34] Neglect, of the typical kind manifested by

inadequate cleanliness, food, shelter, or clothing, is infrequently found. As Putnam has noted, it is not neglect but a "malignant concern" that is the principal problem for these children.[18]

The section on psychological abuse is extensive, in part because this is often thought to be "soft" or "gray" area, difficult to document or assess. This outline follows Amnesty International's definitions and those developed to assess cults and families of violence.[35–38] Paranoia in the controlling parent can contribute to the development of a psychologically abusive environment.[32] The psychological factors that contribute to the traumatic impact of physical abuse have been well described by Lenore Walker[39] and others as the the "battered wives' syndrome." Roland Summit[40] described the "sexual abuse accomodation syndrome" which includes the psychologically abusive factors that perpetuate sexual abuse: The child feels responsible to obey and comfort the abusive adult, does not know how to ask for help and feels no one will believe her, feels guilty about having "allowed" the abuse to continue without complaining, and ultimately decides she must somehow have caused the sexual abuse, especially if she has experienced pleasure or engaged in sexual experimentation semi-independently.

I have used the mnemonic BLIND as a shorthand for the multiply and severely abusive family environment (see chapter 1): *b*rainwashing, *l*oss of a loved one, *i*solation, "*n*ot awake or alert," and *d*eath threats. Multiplicity of traumata and absence of nurturance combine to produce the type of setting illustrated by the following case.

> A 17-year-old was admitted to a psychiatric hospital from a group home with a chief complaint of "voices trying to control my brain." The patient had been followed by a child protective agency since age 14 when she had revealed a 10-year sexual involvement with her father. She had gathered "evidence" including audiotapes of their contacts but after a few days destroyed the tapes and refused to talk with police or testify. Sexual contact included stripping, drinking alcohol, and mutual genital fondling. She said she had enjoyed this and was equally responsible with her father. The father agreed to treatment but never acknowledged having sexually abused his daughter. Multiple placements after the allegations mirrored the girl's lifelong rootlessness. Her father had kidnapped her at age 2 from her mother, and was in process of his third divorce. The girl had lived with many relatives. On admission she worried that an 8-year-old half-sister had been initiated recently by the father into sexual activity.

IV. Psychological symptoms in the child or adolescent
  A. Presence of dissociative symptoms
    1. Amnesia; may present as "forgetfulness," "lost time," or "lost years"
    2. Accusations; dissociative symptoms may be interpreted as lies or intentional daydreaming or misbehavior
    3. Active fantasy life; imaginary companions, fantasy worlds; may occur in context of high intelligence or creativity

4. Trancelike states; may be diagnosed as attention deficit states
5. Multiple ego states; the child may use several names, hear voices, or be described by others as "like two different children." Parapsychological language may be used to describe these experiences
6. Episodes of extreme, stereotyped, or compulsive behaviors, which may be regressive, sexual, or assaultive, and which resemble "flashbacks"
7. Runaways, which have fuguelike qualities

B. Presence of extreme depression and/or suicidality which may include self-mutilation, accident proneness, or self-destructive substance use
C. Presence of multiple diagnoses which are difficult to integrate such as learning disorder, conduct disorder, and affective disorder
D. Severe Posttraumatic Stress Disorder (see chapter 9)

Fagan and McMahon,[8] Putnam,[18] and Kluft[7] have published symptom check lists for screening for dissociative symptoms in children. O'Brien[27] has offered some mnemonics to help clinicians remember key dissociative symptoms: the three A's—amnesias, accusations, and active fantasy; and the three P's (as pointers to the presence of "lost time" secondary to amnesia)—perplexing people, places, and possessions. The presence of staunch denial of witnessed behavior should raise the question of dissociation in a child being evaluated for conduct disorder. Overactive fantasy life may be camouflaged as seemingly age-appropriate interests. At times a particular complex of fantasies can be traced, like other posttraumatic play, to some element in the trauma itself. For example, a girl who was sadistically sexually abused by both father and brother while watching Saturday morning children's television became a "television addict" and wrote numerous stories for her favorite series. Not all children have the ability to dissociate, even under extreme stress. Svendsen[41] and others[42, 43] have postulated that children with high intelligence are more likely to elaborate an imaginary companion.

Trancelike states and multiple ego states may be noted at school or by parents. The child may be described as "spacey" or as having "wild" or otherwise uncontrolled episodes. Other clues are wide fluctuations in school performance from year to year or the presence of an activity or relationship that is strangely untouched by the symptoms which disable the child in other settings. Spiegel and Rosenfeld[44] have described a 17-year-old whose presentation as dual personality could be traced clearly to episodic encapsulated flashbacks with age regression in which the girl relived extreme abuse which occurred at age 4. Assaultive and suicidal behaviors and perceptual experiences that occur in an altered state of consciousness may also represent flashbacks, but be misinterpreted as psychosis.[45, 46] Children may use parapsychological concepts to describe this experience of alternately inhabiting two or more different worlds.[47]

Adolescent runaways should trigger a search for other dissociative indicators, especially when the child has amnesia for parts of the runaway or when pseudoseizures or other alterations of consciousness take place during the runaway.[48] About 50% of female teenage runaways are incest victims (see chapter 20).

In almost every report describing children with dissociative symptoms—depersonalization, fugue, multiple personality—the clinical picture includes a pervasive dysphoria. Suicidal behaviors occur with frequency in families of abuse[17] (see chapter 12) and also in patients with multiple personality disorder.[49] Bliss found that all 14 of his series of patients with MPD had experienced depression and that 13 had attempted suicide.[49] In my series of six women whose dissociative disorder was recognized in an adult incest victims' group, four had multiple suicide attempts beginning in adolescence (see chapter 15).

In the preceding section I listed multiplicity of trauma as an indicator. Here multiplicity of diagnosis is listed as an indicator. Kluft[7] has identified one group of MPD patients who were referred and finally correctly diagnosed after having been in treatment for 10 or more years without significant benefit. The assignment of many different diagnoses by many different therapists may reflect a contagion to the treatment team of the patient's internal fragmentation. One diagnosis does tend to coincide with dissociative disorders; Spiegel[50] and Putnam[51] have commented on the regular occurrence of dissociative symptoms in patients with posttraumatic stress disorders. Further research may show that the natural history of dissociative disorders requires at the onset a severe or unresolved post-traumatic stress disorder.

The following case illustrates the kind of clinical material obtained at psychiatric evaluation of an adolescent which might trigger a search for the family and medical factors described earlier.

> A 17-year-old girl sought psychiatric evaluation after an episode of panic in a restaurant. Empathic questioning revealed that this affective storm was only one of many "mysteries" in her life. She often awoke in the morning with scratches on her face. It was always a surprise for her when she opened her closet door. At times she would find something missing—like the school uniforms which she wore every day. At other times she would find new shoes or dresses that she could not recall having bought. Most distressing to her was when she would find her pet dog shut up in the closet. She had overdosed at age 14, but could not recall details of the incident. She had been raped several times. Asked about voices, she struggled for the right words: "It's not that I talk to myself. I answer myself. The voice is me but it's another person."

DISCUSSION

For those readers experiencing an uncanny sense of familiarity as this listing of symptoms concludes, I offer a final case example.

The patient presented at age 15 with a right hemiparesis and hemianesthesia. Hysterical seizures were observed as were trancelike states during which she replayed past conversations. She was the eldest of seven children born into a lower-class family. Five siblings died in infancy. At age 6 she had been sent to a boarding school where she was severely punished, including being locked in her room and exorcised. In preadolescence she fled this school, but on return home, she was raped by her mother's boyfriend. Prior to admission she had lived on the streets, peddling sexual favors to survive.

This is a case history of Louise, one of Charcot's famous hysterics who was presented many times to the trainees at the Salpetrière, an illustrious group which included Freud, Axel Munthe, Babinsky, and Gilles de la Tourette.[52] Breuer and Freud in *Studies in Hysteria*[53] did not even feel the need to define hysteria; the syndrome was utterly familiar with its 2000 years of history and its intensive nineteenth-century study.[54]

Twentieth-century psychiatry lost sight of this entity in part because of an overemphasis on the personality factors sometimes found in sufferers[55, 56] and in part because of an underemphasis on the presence of extreme trauma and dissociative responses to trauma.[57] Freud warned of this tendency: "[The physician] attributes every kind of wickedness to [hysterical patients], accuses them of exaggeration, of deliberate deceit, of malingering. And he punishes them by withdrawing his attention from them."[58] Some patients with dissociative symptoms do have histrionic gifts but these can be best understood in the light of survival needs to act a role in a family fiction. Putnam[51] has pointed out that the female preponderance among patients with dissociative disorders parallels almost exactly the female preponderance (80%) among sexual abuse victims. Males probably are further underrepresented among diagnosed cases because their symptoms are more readily masked as criminal or other behavior disorders.

Nihilism about the potential for treating patients with these symptoms may have played a part in delaying recognition and the development of screening strategies. Many clinicians are pessimistic about treating severe somatization and dissociative disorders, especially when histrionic, borderline, or other personality disorders are diagnosed, or when the patient's dysphoria has proved resistant to medication. It should be noted in this regard that Charcot's patient Louise was discharged as cured after 5 years despite the severity of her symptoms and the many deficiences in the therapeutic milieu of the Salpetrière. With a comprehensive biopsychosocial approach to the diagnosis and treatment, present-day adolescents with similar symptoms can hope to be treated at least as successfully as was Louise, and possibly more efficiently.

REFERENCES

1. Wilbur C: Multiple personality and child abuse. *Psychiatr Clin North Am* 7:3–8, 1984.

2. Braun B, Sachs R: The development of multiple personality disorder: predisposing, precipitating, and perpetuating factors, in Kluft R (ed): *Childhood Antecedents of Multiple Personality*. Washington, DC, American Psychiatric Association, 1985, pp 37–64.
3. Kluft R: The natural history of Multiple Personality Disorder, in Kluft R (ed): *Childhood Antecedents of Multiple Personality*. Washington, DC, American Psychiatric Association, 1985, pp 197–238.
4. Ellenberger HF: *The Discovery of the Unconscious*. New York, Basic Books, 1980.
5. Noshpitz JD (ed): *Basic Handbook of Child Psychiatry*. New York, Basic Books, 1979, vols 1–4.
6. Kluft R: Multiple personality in childhood. *Psychiatr Clin North Am* 7:121–134, 1984.
7. Kluft R: Childhood multiple personality disorder: Predictors, clinical findings, and treatment results, in Kluft R (ed): *Childhood Antecedents of Multiple Personality*. Washington, DC, American Psychiatric Association, 1985, pp 176–196.
8. Fagan J, McMahon P: Incipient multiple personality in children: four cases. *J Nerv Ment Dis* 172:26–36, 1984.
9. Bowman EE, Blix S, Coons PM: Multiple personality in adolescence: Relationship to incestual experiences. *J Am Acad Child Psychiatry* 24:109–114, 1985.
10. Kluft RP: Treatment of Multiple Personality Disorder. *Psychiatr Clin North Am* 7:9–29, 1984.
11. Kluft RP, Braun BG, Sachs R: Multiple personality, intrafamilial abuse, and family psychiatry. *Int J Fam Psychiatry* 5:283–301, 1984.
12. Sachs R, Goodwin J, Braun B: The role of child abuse in the development of multiple personality disorder, in Braun BG, Kluft RP (eds): Multiple Personality and Dissociation. New York, Guilford, in press.
13. Spiegel H, Spiegel D: *Trance and Treatment: Clinical Uses of Hypnosis*. New York, Basic Books, 1978.
14. Woodruff RA, Goodwin DW, Guze SB: *Psychiatric Diagnosis*. New York, Oxford University Press, 1974.
15. Finkelhor D: *Child Sexual Abuse: New Theory and Research*, New York, Free Press, 1985.
16. Carmen EH, Rieker PP, Mills T: Victims of violence and psychiatric illness. *Am J Psychiatry* 141:378–383, 1984.
17. Yesavage JA, Widrow L: Early parental discipline and self-destructive acts. *J Nerv Ment Dis* 173:74–77, 1985.
18. Putnam FW: Childhood multiple personality disorder proposal. Unpublished data, 1981. Reprinted in Kluft RP: Multiple personality in childhood. *Psychiatr Clin North Am* 7:128, 1984.
19. Klerman GL, Weissman MN, Rounsaville BJ, et al: *Interpersonal Psychotherapy of Depression*. New York, Basic Books, 1984.
20. Braun B: The transgenerational incidence of dissociation and Multiple Personality Disorder: A preliminary report, in Kluft R (ed): *Childhood Antecedent of Multiple Personality*. Washington, DC, American Psychiatric Association, 1985, pp 127–150.
21. Frischholz E: The relationship among dissociation, hypnosis and child abuse in the development of Multiple Personality Disorder, in Kluft R (ed): *Childhood Antecedents of Multiple Personality*. Washington, DC American Psychiatric Association, 1985, pp 99–126.
22. Bliss EL, Larson EM: Sexual criminality and hypnotizability. *J Nerv Ment Dis* 173:522–526, 1985.

23. Bergmann MS, Jucovy ME: *Generations of the Holocaust*. New York, Basic Books, 1982.
24. Terr LC: Children at acute risk: psychic trauma, in Grinspoon L (ed): *Psychiatric Update*. Washington, DC, American Psychiatric Association, 1984, vol 3 pp 104–119.
25. Bliss EL: Multiple personalities, related disorders and hypnosis. *Am J Clin Hypn* 26:114–123, 1983.
26. Greaves GB: Multiple personality 165 years after Mary Reynolds. *J Nerv Ment Dis* 168:577–596, 1980.
27. O'Brien P: The diagnosis of multiple personality syndromes: overt, covert and latent. *Compr Ther* 2:59–66, 1985.
28. Yates A, Steward M: Conversion hysteria in childhood: case report and a reminder. *Clin Pediatr* 15:379–382, 1976.
29. Rae W: Childhood conversion reactions: A review of incidence in pediatric settings. *J Clin Child Psychol* 69–72, 1977.
30. Goodyer I: Hysterical conversion reactions in childhood. *J Clin Psychol Psychiatry* 22:179–188, 1981.
31. Roy A: Psychiatric concepts, definitions, and diagnosis of hysterical seizures, in Riley T, Roy A (eds): *Pseudoseizures*. Baltimore, Williams & Wilkins, 1982, pp 1–24.
32. Goodwin J: Persecution and grandiosity in incest fathers, in Pichot P, Berner P, Wolf R, Thaw K (eds): *Psychiatry: The State of the Art*. New York, Plenum, 1985, vol 6, pp 309–322.
33. Greenberg J: *I Never Promised You a Rose Garden*. New York, Signet, 1977.
34. Saltman V, Solomon RS: Incest and multiple personality. *Psychol Rep* 50:1127–1141, 1982.
35. Halperin D: Psychiatric approaches to cults: therapeutic and legal parameters, in Schetky D, Benedek E (eds): *Emerging Issues in Child Psychiatry and the Law*. New York, Brunner-Mazel, 1985, pp 250–265.
36. Boulette TM, Anderson SM: "Mind control" and the battering of women. *Community Ment Health J* 21:109–118, 1985.
37. Burgess AW: *Child Pornography and Sex Rings*. Lexington, Mass, DC Health, 1984.
38. Farber IE, Harlow H, West LJ: Brainwashing, conditioning and DDD (debility, dependency and dread). *Sociometry* 20:271–285, 1957.
39. Walker L: *The Battered Woman*. New York, Harper & Row, 1979.
40. Summit R: The reluctant discovery of incest, in Kirkpatrick M (ed): *Women's Sexual Experience*. New York, Plenum 1982, pp 112–144.
41. Svendsen M: Children's imaginary companions. *Arch Neurol Psychiatry* 32:985–999, 1934.
42. Baum EA: Imaginary companions of two children. *J Am Acad Child Psychiatry* 32:324–330, 1978.
43. Myers WA: Imaginary companions in childhood and adult creativity. *Psychoanal Q* 48:292–307, 1979.
44. Spiegel D, Rosenfeld A: Spontaneous hypnotic age regression: A case report. *J Clin Psychiatry* 45:522–524, 1984.
45. Simonds JF, Glenn T: Folie à deux in a child. *J Autism Child Schiz* 6:61–73, 1976.
46. Steingard S, Frankel FH: Dissociation and psychotic symptoms. *Am J Psychiatry* 142:953–955, 1985.
47. Stern CR: The etiology of multiple personalities. *Psychiatri Clin North Am* 7:149–159, 1984.

48. Akhtar S, Brenner I: Differential diagnosis of fugue-like states. *J Clin Psychiatry* 40:381–385, 1979.
49. Bliss EL: Multiple personalities: a report of 14 cases with implications for schizophrenia and hysteria. *Arch Gen Psychiatry* 37:1388–1397, 1980.
50. Spiegel D: Multiple personality as a post-traumatic stress disorder. *Psychiatr Clin North Am* 7:101–110, 1984.
51. Putnam F: Dissociation as a response to extreme trauma, in Kluft R (ed): *Childhood Antecedents of Multiple Personality*. Washington, DC, American Psychiatric Association, 1985, pp 65–98.
52. Drinka GF: *Birth of Neurosis: Myth, Malady and the Victorians.* New York, Simon Schuster, 1984.
53. Breuer J, Freud S: *Studies in Hysteria* [1895], Strachey J (trans-ed). New York, Basic Books, 1983.
54. Janet P: *L'Automatisme psychologique*. Paris, Felix Alcan, 1889.
55. Hollender MH, Hirsch SJ: Hysterical psychosis. *Am J Psychiatry* 120:1066–1074, 1964.
56. Slavney PR, McHugh PR: The hysterical personality: A controlled study. *Arch Gen Psychiatry* 30:325–329, 1974.
57. Herman JL: Histories of violence in an outpatient population: an exploratory study. *Am J Orthopsychiatry* 56:137–141, 1986.
58. Freud S: Five lectures on psycho-analysis delivered on the occasion of the celebration of the twentieth anniversary of the foundation of Clark University, Worcester, Massachusetts, September 1909 [1910] in *Standard Edition*, Strachey J (trans-ed). London, Hogarth, 1963, vol 11, p 12.

17

Physical and Sexual Abuse of the Children of Adult Incest Victims

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Previous studies have indicated that most abusing parents have a history of physical abuse or neglect in their own childhoods. There are little data on the frequency of prior sexual abuse among parents who physically or sexually abuse their children. Many case reports describe the uncovering of a prior incest experience in a parent during the investigation of the child's current incest accusation, but it is unclear how frequently this occurs. One hundred mothers of abused children were asked about sexual incidents that occurred before age 18; the control group consisted of 500 normal women from the same community who were surveyed during meetings of various voluntary organizations. Age and ethnicity did not differ in the two groups. Of the mothers of abused children, 24% reported a prior incest experience, whereas only 3% of the control women reported prior incest. This eightfold difference was highly significant. The 34 mothers from families where sexual abuse was occurring were no more likely to report prior incest than were the 66 mothers from families where physical abuse occurred. The one case of genital mutilation of a child occurred in a family where both parents had been incest victims. Case studies indicate that the parent who has been an incest victim has inhibitions and fears about tenderness, traceable to the childhood incest experience, which are important in the development of either physical or sexual abuse in the family.

PREVIOUS STUDIES

Steele and coworkers[1, 2] have reported that almost all abusing parents have a personal history of deprivation, neglect, or physical abuse in childhood. Such a history is found more commonly in abusing parents than is any other single demographic or diagnostic factor. In working with abusing parents we have been impressed that many mothers have been victims of sexual abuse in childhood, as well as of other forms of abuse. This chapter reports a series of clinical observations which define the frequency of prior sexual abuse in mothers in incest families, in mothers in physical abuse or neglect families, and in women in the general population. Cases are also described in which deficits in mothering can be traced to defensive reactions to the prior incest.

Many anecdotal accounts describe incestuous families in which one or both parents had been incest victims in childhood.[3–8] Some investigators have postulated a multigenerational victim-to-victim relationship underlying incest.[4, 5, 9, 10]

However, there are little statistical data to support this hypothesis. Gebhard and and Gagnon[11] found that only 12% of imprisoned incestuous fathers had experienced sexual contact with an adult before puberty; (one half of those contacts were with women and one half with men). This was higher than found in general population controls (5%), but lower than found in the general prison population (28%). Brant[10] cites an unpublished study that 31% of the mothers in incestuous families were themselves victims of childhood incest.

Even fewer data are available about prior incest in parents involved in physical abuse. One report estimates that as many as 90% of Parents Anonymous participants have been victims of sexual abuse in childhood.[5] There are no published comparisons of the frequency of prior incest in abusing parents with the frequency in the general population.

METHODS

Information about childhood sexual experience was obtained through psychiatric interview or administration of the Sexual Stress Questionnaire (DiVasto P,) unpublished data, 1979; see Appendix II). Data were obtained from the following populations:

A. Five hundred normal women in the community: The sexual stress questionnaire was distributed to women in community, voluntary, and church groups. The questionnaire asks if subjects have experienced any upsetting sexual events in childhood, gives examples of such events, and then asks respondents to describe their experiences on the anonymous questionnaire. Nursing and medical students went to

meetings of these groups, explained the nature of the questionnaire and the need for 100% return, and collected the questionnaires. The method is similar to that developed by Kinsey.[11] Five hundred sixteen questionnaires were collected, but 16 had to be discarded because of incomplete responses.

B. One hundred mothers of abused children, including:
   1. Twenty mothers from families where physical abuse or neglect was occurring.
   2. Twenty mothers from incestuous families: Mothers in these first two groups were referred for psychiatric evaluation after child abuse was substantiated. Psychiatric evaluations were reviewed for reports of incest experiences or childhood rape.
   3. Twenty-seven unselected mothers from families in which physical child abuse or neglect had been substantiated by a child protective agency: These women were given the Sexual Stress Questionnaire anonymously during required psychological group testing at intake. About one half of all mothers admitted for treatment actually came for this required testing. All mothers who presented for testing during the study period returned the questionnaire; five of the 27 failed to check either yes or no when asked about childhood sexual stress. These nonresponses were counted as negative responses.
   4. Fourteen unselected mothers were from families where incest had been substantiated. These women were given the Sexual Stress Questionnaire with several other self-tests at the time of intake. During the time of data collection, three mothers refused all questionnaires.
   5. Ten mothers with a child who died from maltreatment: After child abuse was substantiated, these women had psychiatric evaluations which were reviewed. Mothers were also mailed the Sexual Stress Questionnaire and asked to complete and return it; four of the ten returned the mailed questionnaire. Two revealed incest experiences that had not been mentioned at the time of psychiatric evaluation. (See chapter 19 for more detailed analysis of this subgroup.)
   6. Nine mothers attending a Parents Anonymous group: The Sexual Stress Questionnaire was distributed by the group coordinator and completed anonymously by the members as had been the procedure in other community groups.

All 100 mothers in these six groups will be referred to as mothers from abusive families or as abusive mothers. Many reports describe the difficulty in defining a single perpetrator in families where incest or physical abuse has occurred.[7, 12] The mother in an incest family is often described as a nonperpetrator. However, three of the incest mothers in this sample had married more than one husband who sexually abused the daughters. As

used in this chapter, "abusive mothers" are mothers who have contributed in some way to the development of a family situation where child abuse or neglect is substantiated.

RESULTS

Of the 500 control women surveyed, 15(3%) had experienced some form of incest before age 18 (Table 17–1). Five (1%) were involved with the father or stepfather, four with uncles, three with brothers, and three with other relatives. Eight of the 15 had told a parent at the time of the incident, although three reported their mothers did not believe them. Of these 500 control women, 122(24%) had experienced some kind of sexually stressful incident prior to age 18. One of the five women who reported a father-daughter incest experience wrote on the questionnaire that she had never told anyone about the incest until she sought psychotherapy after the birth of her son because she was afraid that she might harm the child.

The 500 women in the general population sample had an average age of 27.6 years, almost the same as the average for the 100 mothers in the child abuse group (29.9 years). In the general population group 61% were Anglo (English-speaking whites) and 31% Spanish-American. This too, was similar to the proportion in the abusing mothers (62% Anglo and 30% Spanish-American). Women in the general population sample had more years of schooling (13.5 years) than did mothers in abusive families (11.6 years). This difference of 1.9 years is statistically significant ($P < .01$). However, in the general population sample, women who had been incest victims tended to have even more schooling (14.4 years) than the group as a whole. The incest victims were also more likely to be English-speaking whites; 12 of the 15 incest victims were Anglo (80%), a higher percentage than found in the general population sample as a whole.

Among the 100 mothers from families involved in child abuse, 24 (24%) described incest experiences in childhood (Table 17–2), about 8 times the rate found in the general population sample ($\chi^2 = 60.5$, $P < .01$). An additional 14 women described other types of sexual stress in childhood; thus 38% of the women in this sample described some type of sexual stress in childhood.

Rates of prior incest in six subgroups were as follows: (1) physical abuse mothers referred for psychiatric evaluation, 15%; (2) incest mothers referred for psychiatric evaluation, 20%; (3) unselected physical abuse mothers, 19%; (4) unselected incest mothers, 29%; (5) mothers of children who died as a consequence of child maltreatment, 40%; and (6) mothers in a Parents Anonymous group, 44%. The psychiatric evaluation was apparently no more likely to produce positive histories than was the questionnaire. The rates in groups 5 and 6 are somewhat higher than in other groups; these women were in a treatment rather than in an evaluation setting at the time

Table 17–1
Incest Victims in the General Population*

No. of Victims	Age at Interview	Ethnicity	Age at Incident (years)	Incident	Told Someone
1	47	SA	"Young"	Molested by uncle–ongoing	No
2	25	A	13	Incest with family member for 3 months	Mother
3	24	A	11	Uncle exposed himself	Never
4	26	SA	4 or 5	Relative exposed himself and fondled	Mother
5	31	A	13	Fondled by father	Never
6	38	A	7 or 8	Oral sex with uncle	Mother
7	29	A	12–16	Incest with father	Therapist at age 28
8	33	A	8–11	Paternal grandfather exposed himself; stepfather raped	Neighbor and mother
9	30	A	Grade school	Oral sex with brother for 2 years	Parents "found out"
10	30	A	Preadolescent	Incest with 2 older brothers	"Mother called me tattletale"
11	52	A	10	Foster uncle fondled	Father
12	42	A	14–17	Stepfather fondling and exposure	No
13	30	A	14	Stepfather fondling and attempted rape	Mother "did not believe"
14	32	SA	15–16	Older cousin exposed himself	Never
15	32	A	17–18	Intercourse with older brother	Therapist age 26
Summary	33.4	12 (80%) Anglo	8 (53%) were involved before age 13	5 (33%) involved a parent figure 2 (13%) involved exposure only	8 (53%) told a parent, 5 (33%) successfully

A = English-speaking white; SA = Spanish-American.
*Fifteen (3%) of the 500 women surveyed reported incest experiences.
Reprinted with permission from Goodwin et al.[13]

Table 17–2
Incest Victims in Six Populations of Abusing Mothers*

No. of Victims	Age at Interview	Ethnicity	Age at Incident	Incident	Told Someone
Physical abuse mothers at psychiatric evaluation (N = 20)					
1	21	A	17–18	Fondling by stepfather	Mother "did not believe"
2	28	A	10–15	Intercourse with father	No one; brother knew
3	27	A	9–10	Fondling with uncle	No one
Sexual abuse mothers at psychiatric evaluation (N = 20)					
4	27	SA	12–15	Fellatio and attempted intercourse with stepfather	Mother "didn't protect"
5	35	Navajo	Approx. 12	Fondling with uncle	No one
6	29	SA	12	Attempted rape by father	No one
7	26	SA	12–14	Intercourse with uncle and mother's boyfriend	No one
Physical abuse mothers, unselected (N = 27)					
8	22	A	10	Stepmother–fondling and fellatio	No one
9	29	A	9–13	Oral sex, then raped by stepfather	Priest, police
10	27	A	5	Intercourse with father and older brother	Friend
11	20	A	11	Stepfather–"heavy petting"	Mother
12	22	SA	7	Older brother–attempted seduction	Mother "didn't care"
Sexual abuse mothers, unselected (N = 14)					
13	34	A	12	Fondled by older brother	No one
14	36	A	17	Molested by uncle	Aunt
15	23	SA	6	Fondled and fellatio with uncle	No one
16	31	A		"Brothers fondled me"	No one

(continued)

(Table 17–2 cont'd)

No. of Victims	Age at Interview	Ethnicity	Age at Incident	Incident	Told Someone
Mothers with a child who died of maltreatment (N = 10)					
17	24	Navajo	9–16	Multiple intercourse with stepfather	No one
18	26	A	6	Intercourse with mother's boyfriend	No one
19	32	A	10	Fellatio with uncle	No one
20	18	SA	9	Fondling and intercourse with stepfather	No one
Mothers in a Parents Anonymous group (N = 9)					
21	28	A	11–12	Raped by uncle, fondled by another uncle	No one
22	34	SA	4	Hanged and fondled by uncle	Yes—no one believed
23	19	SA	9	Fondled by grandfather	No one
24	23	A	12	Raped by stepfather	No one
Summary	26.4	14 (58%) Anglo 8 (33%) SA	21 (88%) were involved before age 13	13 (54%) involved a parent figure 0 (0%) involved exposure only	5 (21%) told a parent, 1 (4%) successfully

A = English-speaking white; SA = Spanish-American.
*Twenty-four (24%) of the 100 women surveyed reported incest experiences.
Reprinted with permission from Goodwin et al.[13]

they completed the Sexual Stress Questionnaires. Two mothers in the unselected incest group have recently described prior incest experiences to therapists and have stated that they could not admit to those experiences at the time they were given the Sexual Stress Questionnaire. It is likely that figures for all groups would be higher if subjects had been subjected to psychotherapy for a long period. However, even if those 19 abusive mothers who were in treatment are removed from the sample, the difference in incidence of prior incest between the abusive mothers and the normal women remains significant ($\chi^2 = 33.7$, $P<.01$).

According to these data, mothers of incest victims seem no more likely to have a history of incest than are mothers of children who are physical abuse victims. Eight of the 34 incest mothers (24%) and 16 of the 66 physical abuse mothers (24%) had experienced prior incest. Particular patterns of physical abuse may occur when the parent has been an incest victim. For example, of the ten maltreatment deaths that were reviewed, genital mutilation was found in only one child at autopsy; both parents had been incest victims, the mother was involved with her father and the baby's father had been incestuously involved with his uncle.

The 24 incest victims in the abusive group differed from the women in the general population group who reported prior incest. Fewer of the victims in the abusive sample had told anyone. Only five (21%) of the 24 told a parent at the time, and four of these noted that they were not believed or protected. So, whereas 33% (5/15) of the general population victims were able to successfully tell a parent about the incest at the time, only 4% (1/24) of the abusive victims did so ($\chi^2 = 6.0$, $P<.02$). In contrast to the incest victims in the general population group who tended to have more education than did the overall sample, incest victims in the abusive group tended to have fewer years of schooling than other abusive mothers (10.7 *vs* 11.6 years). Incest victims in the abusive populations were also more likely to have experienced incest prior to age 13 than were victims in the control population ($\chi^2 = 5.6$, $P<.02$).

DISCUSSION

There is little statistical information about the number of childhood sexual experiences with an adult or with an adult relative in women in the normal population. Data on prior sexual abuse from the 500 control women in this study compare well with previously published reports which find that 20% to 30% of adult women recall some kind of childhood sexual experience with an adult, and that in 3% to 12% of those incidents a relative was involved.[14–16]

Comparison of data from control women with 100 mothers from abusive families indicates that the abusive women have an incidence of prior incestuous experiences 8 times greater than that reported by women in the

general population. This percentage is in the range of the highest incidences reported for delinquent women (15%) or psychiatrically symptomatic women (33%).[17] While the normal and abusive women did not differ in ethnicity or age, they did differ in education in that the normal group had on average 2 more years of education (13.5) than did the group of abusive mothers (11.6).

Prior victims in the two groups differed as follows: (1) Significantly more incest victims in the control group successfully reported the incident to a parent; (2) the incest victims in the abusive group were more likely to have been under 13 when the abuse began; and (3) the incest victims in the control population seemed to have slightly more education (14.4 years) than the remaining normal women, while the incest victims among the abusive mothers averaged 1 year less education (10.6 years) than the other abusive mothers. These data are consistent with the hypothesis that the girls who later became involved in child abuse suffered a more difficult incest situation and were able to cope with it less well.[18]

Because of the educational differences between the two groups, it might be argued that the differences are merely socioeconomic, with abusive mothers coming from a world where both paternal incest and child abuse are common. Several observations indicate this explanation is too simple: (1) The incest victims in the control group actually had more education than nonvictims; (2) one of those victims in the control group reported having sought psychotherapy when she became afraid of harming her baby; (3) the only case of genital mutilation[19] in the abuse group occurred in a family where both parents had been incest victims; and (4) in the cases reported below, where a clinical connection could be traced between prior incest and subsequent abuse, families of origin and procreation were in the middle class.

Survey of another symptomatic population, female psychiatric inpatients, shows a similar pattern of increased severity of the sexual abuse[20] as compared with incest reported in the general population. Of 40 inpatients, 14 (35%) had been molested by a family member; of those, 11 (79%) were molested before age 13 and 9 (64%) were molested by a parental caretaker. None of the contacts was limited to exposure only. Only one (7%) of the 14 incest victims in this population made a successful complaint at the time of the molestation. This group differed from the child abuse population in that a higher percentage of abusers were mothers or grandparents (43%).

Herman et al[21] have found significant correlations between severity of symptoms and severity of sexual abuse in a large nonclinical sample of 152 women. Having a caretaker as perpetrator, severity of bodily violation, degree of force involved, and duration of incest were significantly correlated both with symptoms and the individual's perception of severity of effects.

As in other kinds of trauma, the victimized child uses the coping mechanisms that her personal experience, her family, and her society have

provided to reconstruct herself after the disorganizing and conflicting experience. If coping mechanisms are few, the reorganized self may be more fragile and more vulnerable to disintegration under certain types of stress.[22] An example of vulnerability is that one of the prior incest victims in this study was forcibly raped, and only after that repetition of the original trauma did she begin beating her 1-year-old daughter.

One of the consequences of unresolved trauma is the "coincidental" repetition of the trauma. The mother's repressed memories of her own abuse emerge as she unconsciously recreates a similar situation for her child, thereby allowing herself another chance to resolve her repressed conflicts.[10, 11] This pattern is most clearly illustrated by case reports where the child's sexual abuse occurs at the same age as the mother's prior sexual abuse.[23, 24] Another example of this projective identification from the parent to the child has been described in families where the parent of a delinquent child reveals a secret history of juvenile delinquency which may be almost identical to the child's pattern.[25] The parent can disavow a rejected aspect of herself by projecting it on the child ("She liked the incest; I did not") and, at the same time, can vicariously relive it.[26]

The most commonly reported sequela of incest trauma is impairment of the ability to experience orgasm,[6, 16, 27] which occurs in 20% to 75% of incest victims. Frigidity in the mother and the cessation of marital intercourse has also been reported as a prelude to incest.[3, 9, 28] This sequence—victimization of the mother, consequent frigidity in the mother, victimization of the child—could be part of the link between incest victimization occurring in the mother and, subsequently, in the child. The husband's reaction to his wife's prior victimization is also important. One woman told her husband shortly after their marriage about her prior incest experience. He became obsessively preoccupied with what had happened to his wife and would become explosively enraged whenever he heard particular melodies that reminded him of his wife's incestuous father, a musician. Years later, he claimed that it was his sexual disgust toward his incest-victim wife that had led him to seek sexual gratification with his daughters.

Given the many hypotheses that "an incestuous model" in the parent[11] or an "incest carrier" predisposes to incest in the next generation, it was surprising to find that prior incest was no more common in mothers in sexual abuse situations than in physical abuse mothers. However, the intimate tenderness involved in parenting can be as intense, as overwhelming, and as physical as the intimacy of mating. The link between prior incest in the mother and subsequent physical abuse in her child may occur because sexually abused mothers feel as frozen and frustrated in expressing maternal tenderness[29] as they do in expressing sexual tenderness. Kaufman et at[12] proposed a trigenerational model for incest: A woman who had had an ambivalent hostile relationship with her own mother marries a man who has been deserted by his own father,[30] and the combined efforts of both

parents to receive nurturance from the daughter lead to her incestuous victimization. The present data indicate that there may be a fourth generation of incest: A victimized daughter desperate for control and terrified by tenderness who lashes out at her baby or neglects it when she feels out of control or unable to love.

Case Reports

The sexualization, concealment, and fear of tenderness experienced by a prior incest victim trying to be a mother are illustrated in the following case example.

Case 1 Amy, a 19-year-old housewife, called Parents Anonymous when her first baby, a son, was 2 months old. "I'm spanking my baby too hard. He keeps trying to attract me sexually. He squirms to get my attention and then has erections." She was afraid that other people might think her breast-feeding of the baby was sexual, and was secretive about all of her physical contacts with her baby. One week after her first call the baby sustained a skull fracture, which fortunately left no permanent damage. Treatment was begun. Amy felt that her body had been "marred" by the pregnancy. She was almost delusionally convinced that her husband was having an affair, despite his denials. Amy's mother had been a prostitute and Amy had a chaotic life before her natural father invited her to live with his family when she was 10. Shortly thereafter he initiated genital fondling with her which progressed to intercourse. At age 14, she reported the incest and subsequently lived in ten different foster homes. Individual psychotherapy centered on helping Amy to differentiate tenderness from sexuality. Amy had projected on her baby her own sense of having to "beg for love." She could not believe that anyone could ever love her for herself or that love could exist apart from a destructive, frightening sexuality. Her constant guilty daydreams about extramarital affairs had formed the nucleus for her conviction that her husband was being unfaithful. As therapy progressed she was able to fantasize nonsexual tendernesses in addition to the sexual affairs. She also became more comfortable with orgasm, which she had previously avoided because it made her feel out of control.

The experience of being out of control was described by another prior incest victim.

Case 2 Barbara, a 23-year-old housewife, sought psychotherapy after she left bruises on her 9-month-old son when she spanked him for opening a box. "I told him to stop touching it, but he wouldn't," she said. Barbara's father had begun fondling and licking her genitals when she was five, and the relationship continued for almost 10 years until a younger sibling, also a victim, revealed the secret. Barbara said the she had tried not to have orgasm with her father but "had them anyway." At age 9, she had severely beaten her cat when it licked her in the ear. After delivering her baby, Barbara had moved out of her mother's house, "because she used to watch me breast-feeding as if there was something wrong with it." She had felt ashamed to talk with her husband about feeling out of control with the baby. Treatment centered around helping her remember and rework the incest experience, giving words to the instinctive feelings and responses she had experienced.[31]

In both of these cases the mothers experienced maternal tenderness as sexual, threatening, and shameful, and reacted with anger and frustration

not only to their inability to consummate their tender feelings but also to their experience of tenderness as an imposed loss of control. The anger acted to turn off the threatening tenderness as well as to express the mother's frustration.

Lage and Marohn[32] have described several cases of women who concealed a pregnancy from everyone and then killed the baby at birth. In one case the woman had previously been involved in mutual genital fondling with her father, which had also been secret. Her therapists felt that the concealed prior incest had set the stage for the concealed infanticide by giving her the message, "Children are our possessions and we can do with them as we please," and, "Only appearances count." So long as the young mother continued to conceal and to rationalize at some level her father's sexual abuse of her, she continued to rationalize her own maltreatment of her child.

Some of the children of incest victims are physically abused by family members other than the mother. In the following case the mother was not the abuser, but her own prior sexual and physical abuse and her fears that she could not protect her children from a similar fate were part of the sequence of events that led to their being placed out of the home.

Case 3 Lisa was physically and sexually abused by her father from age 6. When she was 12, she took her 18-month-old sister and ran away from home. She was afraid that something terrible would happen to her sister unless she got the baby away. They were caught and returned home. Lisa was severely beaten by her father. The next day the school reported her bruises to child-protection authorities. A caseworker spoke with the father and decided to close the case. A few months later, the family home burned down and the baby that Lisa had tried to protect was killed. After the fire, Lisa's mother had a nervous breakdown and was institutionalized. Lisa has always wondered if her life would have been different had she been removed by child-protection workers.

Lisa herself has had seven children by four different men. Each of the children has been removed from Lisa at around age 18 months. All have been permanently placed in other homes by age 12. It is Lisa's current husband who always is identified as the abuser. Child-protection workers are repeatedly surprised by Lisa's failure to cooperate and by her deliberate breaking of rules at critical moments in her case. In other contexts she is a cooperative and reliable citizen.

This woman's unconscious wish that her own children be protected in the way that she and her own sister were not may have determined the paradoxically self-defeating behaviors that led to protective placement of the children in other homes.

CONCLUSIONS

The rate of prior incest was 24% in 100 mothers from abusive families and 3% in 500 normal women in the community. The rate of prior incest was no higher in mothers in incestuous families than in mothers in families where other kinds of abuse were substantiated. In some cases the working through

of the prior incest experience can be crucial to restoring the ability to mother.[13]

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REFERENCES

1. Steele BF, Pollock CB: A psychiatric study of parents who abuse infants and small children, in Helfer RE, Kempe CH (eds): *The Battered Child.* Chicago, University of Chicago Press, 1968, pp 103–147.
2. Steele BF: Parental abuse of infants and small children, in Anthony EJ, Benedek T (eds): *Parenthood. Its Psychology and Psychopathology.* Boston, Little, Brown 1970, pp 449–477.
3. Weiner IB: Father-daughter incest, a clinical report. *Psychiatr Q* 36:607–632, 1962.
4. Raphling DL, Carpenter BL, Davis A: Incest, a genealogical study. *Arch Gen Psychiatry* 16:505–511, 1967.
5. Summit R, Kryso J: Sexual abuse of children, a clinical spectrum. *Am J Orthopsychiatry* 48:237–251, 1978.
6. Meiselman K: *Incest.* San Francisco, Jossey-Bass, 1978.
7. Machotka P, Pittman FS, Flomenhaft K: Incest as a family affair. *Fam Process* 6:98–116, 1967.
8. Anderson LM, Shafer G: The character-disordered family, a community treatment model for family sexual abuse. *Am J Orthopsychiatry* 49:436–445, 1979.
9. Rosenfeld AA: Endogamic incest and the victim-perpetrator model. *Am J Dis Child* 133:406–410, 1979.
10. Brant R: *Manual on Sexual Abuse and Misuse of Children.* Boston, New England Resource Center for Protective Services, 1977.
11. Gebhard PH, Gagnon JH: *Sex Offenders: An Analysis of Types.* New York, Harper & Row, 1965.
12. Kaufman I, Peck AL, Tagiuri CK: The family constellation and overt incestuous relations between father and daughter. *Am J Orthopsychiatry* 24:226–279, 1954.
13. Goodwin J, McCarty T, DiVasto P: Prior incest in abusive mothers. *Child Abuse Neglect* 5:1–9, 1981.
14. Finkelhor D: *Sexually Victimized Children.* New York, Free Press, 1979.
15. Landis JT: Experiences of 500 children with adult sexual deviation. *Psychiatr Q* 30(suppl): 91–109, 1956.
16. Herman J, Hirschman L: Father-daughter incest, families at risk. Read before the Annual Meeting of the American Psychiatric Association, San Francisco, 1980.
17. Rosenfeld AA: Incidence of a history of incest among 18 female psychiatric patients. *Am J Psychiatry* 136:791–795, 1979.
18. Tsai M, Feldman-Summers S, Edgar M: Childhood molestation, variables related to differential impacts on psychosexual functioning in adult women. *J Abnorm Psychol* 88:407–417, 1979.
19. Slosberg EJ, Ludwig S, Duckett J, et al: Penile trauma as a sign of child abuse. *Am J Dis Child* 132:719, 1978.
20. Goodwin J, Attias R, McCarty T, et al: Effects on psychiatric inpatients of routine questioning about childhood sexual abuse. *Victimology*, in press.

21. Herman J, Russell D, Trocki K: Long-term effects of incestuous abuse in childhood. *Am J Psychiatry* 143:1293–1296, 1986.
22. Titchener JL, Ross WD: Acute or chronic stress as determinants of behavior, character and neurosis, in Arieti S (ed): *American Handbook of Psychiatry.* New York, Basic Books, 1974, vol. 3, pp 39–60.
23. Rosenfeld AA, Nadelson C, Krieger M: Fantasy and reality in patient reports of incest. *J Clin Psychiatry* 8:159–164, 1979.
24. Brown BS: Clinical illustrations of the sexual misuse of girls. *Child Welfare* 58:435–442, 1979.
25. Johnson A: Sanctions for super ego lacunae of adolescents, in Eissler K (ed): *Searchlights on Delinquency.* New York, International Universities Press, 1949, pp 225–245.
26. Zinner J, Shapiro R: Projective identification as a mode of perception and behaviour in families of adolescents. *Int J Psychoanal* 53:523–530, 1972.
27. Lukianowicz N: Incest. *Br J Psychiatry* 120:301–313, 1972.
28. Cormier BM, Kennedy M, Sangowicz J: Psychodynamics of father-daughter incest. *Can Psychiatr Assoc J* 7:203–217, 1962.
29. Offenkrantz W, Tobin A, Freedman R: An hypothesis about herion addiction, murder, prostitution, and suicide: Acting out parenting conflicts. *Int J Psychoanal Psychother* 7:602–608, 1978.
30. Lustig N, Dresser J, Spellman S, et al: Incest, a family group survival pattern. *Arch Gen Psychiatry* 14:31–402, 1966.
31. Zetzel E: Therapeutic alliance in the analysis of hysteria, in Zetzel E (ed): *The Capacity for Emotional Growth.* New York, International Universities Press, 1970.
32. Lage G, Marohn R: Adolescent pregnancy as a threat to the organization of the self. Read before the Michael Reese Hospital Conference on Parenthood as an Adult Experience, Chicago, September 1980.

18

Defining A Syndrome of Severe Symptoms in Survivors of Extreme Incestuous Abuse

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Prior surveys of child and adult survivors of incestuous abuse have tended to support the hypothesis that their symptoms represent posttraumatic sequelae.[1–8] As many as 80% of sexually abused children report some acute symptoms.[9, 10] The most commonly seen symptoms, each found in 10% to 33% of sexually abused children, include: (1) emotional upset and fears, (2) regression in behavior and abandonment of former activities, (3) repressed and overt anger, (4) recurrent nightmares, and (5) low self-esteem with depression. In previous chapters, the mnemonic FEARS has been used to designate these five types of common sequelae: (1) fears, (2) ego constriction, (3) anger dyscontrol, (4) repetitions (in nightmares or flashbacks), and (5) sadness with sleep disturbance.[3, 4] These symptoms constitute the five cardinal signs of post-traumatic stress disorder originally described by Kardiner[11] in shell-shocked combat veterans. In studies of adults,[12–16] these five types of symptoms are each found in over half of incest victims entering treatment. The higher frequency of symptomatology in this adult group may result from the fact that it is the more symptomatic survivors who seek treatment; however, data from victims not in treatment also document the occurrence of these symptoms at higher frequencies than found in child populations.[14, 16] Adult incest victims complain of being hyperalert (76%)[15] and nervous (63%),[16] of having inhibitions around sexuality (61% to 94%)[12, 15] and socialization (61%),[12] of experiencing continuing anger about the incest (70%),[12] and of having flashbacks (80%),[12] nightmares (70%),[12] guilt (100%),[15] and depression (66%).[16] Most

adult incest victims' groups are designed to explore these symptoms and connect them with the childhood sexual and other abuse.[17]

The present study describes a cluster of severe symptoms found in a small sample of adult incest victims, all of whom had sustained at least one prior psychiatric hospitalization. Using detailed clinical data, we explore the possibility that these severe symptoms might be sequelae of the extreme incestuous abuse that was present in all cases.

Severe symptoms have been described previously in incest victims but at relatively low frequencies. In 318 children sexually abused within the past 6 months severe symptoms included: (1) daydreaming with memory loss (14%); (2) body image problems (8%); (3) problems with police (3%) and drugs or alcohol (2%); (4) age-inappropriate sexual behavior (7%) and self-endangering behaviors (5%); and (5) suicidal thoughts (6%), psychosomatic complaints (10%), and eating disorders (1%).[9] Adult incest victims report a higher frequency of severe symptoms with 33% reporting dissociative symptoms[15] and 8% diagnosed as Multiple Personality Disorder (MPD)[18–20]; 17% have Borderline Personality Disorder (BPD).[13] Alcohol and substance abuse are found in 12% to 31% of adult victim samples.[12, 13, 16] Rape or other crime victimization is found in 20% to 46%.[16, 18, 21, 22] Suicidal thoughts are reported by 46% to 48%,[12, 15] with 21% to 24% having made prior attempts,[13, 15] and 23% report medical problems.[12]

Previous studies of hospitalized psychiatric patients also describe a subgroup of incest victims with severe symptoms. Livingston[6] found prior sexual abuse in 13 of 100 consecutive admissions to a child inpatient unit; these children were more likely than either physically abused or nonabused inpatients to have psychotic symptoms, major depression, and somatic complaints. Kohan and coworkers[23] found sexual and violent acting out in over 50% of child inpatients with sexual abuse histories. However, Emslie and Rosenfeld[24] found no direct effects of incest in psychotic child inpatients. Goodwin and coworkers[25] found prior sexual abuse in half of 40 adult female inpatients. The half of the sample with prior sexual abuse contained all of the patients with current family violence problems and all with diagnoses of substance abuse, explosive disorder, and multiple personality disorder. Rieker and Carmen[26] found increased suicidal behavior in the 20% of adult inpatients who reported sexual abuse in childhood. Inpatients with both physical and sexual abuse in childhood were most likely to have harmed themselves (30%), followed by the sexual abuse only group (20%), then the physically abused group (14%), and the nonabused group (10%).

To explore the severe symptoms clustering in the 10 patients in this study, detailed clinical data were collected regarding (a) posttraumatic symptoms, (b) severe symptoms, and (c) childhood experiences of physical and sexual abuse.

METHODS

The present study describes 10 consecutive members of a 12-week incest victims' group for survivors who had also sustained at least one psychiatric hospitalization. Included are all individuals who participatd in at least one group meeting. This group was designed to provide services to victims who might be "screened out" of other survivor groups in the community which are volunteer-led support groups.

At entry, group members completed (1) a symptom questionnaire that produces scores for anxiety, depression, somatization and hostility,[27] (2) a sexual abuse screening questionnaire,[28] and (3) checklists for somatic symptoms, dissociative experiences, and family violence experiences. Hospital charts and transcripts of group meetings were reviewed.

RESULTS

The 10 incest survivors ranged in age from 21 to 47. All were supported by disability income. Five had high school education only; five had some college in addition. Five were divorced, three single, and two married. Three lived with male partners, and each of those three had a child in the home (one had relinquished parental rights but lived in an extended family arrangement with the adoptive mother and this child; both other mothers had regained custody after the child had been placed by protective services).

Posttraumatic Symptoms

Although none had been diagnosed previously as having posttraumatic stress disorder, the 10 victims in this sample met criteria and manifested extreme forms of the posttraumatic symptoms previously reported in incest survivors.

Fear and anxiety Eight of the 10 scored as anxious on the symptom questionnaire. Five of the 10 described barricading themselves in their blacked-out rooms at times when they were frightened of men.

Ego constriction—sexuality All 10 had at least one sexual dysfunction. Four were anorgasmic. Two were unable to tolerate certain sexual practices—one kissing and one the inferior position in intercourse. Three had sought sexual relationships with women because of orgasmic difficulties with men. One with MPD was orgasmic only in a highly sexualized alter identity. Two practiced compulsive masturbation—up to 70 times per day—with various objects including toothpaste tubes, brooms, and bottles. One had "flashed" men, opening what she described as a "nun's costume" to reveal her naked body.

Anger dyscontrol All 10 had high hostility as measured by the symptom questionnaire. Four had detailed plans to murder their primary incest perpetrator.

Repetitions All 10 had waking flashbacks to the sexual abuse. Visual, olfactory, and auditory flashbacks were present and were often identical with recurrent nightmare images. Six of the 10 had complained of hearing voices; all heard the perpetrator, and some heard other voices as well. One victim's description is typical: "It's like my father's beside me again telling me to commit suicide."

Sadness Nine of the 10 scored as significantly depressed on the symptom questionnaire. One group member articulated the universal problem of low self-esteem: "I feel I'll go crazy if I don't do something about my bad feelings about myself".

Severe Symptoms

Fugues and other dissociative symptoms All 10 had at least one major dissociative symptom. One was diagnosed as having MPD; her many symptoms are not included in the tallies below. One was diagnosed as having a fugue; she had found herself inexplicably in a foreign country. Seven had trancelike episodes. Four had no memory for important life events. Three had prominent imaginary playmates persisting into late adolescence: two had named childlike playmates that they conversed with, and the third had a "little man" three inches high she "kept in her pocket." Two had "perplexing people, places, and possessions," that is, the recurrent experience of not recognizng persons, places, or objects which circumstances indicated should have been familiar. Four were able to ignore pain; these four were also repetitive self-cutters. Two used different names in the group. One had recurrent episodes of believing she was Marilyn Monroe. One had episodes of "feeling seventeen years old or four."

Ego splitting with borderline ego pathology Nine of the 10 had been diagnosed as having BPD. The tenth carried a diagnosis of dependent personality. Of these nine, eight had greater than five hospitalizations, seven did repetitive self-cutting and seven had eating disorders.

Antisocial behaviors This term is used descriptively as none of the victims met criteria for Antisocial Personality Disorder. All six victims with children had lost custody of their children, five with protective service involvement, and three permanently. Parenting problems included neglect in two cases, abandonment in two and physical abuse in two cases ("I threw my 3-year-old into a wall and he hit his head on the bathtub"). Five had other legal involvements including arrests for prostitution (three had had venereal diseases), drug possession, shoplifting, vandalism, and disturbing the peace. Seven had alcohol abuse diagnoses and all seven had other polydrug abuse; six had been hospitalized with a primary substance abuse diagnosis.

Reenactments All 10 had been raped subsequent to their incest victimization. Three had been raped once, three twice, two three times, and

two four times. One rape had led to criminal conviction. One rape resulted in a pregnancy and stillbirth. Five had been sexually abused by someone in a caretaking or authority role: two by policemen, one by a teacher, one by a family physician, and one by a therapist. The vulnerability of incest victims to sexual abuse by therapists has been previously described by DeYoung.[21] Two women had reported rapes to the police only to learn later that they had invited the man involved to a sexual encounter but had dissociated this event; this phenomenon has been reported previously in patients with dissociative disorders.[29, 30] Seven had been physically abused by sexual partners. In four women this had occurred with more than one partner. Two cases involved death threats and weapons. In one of these cases the husband harangued the wife about her incest experiences during beatings. In the other extreme case the husband inserted objects into the wife's vagina during beatings; she was one of two women in the sample to experience a bone fracture secondary to spousal abuse.

Suicidality and somatization All 10 had attempted suicide; nine had made more than one attempt. Nine had taken multiple overdoses; seven practiced self-cutting; four practiced head-banging or hand-banging (one had broken her hand in this way); three pulled out hair or peeled off skin.

All 10 had been diagnosed as having a major affective disorder. Six had been diagnosed as depressed, two as schizoaffective, and two as having atypical affective disorders. All 10 were taking antidepressant and/or mood stabilizing medication at entry to the group. All 10 had undergone more than three psychiatric hospitalizations.

Nine of 10 had multiple somatic complaints as measured by the symptom questionnaire. Eight met Othmer and DeSouza's criteria for Somatization Disorder.[31] Nausea and vomiting and fainting were the most common symptoms, occurring in seven patients. Two women reported prior conversion disorders; both had experienced blindness and paralysis. Two reported prior seizures; both pseudoseizures and neurological seizures have been reported in incest victims.[4, 32] Four of the 10 had been diagnosed as having endocrine disorders: two thyroiditis, one hypothyroidism, and one hyperprolactinemia. Two were taking medication for asthma and two for seizures. Two had undergone multiple knee surgery. In all, eight of the 10 were taking medication for nonpsychiatric diagnoses.

Seven of the 10 had been diagnosed as having an eating disorder; three had bulimia with obesity; two had bulimia without obesity; two had bulimia with anorexia. Two others had episodes of fasting and vomiting which had not been diagnosed as an eating disorder. Two of the bulimics and both of the anorexics had been hospitalized for the eating disorder.

Characteristics of Childhood Abuse

All 10 had sustained intrafamilial sexual, physical, and emotional abuse and all 10 had witnessed other family members being physically abused.

In all 10 cases there were multiple sexual abusers in childhood. Natural families were involved in all except one case, which involved the foster family with which the woman lived from age 2 to 9. Father and brother or brothers were involved in eight cases; in three of these situations, additional perpetrators were named as well (cousin, uncle and mother, and brother's friends). In two cases an uncle was the primary sex abuser, with non-family members sexually abusing as well. In all 10 cases vaginal intercourse took place; oral intercourse was present in eight cases; and vaginal insertion of objects was a feature of two. Nine of the 10 were aged 8 or younger at the onset of the intrafamilial sexual abuse; the tenth patient was sexually abused by a neighbor at age 5 but was 12 when sexual abuse began with her uncle. Total duration—adding the duration with all intrafamilial abusers—was over 5 years in 9 of the 10. All 10 felt their mothers had failed to protect them. The spectrum of mother's involvement included (1) participation in the sexual abuse, one case; (2) participating in physical abuse by the sexual abuser, one case; (3) watching the sexual abuse, two cases; (4) instructing the daughter to keep the secret, one case; (5) blaming the daughter when told, one case; and (6) doing nothing when told, four cases. Protective services were involved in one case; in one other case disclosure was made to a therapist who did not report it. However, although only one was removed from home by protective services, eight others left home prior to age 16 by running away. Six of the 10 identified other sexual abuse victims in the family.

All 10 were physically abused in childhood. In two cases beating and choking were part of the sexual abuse. Two were kicked; eight were beaten with objects; two were threatened with knives or guns. The one patient who was sexually abused in foster care had been placed after being found abandoned in an alley.

All 10 had witnessed other family members being beaten. In nine of these, parental fights were prominent, as: "He used to rape her anally and then beat her with a strap." In the tenth case, a brother had murdered the physically abusive father.

All 10 reported "yelling and screaming" at home. Nicknames in childhood included "ugly," "filthy," "prick tease," and "fat ass." In eight of 10 cases one or both parents were alcoholic; seven fathers and four mothers were alcoholic. One patient reported alcoholism in four generations of family women from her great-grandmother to herself. Two fathers and one mother were psychiatrically hospitalized for paranoia or depression.

DISCUSSION

The 10 women seen in this group experienced the posttraumatic symptoms usually found in adult survivors but in more extreme forms. However, their clinical courses were dominated by five additional groupings of more severe symptoms. These more severe findings included dissociative symptoms

(10/10), borderline personality diagnoses (9/10), legal problems including child custody matters or arrests (all six with children had lost custody of the child at least temporarily) and other antisocial behaviors including alcohol and substance abuse (7/10), revictimization in the form of subsequent rapes (10/10) and physical abuse by sexual partners (7/10), and multiple suicide attempts (9/10). All 10 had been diagnosed as having major affective disorder, and all had been multiply (three times or more) psychiatrically hospitalized. Eight of 10 had multiple somatic symptoms, and seven had diagnosed eating disorders. All 10 survivors in the group had at least seven of these 11 severe symptoms.

I would suggest a second FEARS mnemonic for these severe symptoms: *f*ugues and other dissociative symptoms, *e*go splitting and disintegration (borderline personality disorder), *a*ntisocial acting out (arrests, abuse of own children, alcoholism or substance abuse), *r*eenactment of the abuse (rape, battering), and *s*uicidality and *s*omatization (including mood disorder, multiple hospitalization, eating disorder).

The child abuse histories were extreme in these cases. Abuse was multimodal including sexual, physical, and emotional abuse, as well as witnessed violence. The sexual abuse was severe, involving penetration and multiple partners in all cases. Age at onset was early, duration was long, and maternal protection was not available. Previous studies have reported associations between these indices of severity of incestuous abuse and the severity of later symptoms.[14, 25, 28]

In group psychotherapy there were indications that certain of the severe symptoms usually considered part of BPD were integrally related to prior abuse. Previous studies have reported a 30% to 70% frequency of prior incest in patients with BPD.[33–35] Both homosexuality and paraphilias are found with sixfold higher frequencies in women with BPD[36]; in this group extreme sexual behaviors appeared to be related to the sexual dysfunction aspect of their posttraumatic disorder. Self-mutilation may be another borderline symptom which can be linked to prior child abuse. Three of the self-cutters in our group also described detailed revenge plans to stab the incest perpetrator. Two found themselves frequently holding knives with amnesia for how this had happened. Two described the self-cutting as a way "to keep bad memories away." One patient with multiple overdoses had been chemically abused from infancy by her substance abusing mother.

Eating disorders have been reported previously in patients with dissociated traumatic experiences involving eating:[37] Five of the seven survivors in this group diagnosed as having eating disorders related their habitual vomiting to oral sex. "If I could get the semen out of my stomach I'd feel better." "I have the feeling of the penis in my mouth all mixed up with food." "When I self-induce vomiting it's like my father's right behind me pressing against me." "It's like I'm pretending I'm purging all over him."

It is perhaps expectable that multiple and extreme symptoms would be associated with multiple and extreme environmental risk factors. More research is needed to document the link found in this small sample between severe symptoms and prior extreme incestuous abuse and to determine whether treatment focused on the child abuse can mitigate the disabling severity of these problems. These preliminary data suggest that patients with severe symptoms may be at risk for multiple diagnoses and multiple medications while their ongoing family violence experience remains relatively unexplored and their severe symptoms continue.

REFERENCES

1. Briere J, Runtz M: Post-sexual abuse trauma: Data and implications for clinical practice. *J Interpersonal Violence* 2:367–379, 1987.
2. Burgess AW, Holmstrom LL: Rape trauma syndrome. *A J Psychiatry* 131:981–986, 1974.
3. Goodwin J: Post-traumatic symptoms in incest victims, in Eth S, Pynoos RS (eds): *Post-Traumatic Stress Disorder in Children*. Washington, DC, American Psychiatric Press, 1985.
4. Goodwin J: Developmental impacts of incest, in Noshpitz J, Berlin I, Call J, et al (eds): *Handbook of Child Psychiatry*. New York, Basic Books, vol 5, 1987, pp 103–110.
5. Herman JL: *Father-Daughter Incest*. Cambridge, Harvard University Press, 1981.
6. Livingston R: Sexually and physically abused children. *J Am Acad Child Psychiatry* 26:413–415, 1987.
7. Meiselman K: *Incest*. San Franciso, Jossey-Bass, 1978.
8. Mrazek PB, Kempe CH (eds): *Sexually Abused Children and Their Families*. New York, Pergamon Press, 1981.
9. Conte J, Schuerman JR: Factors associated with an increased impact of child sexual abuse. *Child Abuse Neglect* 11:201–211, 1987.
10. Gomes-Schwartz B, Horowitz JM, Sauzier M: Severity of emotional distress among sexually abused preschoolers, school age and adolescent children. *Hosp Community Psychiatry* 36:503–509, 1985.
11. Kardiner A: The traumatic neuroses of war, in Arieti S (ed): *American Handbook of Psychiatry*. New York, Basic Books, vol 1, 1941.
12. Donaldson MA Gardner R: Diagnosis and treatment of traumatic stress among women after childhood incest, in Figley C (ed): *Trauma and its Wake: The Study and Treatment of Post-Traumatic Stress Disorder*. New York, Brunner-Mazel, 1985, pp 356–377.
13. Herman J, Schatzow E: Recovery and verification of memories of childhood sexual trauma. *Psychoanal Psychol* 4:1–4, 1987.
14. Herman J, Russell D, Trocki K: Long-term effects of incestuous abuse in childhood. *Am J Psychiatry* 143:1293–1296, 1986.
15. Lindberrg FH, Distad LJ: Post-traumatic stress disorder in women who experienced childhood incest. *Child Abuse Neglect* 9:329–334, 1985.
16. Sedney MA, Brooks B: Factors associated with a history of childhood sexual experiences in a nonclinical female population. *J Acad Child Psychiatry* 23:215–218, 1984.

17. Tsai M, Wagner N: Therapy groups for women sexually molested as children. *Arch Sex Behav* 7:417–427, 1978.
18. Cole C: A group design for adult female survivors of childhood incest. *Women Ther* 4:71–82, 1985.
19. Goodwin J: Recognizing Multiple Personality Disorder in adult incest victims. *Victimology*, in press.
20. Putnam FW, Guroff JJ, Silberman EK, et al: The clinical phenomenology of Multiple Personality Disorder: Review of 100 recent cases. *J Clin Psychiatry* 47:285–293, 1986.
21. DeYoung M: Case reports: The sexual exploitation of victims by helping professionals. *Victimology* 6:92–98, 1983.
22. Miller J, Moeller D, Kaufman A, et al: Recidivism among sexual assault victims. *Am J Psychiatry* 135:1103–1104, 1978.
23. Kohan MJ, Pothier P, Norbeck JS: Hospitalized children with history of sexual abuse: Incidence and care issues. *Am J Orthopsychiatry* 57:258–264, 1987.
24. Emslie GJ, Rosenfeld A: Incest reported by children and adolescents hospitalized for severe psychiatric disorder. *Am J Psychiatry* 140:708–711, 1983.
25. Goodwin J, Attias R, McCarty T, et al: Routine questioning about childhood sexual abuse in psychiatry inpatients. Victimology, in press.
26. Rieker P, Carmen EH: The victim-to-patient process: The disconfirmation and transformation of abuse. Presented at the 138th Annual Meeting of the American Psychiatric Association, Dallas, Texas, 1985.
27. Kellner R: A symptom questionnaire. *J Clin Psychiatry* 48:268–274, 1987.
28. Goodwin J, McCarty T, DiVasto P: Physical and sexual abuse of the children of adult incest victims, in Goodwin J (ed): *Sexual Abuse: Incest Victims and Their Families*. Littleton, Mass, PSG Publishing Co, 1982.
29. Goodwin J, McCarty T: Atypical accounts of rape in patients with dissociative symptoms. Presented at the Second International Conference on Multiple Personality and the Dissociative States, Chicago, October, 1985.
30. Schafer DW: Recognizing multiple personality patients. *Am J Psychother* 40:500–511, 1986.
31. Othmer E, DeSouza C: A screening test for somatization disorder (hysteria). *Am J Psychiatry* 142:1146–1149, 1985.
32. Goodwin J, Simms M, Bergman R: Hysterical seizures in adolescent incest victims. *Am J Orthopsychiatry* 49:704–708, 1979.
33. Herman J, Van der Kolk B: Traumatic antecedents of borderline personality disorder, in Van der Kolk B (ed): *Psychological Trauma*. Washington, DC, American Psychiatric Press, 1987.
34. Saltman V, Solomon RS: Incest and multiple personality. *Psychol Rep* 50:1127–1141, 1982.
35. Schultz R, Kluft RP, Braun BG: Interface between Multiple Personality Disorder and Borderline Personality Disorder. Presented at the Third International Conference on Multiple Personality and Dissociative States. Chicago, October, 1986.
36. Zubenko GS, Anselm WG, Soloff PH, Schulz P: Sexual practices among patients with borderline personality disorder. *Am J Psychiatry* 144:748–752, 1987.
37. Torem MS: Dissociative states presenting as eating disorder. *Am J Clin Hypnosis* 29:137–142, 1986.

19

Why Physicians Should Report Child Abuse: The Example of Sexual Abuse

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Twenty-five years ago, the reasons why physicians should report child abuse were more clear than they are today. At that time state laws were passed which required the reporting of child abuse; this was clearly a medical advance. Prior to that, physicians simply had not been able to talk about the possibility that a child had been battered. It was hypothesized that there might be a genetic defect in some children which resulted in the triad of easy bruising, spontaneous subdural hematomas, and brittle bones causing multiple fractures.[1] Children's complaints of sexual abuse were explained away as fantasies, and children were chided by physicians for derogating their fathers.[2] Physicians, including pediatricians like C.H. Kempe, fought to make child abuse and neglect part of a civil juvenile code so that parents would not have to face criminal prosecution if they did admit that they had injured a child.[3] Once these laws made it safe for parents to talk about child abuse, physicians learned about an area of human experience which previously had been taboo.[4]

Today, physicians are much more familiar with the problems caused by the child protection laws than with the problems solved by those laws. As in other medical breakthroughs, such as the development of anesthesia or the development of immunization, modern-day physicians have much experience with the damaging side effects of these treatments, but little or no experience in dealing with the catastrophes that the innovations were designed to prevent.

There are now those who say that the child abuse laws are too radical,

that they infringe on parental rights to discipline and to educate their children, and that they infringe as well on the physician's right to a confidential relationship with the patient.[5] The child protection laws specifically exclude physician-patient confidentiality as a reason for not reporting. If physicians are mandated to report child abuse, should they also be required to give a Miranda-type warning[6] to each parent they interview? Physicians who report are protected from subsequent civil suit, and physicians who fail to report may be subject to a fine or a jail term. In New Mexico no physician has yet been fined for not reporting. However, courts have held physicians liable for damage which occurred to a child after the physician failed to report an abusive family situation.

Goldstein et al[7] have recommended severely limiting the jurisdiction of the child protection laws. They suggest that legal intervention be used only in cases in which (1) both parents have died or disappeared, (2) a caretaker has been successfully criminally prosecuted for a sexual offense against a child, or (3) a child is threatened by imminent death or serious bodily harm. In such cases they recommend that intervention should be vigorous and usually should result in placement of the child in an adoptive home. One problem in this plan is that a family would not be reported if the child were merely locked in a closet for days on end but had no bodily signs of injury. It is not clear that this system would simplify decision making for physicians. Physicians have difficulty in making judgments about the imminence of death, even in more clear-cut diagnostic entities than child abuse. One can imagine the dilemmas that would be created if, for example, venereal disease were to be reported only if the case was imminently life-threatening—to whose life? the lives of the patient's offspring? of the patient's contacts?

In addition to these critics, there are those who say that the child abuse laws are not tough enough. This group argues that these laws, which provide for removal of the child from his parents, actually only punish the victim by sending the child into a dangerous impersonal world of foster care while allowing the parents to go unmolested. These advocates suggest that if children are to have equal rights, those who assault, murder, or rape children must face the same penalties they would face had they chosen a larger victim. They point out that law enforcement personnel are likely to do a better job of investigation than are caseworkers who have not been trained to interrogate suspects or to elicit confessions. Critics in this group, like psychiatrist Thomas Szasz,[8] suggest that making exceptions to the law on the grounds of emotional impairment in the parent-perpetrator can ultimately jeopardize the rights of the parent. Indeed, parents do at times face a double-jeopardy system: Legal action through the child protection laws and criminal prosecution as well.

Critics in both groups point to problems in the child protection system. Perpetual foster care in a series of different homes is not good for

children.[9] Workers in state child protective agencies are often untrained, overworked, and incapable of maintaining good communication with the referring physician. A report of child abuse can often cause as many family problems as it resolves; for example, when the adversary civil court system returns a child to the abusing parents to be punished for having "told on" them.[6] The frequency of reporting by physicians and families increases with the availability of helpful protective services. We have found that a change from a more sensitive to a less sensitive intake worker reduced sexual abuse reports by one half in the first 6 months after the change.

In addition to all of these problems, there is conflicting evidence about whether reporting ultimately improves outcome for the child. In certain model programs, such as the sexual abuse treatment program in Santa Clara County, California, more than 75% of parents and children show measurable improvement, and recurrence of abuse is almost nonexistent.[10] Not all programs are this successful.

How, then, can the physician expose a family and himself to the stigmatization, stress, and risks of family separation which reporting implies? This chapter reviews five reasons for reporting child abuse:

1. To decrease morbidity for abused and neglected children
2. To generate accurate information about the incidence of child abuse and neglect
3. To routinize and destigmatize the process of reporting
4. To provide help for families who are otherwise unknown to and unhelped by social or psychiatric agencies
5. To increase physicians' influence with state social agencies

The data and discussions are presented from the perspective of a psychiatrist (JG), who serves as a consultant to a protective service agency, and of a pediatrician (CG), who coordinates the treatment of abused children at a large county hospital.

DECREASING THE MORBIDITY FOR ABUSED AND NEGLECTED CHILDREN

Some of the most discouraging data about child abuse and also about the preventive value of reporting are found in studies of battered babies. Smith and Hanson[11] studied 134 battered babies reported to a child protection agency in Birmingham, England. Of those 134, 21 (15%) died. Another 20 (15%) suffered permanent neurologic damage from the initial battering. Another study indicates that in 3% of children hospitalized for mental retardation, the handicap was caused by injuries inflicted by parents.[12] In another 21% of institutionalized children, physical abuse and neglect were judged to have contributed to the developmental retardation. In the Birmingham study, 60% of the babies were rebattered, despite the fact that the initial incident was reported. The critical missing factor here is: How

many babies would have been rebattered, and how severely, had the initial incident not been reported? Another important finding in this study is that of the 134 battered babies, 60% had been diagnosed prior to the battering as having failure to thrive. What would have been the morbidity and mortality statistics had all of those children been reported at the time failure to thrive was first detected?

We now have some data on the effects of increased reporting on morbidity in sexually abused children. In Bernalillo County, New Mexico, in the 5 years from 1975 to 1980, the frequency of incest reports increased from four in 1975 to 125 in 1979. The number of reports approximately doubled in each successive year. In the first half of this time period, 39 families were reported. In four families a child victim had venereal disease, and in one family a victim was pregnant. In the second half of the 5-year interval, there were 200 reports. The absolute numbers of children with either pregnancy or venereal disease remained the same despite an absolute increase in the county's population and more active case finding. The combined frequency of these major complications in child victims decreased from 13% to 3% with increased reporting.

Is this decreased morbidity merely a reflection of a dilution of the serious cases by trivial unsubstantiated cases? We think not. Concurrent with the declining morbidity we have seen a decrease in the average duration of incest at the time of reporting and an increase in the percentage of reports of one-time-only incest rapes. This indicates to us that the increased numbers of reports reflect earlier reporting rather than an increase in trivial cases, and that it is the early case finding that accounts for the decreased percentage of venereal disease and pregnancy now seen in victims.

In an earlier study of incest cases in New Mexico which took place in 1976, we found that 10% of the reported cases of incest involved a pregnant victim. This 10% figure had been reported in many other studies[13] (see also chapter 14) in settings where treatment for victims and families was not readily available. However, contemporary major treatment centers share our experience that fewer than 1% of the victims are pregnant in a setting where early reporting and treatment are emphasized.

In thinking about preventing morbidity, it is important to consider primary prevention for siblings as well as secondary prevention for the identified victim. The following is a case report of an incest situation in which a therapist decided for good reasons and in good faith not to report to child protection authorities. In this case the therapist's decision resulted in significant morbidity to a sibling.

Case 1 L was a 15-year-old girl, referred for psychotherapy when she placed a threatening note on her teacher's car. After a few months of psychotherapy she revealed to the therapist a 4-year history of incest with her father. A family session was held in which the father admitted that he had

made sexual advances to his daughter, but he repeatedly rationalized the advances by saying that he had "just been trying to show her what would happen if she were raped." The mother kept saying that she could not believe that it had happened. Individual therapy with the child continued and family sessions were held intermittently. Two years later, child protection authorities received a referral about the 12-year-old sister in the family. On investigation it was determined that the younger sister had been sexually involved with the father for aboout 1 year. The older sister had debated telling her therapist about her sister's initiation into the incest, but had rationalized not reporting by telling herself, "The trouble with my sister is that she likes it." In a family session at the child protection agency, the father admitted the relationship, but this time with emotion. The mother began treatment in a group of incest mothers. At the first meeting she left the group, sobbing and upset, saying, "I thought I had dealt with this, but I guess I really had not."

Could involvement of the younger sibling have been prevented had the therapist notified child protection authorities as soon as the first instance of incest was revealed? We have seen many other cases in which a protective service approach was taken only after another sibling, a neighbor, or another relative was approached sexually by the abuser. Some perpetrators have told us later in fathers' groups that the therapist's promise not to report the case never allayed their fear of being caught.

Failure to report not only gives the initial perpetrator time and anxiety enough to victimize another child, it may also give the victim time and opportunity to turn the passive experience into an active one by initiating sexual activity with a younger child. Burgess et al[14] have described several cases in which a sexually abused latency-age child dealt with the trauma by beginning to experiment sexually with a younger child or toddler. It is now generally known that many rapists and pedophiles have a history of sexual abuse in childhood.[15] What needs to be weighed by the physician deciding whether to report is that this evolution of sexual victim to sexual aggressor may occur within weeks or months and place this child's younger siblings and neighbors at risk for sexual abuse.

It is well to remember that morbidity in parents, as well as morbidity in children, can sometimes be prevented if the family is forced to receive medical evaluation. The following case is one in which reporting may have been instrumental in saving the lives of both parents.

Case 2 The R family was referred because all five children in the family, all of whom were under 4 years of age, were failing to thrive. Mr R was alcoholic and Mrs R had had a difficult hospital course with her last delivery, a twin birth. She had failed to keep postpartum medical appointments. Despite great anger and resistance in the parents, the children were removed. The removal triggered increased medical contact for the entire family. Mrs R was diagnosed as having panpituitary insufficiency (Sheehan's syndrome) secondary to her most recent delivery, and replacement hormone treatment was begun. Mr R entered an alcoholism treatment program where he revealed a detailed and dangerous suicide plan.

DETERMINING THE INCIDENCE OF CHILD ABUSE AND NEGLECT

In New Mexico in 1976, homicide was the fourth leading cause of death for children aged 1 to 4 years, coming after accidents, anomalies, and pneumonia.[16] Furthermore, it seemed as though the child death rate from homicide had increased in New Mexico from 11.1/100,000 population in 1973 to 19.6/100,000 in 1976. This had apparently occurred despite the initiation of several demonstration projects for the treatment and prevention of child abuse in New Mexico in that time period. However, a closer look at the statistics shows that the increase in homicide deaths was paralleled by a large decrease in accidental deaths. In 1973 the death rate for children aged 1 to 4 due to accidents was 74.6/100,000 population. In 1976 there were 33.2 deaths due to accidents per 100,000 population in that age group. Discussion with the state medical investigators indicated that what was happening in the state was that deaths, which would have been ascribed to accident 10 years previously, were now being correctly diagnosed as instances of battering or homicide.

Intrafamilial sexual abuse or incest is another kind of child abuse in which incidence has been greatly underestimated. A survey of 500 normal women in the Albuquerque area showed that 15 of the 500, or 3%, had experienced intrafamilial sexual abuse prior to the age of 13.[17] As late as 1975, a major textbook of psychiatry estimated that the incidence of incest was one per million.[18]

The problem of proving that intervention in abuse/neglect families improves prognosis is made impossible by the fact that we lack a natural history of this condition before intervention was legally mandated.

Statistics now available indicate that any pediatrician in practice should be seeing cases of child abuse and neglect regularly. The best statistics indicate that six of every 1000 children will be battered; that figure increases to three in every 100 for children who have been residents of newborn intensive care units.[19] One out of 100 children will fail to thrive, some for environmental reasons,[20] and at least three of 100 children will be sexually abused by a parent figure. Only if all suspected cases are reported can the true incidence and spectrum of the problem be appreciated and accurate information be obtained about response to interventions and strategies for preventive intervention.

MAKING THE PROCESS OF REPORTING MORE ROUTINE WHILE REDUCING THE STIGMA

Available evidence indicates that as the reporting of child abuse and neglect increases, the percentage of substantiated cases decreases. In 1980 in Bernalillo County, only 25% of abuse/neglect referrals were substantiated.

In 1975, 50% of reports were being substantiated. Even in substantiated cases, a child or children will be removed from the home in fewer than 5% of these cases. This means that out of 1000 referrals a child or children will be removed from the family in about ten cases. What this means to the individual physician is that it is highly unlikely that a particular child he or she refers will be placed in foster care. Child abuse is recognized well enough by the general public that families are often able to say that they understand why physicians must be concerned about the etiology of injuries in growing children. Parents often understand and appreciate the physician's concerns about the need for protection. As reporting has increased, self-referrals by parents have also increased; in 1980, 10% of reports were self-referrals. Even though a case may be officially considered "unsubstantiated," families referred are often families with problems, which the alert protective service worker may refer to other appropriate resources.

Sexual abuse is a particular instance in which physicians can become very worried about the effects on the family, especially on the offending father, if the sexual abuse becomes known. The myth of false accusations in incest remains active among physicians despite evidence that only 5% to 9% of incest accusations are false.[21] The infrequent false accusations are readily detected. In addition, we have yet to see an instance of false accusation in which family treatment was not indicated. The physician may ask, "But even if the incidence were only one in 1000, would it not be tragic to have a father undergo the shame of an incest accusation and the associated court involvement if he were innocent?" These physicians may not understand how difficult it is to prosecute incest cases. We recently tabulated the court experience in 125 consecutive cases of substantiated sexual abuse in Bernalillo County. Only five persons were criminally charged among those 125 perpetrators. Of the five who were charged, only two were convicted. These data support Russell's findings that only 1% of rape experiences self-reported by women in the general population resulted in criminal conviction.[22] In both convictions there was physical evidence of sexual abuse in the form of photographs taken of the child by the perpetrator. Given this very low rate of convictions in substantiated (by social workers) cases of sexual abuse, it is very unlikely that a false accusation of incest could lead to a conviction, at least not in this jurisdiction.

If one thinks about these false accusations from a medical rather than from a legal viewpoint, one can begin to imagine what dreadful family problems must be present before a child engages in an attempt to have her father jailed. A visit by a social worker who asks, "Is there a problem with your children?" is usually a helpful intervention for such disturbed families.

The sexual abuse area is one in which the move to recriminalize child abuse has been most active. In the model program in Santa Clara County, California,[10] fathers are routinely taken through the criminal court system

to be sentenced to treatment. This is a unique situation because law enforcement and the courts are well coordinated to promote treatment rather than imprisonment of fathers. There is not the deterrent to reporting that there would be in a less ideal system which emphasized criminal prosecution at the expense of treatment approaches.

PROVIDING HELP FOR FAMILIES BY REPORTING THEM

In 1972 in New York City, only eight of 2300 reports of child abuse and neglect came from private physicians.[23] In 1981, in Bernalillo County, about 1% of all referrals came from pediatricians in private practice. Since sexual abuse tends to occur in families with higher annual incomes than the average abusive family, these families were at risk for not being reported by private practitioners and for not receiving help.

Is there a need for reporting in the population that utilizes private practice medical care? Data from ten consecutive cases of fatal child maltreatment indicate a need. Of these ten families; only four were receiving welfare or other social assistance and four of the families had incomes above $10,000 a year. Of the ten mothers, nine were either in the first 3 months postpartum or pregnant at the time of the death of the child. Four of the five woman not known to social agencies had been seen by a private pediatrician or obstetrician in the month prior to the child's death.[17] Of the ten child victims, four were under 6 months of age. Two of those four had been born prematurely and had been treated in a neonatal intensive care setting. These data clearly point to a role in child abuse prevention for the private pediatrician, as well as for the obstetrician.

However, child protection agencies also seem to have failed in prevention in these cases. Of the six children who were over 6 months of age at the time of their death, five had been previously reported to child protection agencies as being mistreated. This returns us to the question of whether reporting does actually reduce morbidity and mortality from child abuse.

On retrospective review, two families were found in which prior infant deaths had occurred, which were later judged to have resulted from the child maltreatment syndrome rather than from accidents. It may be that the chance to prevent battering of the next sibling was lost when those past deaths were misdiagnosed. Reporting may be more effective at preventing abuse for the younger siblings that for the victim who is reported.[24] In some cases it may be a report of the abuse of the mother in her childhood that would have been necessary to preventively protect the children she later bears. The following is a case in point.

Case 3 At 16, A returned to live with her parents after bearing her stepfather's child. The stepfather beat and raped her, and she determined finally to tell someone about the incest situation. She told her story at a hospital

emergency room but was not believed. She was judged to be "hysterical" and was sedated. Five years later, she left her ill 1-year-old son with her intoxicated, angry boyfriend. The child was sodomized and beaten to death.

Her failure to protect the child mirrors her physician's failure to protect her. Of the ten mothers in our series of fatal maltreatment cases, four had been incest victims; none had successfully reported their plight. In a more recent study, sadistic sexual abuse was found in three of nine women imprisoned for fatally maltreating children.[25]

Physicians other than pediatricians may have unique access to families in which child abuse is occurring. Psychiatrists may see these parents. Although fewer than 5% of abusing parents are diagnosed as psychotic, many are diagnosed as having personality disorder, alcoholism, or other substance abuse. Sexual dysfunction, depression, and suicide attempts are seen in the mothers of sexual abuse victims.[26] Psychiatrists who see these parents in times of crisis have an opportunity to detect child abuse.

Hysterical symptoms, particularly hysterical paralyses, have been reported in parents who are trying to defend themselves against abusing a child. Such parents may be seen in an emergency room where an alert physician may recognize the underlying danger of abuse.[27] Impending sexual abuse may also present with somatic complaints, as illustrated by the following case.

Case 4 A 42-year-old veteran demanded admission to a veteran's hospital complaining of back, leg, and stomach pain and saying that he felt he was going to die. Because his anxiety was so extreme, he was admitted. Each time that his symptoms abated enough to warrant discharge, he would develop a new series of complaints. "You can't send me home," he told his physician. A family session was held. The physician discovered that sexual relations had ceased between the patient and his wife and that the patient had been sleeping with his 14-year-old daughter. Although actual sexual contact had not yet occurred, the patient feared that this was imminent. After four sessions of family therapy, the patient's somatic symptoms resolved and he felt ready to go home.

Emergency room physicians also treat childhood poisonings, burns, and other accidents which tend to occur in families where abuse and neglect are also risks. Some investigators have suggested that parents routinely be interviewed after accidents to assess their skills in protecting children. It is clear that "stress" may be a common factor in many injuries, accidental and nonaccidental.[28, 29] Rape of a child, an occurrence that is also thought of as accidental, may also be more likely to occur in families in which "nonaccidental" incest rape is also a problem. One 8-year-old was brought in for examination three days after having been raped by a stranger. The child's alcoholic father had been adamant in his refusal to allow the rape to be reported. On examination the child admitted that she had been having intercourse with her father for several months prior to the rape.

Physicians can become involved by parents as coperpetrators of certain kinds of child abuse. Munchausen's syndrome by proxy has been described

by pediatricians.[30] In this syndrome, a mother simulates an obscure disease in her child and has the child continuously evaluated and reevaluated medically. Several deaths from this syndrome have been reported; one mother who was simulating hypernatremia in her infant miscalculated and administerd more sodium than her child could survive. In the sexual abuse area we have seen disturbed mothers who take their children to different physicians to have pelvic examinations which the mother insists on observing. The mother may then repeat the "pelvic examination" at home and this becomes a part of the abusive sexual behavior. Nineteenth-century cases in which the fathers and physicians collaborated to devise inspections and punishments to prevent children from masturbating probably represent another instance of the cooperation of the professional in the perpetration of sexual abuse.[31]

REPORTING INCREASING THE PHYSICIAN'S INFLUENCE WITH CHILD PROTECTIVE AGENCIES

Most professionals agree that in severe abuse situations treatment is not a one-person job. We recently reviewed the first 9 months of treatment in a family in which sexual abuse had occurred. Thirty-two different agencies were involved with the family in that 9-month period. Why so many different agencies? There were three incest victims in the family and two brothers who were being physically abused. One of the incest victims had become pregnant by the father and needed support in relinquishing that baby; another was severely depressed; the third was involved in prostitution and drugs and kept running away from home and from alternate placements. Both physical abuse victims required medical care and special educational placement. The father was unemployed; the family home burned down; the mother needed birth control counseling; and so forth. Crisis intervention in such a family is an almost daily necessity.

The question for the physician is, "How can I find the help I need?" It is also clear that the problems involved are exceedingly complex and that recognition and reporting are just the first steps in helping the family, although extremely critical ones. It is important for the physician not to consider protective services as only a resource to which he or she refers families, but to realize that he himself should be an important resource to the protective service worker, because of both his medical expertise and his relationship with the family. An ongoing collaboration which involves the family, the physician, and the protective service worker serves the best interests of the child. Perhaps the best incentive to continued reporting by physicians is the experience of participating in a constructive, positive response to the needs of an abusive family which results in adequate protection of the children.

Physicians with a good working relationship with protective services may help to promote better assessment of the health needs of children already in foster placement, such as maintaining growth charts or immunization records. The physician is also in an ideal situation to work cooperatively with protective services concerning high-risk families. For example, a mother had had a previous infant removed to foster care because of failure to thrive and multiple fractures. When she became pregnant again, her private pediatrician was alerted by her protective service worker that this mother would need extra support and monitoring. In this case the mother was successfully able to nurture the second child.

DISCUSSION

Physicians usually have good reasons for not reporting a case of child abuse. For example, when a child complains of sexual abuse, the physician is confronted with a host of worries. Is the child telling the truth? How can the family be confronted? What sort of a forensic examination is required? What legal involvements will occur? Will the family be separated? Will protective service involvement simply make things worse? Might this be "normal" behavior in the family culture? In our experience many of these problems are resolved by reporting, and few are resolved by not reporting. By reporting, the physician gains allies and information. Child-and family-oriented worries are given priority: Does the child feel supported and protected? Is she at risk for gonorrhea? For pregnancy? For physical abuse? For neglect? Are there other family problems? Are other children at risk for sexual abuse by the perpetrator? Are all family members receiving adequate medical care? Does the family have support from extended family, schools, jobs?

As physician and caseworker collaborate, they may effectively challenge in each other untested assumptions about intrafamilial sexual abuse, ie, that children lie about incest, that mothers are never perpetrators, that only daughters are victimized, that the children do not mind being abused, that the children can never return to live with the perpetrator, that natural fathers are never perpetrators, that gonorrhea is transmitted through the bed sheets. It is only because of recent efforts to obtain thorough and accurate reporting that we are beginning to be able to evaluate critically these assumptions.

Increased reporting will inevitably lead to a greater percentage of reported cases that cannot be substantiated. Similarly, more extensive screening of the contacts of patients with venereal disease would be expected to yield a higher percentage of contacts with negative cultures, as well as yielding positive diagnoses in cases which otherwise would have gone undetected. The "unnecessary" bother to the "false-positive" families is horrifying only in the context of our unrealistic expectations that parents should be flawless. Most patients will understand the need for further

diagnostic tests when there is a positive test for syphilis and will understand that there is a possibility that syndromes other than syphilis, or that a laboratory error, caused the positive test.

The need for further testing in cases of incest accusation can be explained along similar lines. The disrupted families that are reported because of intrafamilial sexual abuse are always quick to charge that the state is "killing" them through its intrusive intervention. The children and the families who are actually killed through the "kindness" of nonintervention will be more difficult to detect. Systematic reporting and follow-up will be necessary if we are to adequately weigh the relative risks.

REFERENCES

1. Caffey J: Multiple fractures in long bones of infants suffering from chronic subdural hematoma. *Am J Roentgenol* 56:163–173, 1946.
2. Butler S: *Conspiracy of Silence: The Trauma of Incest*. San Francisco, New Glide, 1978.
3. Kempe CH, Silverman FN, Steele BF, et al: The battered child syndrome. *JAMA* 181:17–24, 1962.
4. Blumberg M: Treatment of the abused child and the child abuser. *Am J Psychother* 31:204–215, 1977.
5. Rosenfeld AA, Newberger EH: Compassion vs. control: Conceptual and practical pitfalls in the broadened definition of child abuse. *JAMA* 237:2086–2088, 1977.
6. Terr LC, Watson AS: The battered child rebrutalized: Ten cases of medical-legal confusion. *Am J Psychiatry* 124:1432–1439, 1968.
7. Goldstein J, Freud A, Solnit A: *Before the Best Interest of the Child*. New York, Free Press, 1980.
8. Szasz T: *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*. New York, Harper & Row, 1974.
9. Goldstein J, Freud A, Solnit A: *Beyond the Interest of the Child*. New York, Free Press, 1980.
10. Giaretto H: Humanistic treatment of father-daughter incest, in Helfer R, Kempe CH (eds): *Child Abuse and Neglect: The Family and the Community*. Cambridge, Mass, Ballinger, 1976, pp 143–162.
11. Smith SM, Hanson R: One hundred-thirty-four battered children: A medical and psychological study. *Br Med J* 3:666–670, 1974.
12. Buchanan A, Oliver JE: Abuse and neglect as a cause of mental retardation: A study of 140 children admitted to subnormality hospitals in Wiltshire. *Br J Psychiatry* 131:458–467, 1977.
13. Maisch H: *Incest*. New York, Stein & Day, 1972.
14. Burgess AW, Groth AN, Holmstrom LL, et al: *Sexual Assault of Children and Adolescents*. Lexington, Mass, Lexington Books, 1978.
15. Hanmer EF: Symptoms of sexual deprivation: Dynamics and etiology. *Psychoanal Rev* 55:5–27, 1968.
16. *Selected Health Statistics 1977*. Santa Fe, NM, Health and Environment Dept, 1977.
17. Goodwin J, McCarty T, DiVasto P: Prior incest in abusive mothers. *Child Abuse Neglect* 5:1–9, 1981.

18. Rush F: *The Best Kept Secret: Sexual Abuse of Children*. New York, Prentice-Hall, 1980.
19. Chadwick DL, Henderson RW, Dean DJ: The incidence of abuse and neglect in infants discharged from a neonatal intensive care unit, abstract. *Clin Res* 26:179A, 1978.
20. Koel B: Failure to thrive and fatal injury as a continuum. *Am J Dis Child* 118:565–567, 1969.
21. Goodwin J, Sahd D, Rada R: Incest hoax: False accusations, false denials. *Bull Am Acad Psychiatry Law* 6:269–276, 1979.
22. Russell D: *Sexual Exploitation: Rape, Child Sexual Abuse, and Workplace Harassment*. Beverly Hills, Calif, Sage, 1984.
23. Helfer RE: Why most physicians don't get involved in child abuse cases and what to do about it. *Child Today* 4:28–32, 1975.
24. Lynch MA, Roberts J: *Consequences of Child Abuse*. New York, Academic Press, 1982.
25. Korbin J: Childhood histories of women imprisoned for fatal maltreatment. *Child Abuse Neglect* 10:331–338, 1986.
26. Goodwin J: Suicide attempts in sexual abuse victims and their mothers. *Child Abuse Neglect* 5:217–221, 1981.
27. Mogelniecki R, Mogelniecki NP, Chandler JE, et al: Impending child abuse: Psychosomatic symptoms in adults as a clue. *JAMA* 237:1109–1111, 1977.
28. Martin HL: Antecedents of burns and scalds in children. *Br J Med Psychol* 43:39–47, 1970.
29. Rogers D, Tripp J, Bentovim A, et al: Non-accidental poisoning: An extended syndrome of child abuse. *Br Med J* 1:793–796, 1976.
30. Meadow R: Munchausen syndrome by proxy: The hinterland of child abuse. *Lancet:* 343–345, 1977.
31. Williams G, Money J: *Traumatic Abuse and Neglect of Children*. Baltimore, Johns Hopkins, 1980, pp 411–414.

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Cross-Cultural Perspectives on Clinical Problems of Incest

Jean Goodwin

Like the blind men with the elephant, anthropologists and psychiatrists have traditionally grasped at different ends of the problem of incest. Anthropologists try to understand the rules that cultures develop about incest. Psychiatrists try to restore to normal functioning those individuals who have broken those rules.

This chapter will describe six clinical *problems* in the treatment of incest victims and their families:

1. Hysterical seizures developing after an incest event
2. Suicide attempts in incest victims and in other members of their families
3. Runaway incest victims
4. How incest operates as a defense against loss
5. Subsequent maternal failure in women who have been incest victims
6. How to talk with children about incest in a nonthreatening way

Clinical aspects of these problems have been discussed in previous chapters. This chapter will focus on the cross-cultural and folkloric data which have been critical to understanding these clinical problems.

In the process of trying to understand these clinical problems in cross-cultural context, I have developed the hypothesis that clinicians like myself, together with storytellers and rule-makers in many different societies, have been observing a single set of symptoms that characterize incest victims and their families. Most of the cross-cultural data referred to here comes from S.K. Weinberg's 1955 book, *Incest Behavior*,[1] which reviews beliefs about

incest from 11 different cultures. These data are limited and somewhat dated, but are unbiased in that they were not originally selected to support the hypothesis that the punishments and consequences of incest reported in these cultures are congruent with the psychological symptoms that American clinicians observe in incest participants. Western folk beliefs about incest will be drawn from Greek mythology and from the medieval cycle of legends about fathers who propose marriage to their daughters; this motif is typified by the Grimms' fairy tale *Thousandfurs*.[2]

HYSTERICAL SEIZURES DEVELOPING AFTER AN INCEST EVENT

My first exposure to the clinical association between hysterical seizures and incest was several years ago when as a psychiatric consultant I saw a young Navajo boy. The clinical question at that time was whether the boy's seizures were "real" or hysterical. When I consulted a psychiatrist who had worked on the Navajo reservation, he advised me to ask the boy whether he had experienced incest and whether he was considered to be a witch. The boy's affirmative answers to these questions opened the door to a therapeutic relationship that controlled his seizures. As the Navajo see things, seizures, witchcraft, and incest are inextricably linked. Any child who has organically based seizures will be *assumed* to have experienced incest and will be compelled to produce hysterical seizures as well in order to confirm his reputation as a witch, so that he can have at least one weapon with which to intimidate the peers who are tormenting and avoiding him.

Several years later, I was surprised to find a similar constellation of symptoms in an Anglo-American teenage girl who had her first hysterical seizure after she had run away from home 2 weeks after her natural father had intercourse with her for the first time. I was intrigued enough by the parallels in the two cases to review the records of 12 consecutive psychiatric admissions for hysterical epilepsy.[3] Four of these 12 patients reported prior incest. Only one of the four was Navajo. On reviewing a previous study from Canada that reported on 25 cases of hysterical seizures, I found that two of the women in that sample had reported a prior incest experience to a neurologist in a context where there was no theoretical suspicion that incest and hysterical seizures might be causally connected.[4]

One could explain the connection between incest, seizures, and witchcraft among the Navajo as the result of cultural programming, but how to explain similar connections appearing in Anglo-American teenagers in the late twentieth century?

Incest has been connected with witchcraft in several areas of Western folklore. Incest was said to occur as part of the witches' sabbath.[5] The child born of mother-son incest was reputed in various parts of Europe to have powers as a witch, magician, or vampire.[6] Anne Boleyn, wife of

Henry VIII of England, was convicted as a witch in part because incest had been proved against her.[5] Anglo-Americans and Navajos are not the only cultures with traditions linking incest and witchcraft. Two of the 11 cultures reviewed by Weinberg make similar connections. The Mojave Indians say that most shamans have experienced incest, and the Wayao of Africa commit incest in order to gain magical powers.[1]

Folkloric connections were also made between incest and seizures. Galen, the second-century Greek physician whose opinions became dogma during the Renaissance, taught that seizures were the result of premature intercourse in childhood; that is not in fact too distant from Freud's hypothesis that an hysterical seizure repeats a traumatic event.[7] The Navajo remedy for seizures is to subject the sufferer to the Moth Way chant, a ceremony that retells the story of a disastrous cultural experiment with incest.[8] Since the thirteenth century, European seizure victims have been advised to make a pilgrimage to the Church of Saint Dymphna at Gheel (or Geel) in Belgium. There the epileptic reviews, on prescribed daily circuits of the church, the story of a young princess who fled from her father's sexual advances (see Appendix III). In both of these healing rituals, the review and the reworking of an incest story is the central action. This treatment might work as an efficient "shotgun therapy" for seizures in much the same way that penicillin works for upper respiratory infections. For the minority of cases that are curable, the prescribed treatment will be curative. For the majority of cases where neither an incest experience nor a bacterium has had etiologic importance, the prescribed treatment will have nonspecific beneficial effects. Even though the majority of seizures are probably not incest-related, the seizures that can be cured without modern medicines may well be responsive to an incest story. Patients who were not incest victims might respond to the stories as well because of their impact on unconscious oedipal conflicts, their symbolic impact in creating a liminal situation where realities can be reversed to make regeneration seem possible, or because of less specific placebo effect. In both European and Navajo cultures other mental disorders, including psychoses and possession states, are treated in the same way as epilepsy.

These observations led me to the following hypothesis: Hysterical epilepsy is one of a definable spectrum of responses to the experience of incest which have been observed by various cultures and which can be deduced from the cultural lore about the consequences of incest.

Hysterical epilepsy is a particularly natural symptom choice for an incest victim. The hysterical seizure repeats movements related to sexual stimulation as well as movements that are related to resisting a sexual assault.[9] During a seizure the patient is able to terrify others, rather than being the one terrified as she had been during the sexual attack. Incest must be kept secret, but the hysterical seizure attack, which symbolizes the incest, may take place in public, releasing some of the tension of the secret. One

of our patients repeated the phrase, "I promise," during her hysterical seizures. Therapeutic analysis helped her to recall that her brother "made me promise not to tell" after each episode of fondling. Incest victims often pretend to be asleep during the sexual event and the adult participant, especially if he is alcoholic, will often claim to have no memory of the sexual attack. The feigned sleep and the feigned amnesia that accompany the hysterical seizure repeat these defenses against acknowledging the incest secret.

Other types of dissociative symptoms have been reported in incest victims including multiple personality, and a trancelike withdrawal from unpleasant realities.[10] The dissociated incest victim and those around her often decide that since she is not in contact with ordinary reality, she must be in touch with some more powerful reality. Also, since hysterical seizures and related symptoms such as possession states are easily treated by hypnosis, the incest victim is likely to become the patient or disciple of a hypnotist or shaman who may then train the victim to become a practitioner. This is one possible life history that would link the incest experience to the subsequent hysterical seizure, and then to the eventual identification as a witch or a healer.

SUICIDE ATTEMPTS IN INCEST VICTIMS AND OTHER FAMILY MEMBERS

When I began to collect cases of hysterical seizures in incest victims, I was surprised to find that all six of these teenagers had either threatened or attempted suicide.[3] My acquaintance with the Navajo folk beliefs had not prepared me for suicide attempts, but only for seizures and witchcraft. I went back to my friend, the psychiatrist who had worked among the Navajo, and asked him about suicide. I was reassured to learn that the Navajo had again anticipated my clinical observation. The Navajo say that the act of incest plants a moth into the brain. As this moth matures, it will drive the incest offender into the fire just as a moth flies into the fire. The belief is linked to the Moth Way legend which tells of how delightedly the moth people welcomed a plan to marry their daughters to their sons so that no one would ever need to leave home. However, during the wedding ceremony all the moths flew into the fire. The implication is that the impulse to commit incest is as self-destructive as the impulse to fly into the fire. Several cases have been reported in which Navajo incest victims have actually fallen into the fire in their hogan during an hysterical seizure and have been seriously burned.[8]

In a brief follow-up of 201 urban Anglo-American and Spanish-American families where incest had occurred, I found subsequent suicide attempts in 11 of the families. Of the 13 suicide attempts that occurred in these 11 families, five occurred in mothers and eight in daughters.[11]

Previous studies have also reported suicide attempts in perpetrators; in a study done in Germany, 3% of incarcerated incestuous fathers killed themselves in prison.[5] In our sample the three mothers who made suicide attempts in the first week after the incest accusation had all been incest victims themselves. They also had serious psychiatric diagnoses and substance abuse problems. These three conditions combined made it impossible for them to cope with the incest accusation. The two mothers who made attempts at suicide later did so at a point when they felt they were being forced to choose between husband and daughter. The suicide attempts seemed to express the frustration these mothers had at feeling forced to choose the daughter; the attempts also gave them an excuse to retreat from that mothering choice. Neither of these mothers was able to return to successful mothering of her daughter, and both of the daughters later attempted suicide themselves. All eight of the daughters who attempted suicide were between 14 and 16 years old and had been involved in incest with the father-figure in the family. None of their families had remained intact after the disclosure of the incest. The mothers had actively blamed and disbelieved these eight victims.

The Western cultural experience gives us some warning that suicide attempts may be a problem in incest families. In the Oedipus story, the "victim" Oedipus plucks out his eyes in a self-mutilating gesture; the "perpetrator" Jocasta commits suicide by hanging herself, and an "uninvolved sibling daughter" Antigone ultimately hangs herself. In the story of Phaedra's attempted seduction of her stepson, she too kills herself.[12] In the series of medieval legends and romances which describe a daughter's flight from an incestuous father, the daughter often mutilates herself to discourage the father by cutting off her hands or breasts.[6] In other versions the heroine commits suicide, commonly by drowning, to escape incest.

The cross-cultural experience is similar. In five of the 11 cultures described by Weinberg, suicide was forced on incest participants.[1] It was second only to banishment in frequency of use as a punishment for incest.

Is there some common psychodynamic factor that explains why, like Oedipus and other legendary figures, modern-day teenage incest victims harm themselves? Is it the same factor that made the Tikopians and Gilbert Islanders decide that it was a workable punishment to ask incest participants to canoe out into the Pacific Ocean? Or that made the Greeks and Romans decide that incest partners would take their meaning if they sent each a sword? The Murngin of Australia ask the incest participants to walk into enemy territory where they will certainly be killed.[1]

Sexual guilt is the major theme of the Oedipus story. Certainly, in the victimized teenagers who attempted suicide, the mothers' blame and disbelief, and the chaos that their accusations had loosed upon their families

were constant reminders of the price that had been exacted for their sexual activities. In addition, four of the eight made attempts immediately after a sexual experiment with a boyfriend, for example after a first experience with breast-petting.[11] It may seem logical to attack one's body if that body seems capable of causing so much devastation. All five of the mothers who attempted suicide in my study had been sterilized either surgically or through repeated bouts of gonorrhea. Other studies have shown that hysterectomy in the mother is present with significantly greater frequency in incest families than in the general population. Sixty-five percent of incest mothers have had hysterectomies.[13] This family experience of castration may act to reinforce the family's belief that sexuality is dangerous and that those who have yielded to it will inevitably be mutilated or killed.

Another theme in the Oedipus story and in the lives of my patients is the failure of the child's desperate attempt to keep the family from disintegrating. The tragedy in these stories is that it is the very thoroughness and desperation of the attempt that ensures failure. Oedipus thought that by leaving home he was taking the only possible course that would avoid, for him, the loss of his father; unknowingly, he killed his father on the journey. The eight incest victims in my sample had made an unconscious decision that the only way to keep their mother, and to keep their father for their mother, was to satisfy the father's sexual needs. Yet it was that very sacrifice which led to the father being banished from the home and to the mother turning against the daughter. For a child whose self-esteem is based on her loyalty to the family and on her competence in solving problems to meet her family's needs (as did Oedipus when he bested the Sphinx), this failure is devastating.

A third motive for suicide in these children is that they, like Oedipus, are afraid that if they are allowed to live they might become dangerous and harmful to the parent who has abandoned them. In my series, mothers and daughters were enmeshed in hostile relationships with each other and with other women. The daughter-victim is often afraid even to ask the mother for help, much less to express anger at her. She is afraid this will make the mother withdraw even more, or if the mother is physically ill as she is in 20% of incest familes,[5] the child is afraid that her anger might be the final blow which kills the mother. So as the child sustains more rejection and blame from the mother, she has no outlet for her anger except to turn it against herself. A Lithuanian folk ballad describes a mother who exposed to the ocean her infant sons in a small boat. When they unexpectedly returned alive as adults, she proposed to marry one of them.[6] However, rather than protecting her as Oedipus had done, the sons killed the mother. In clinical practice, as well as in folklore, the anger of the victimized child will occasionally erupt as homicide rather than as the more usual suicidal behavior.[9]

RUNAWAY INCEST VICTIMS

Of all female teenagers who run away, between 30% and 50% are incest victims.[14] A recent survey of 144 runaways found even higher percentages; 73% of girls and 38% of males had been sexually abused.[15] All six teenage incest victims with hysterical seizures and suicide attempts that I and my coworkers have described had also run away from home.[3] Of the eight teenage incest victims with suicide attempts but without seizures, four had also run away from home.[11]

One of the major problems in treating teenage incest victims who can no longer manage or be managed in the family is that these children run away from placements as well as from their homes. In one family the eldest daughter-victim reported the incest and then ran away from placements back to her home 12 times during her teenage years. On the last occasion, she had become 18 years of age and could no longer be removed by child protective authorities. However, when this girl's younger sister reported incest that had now shifted to her, the younger sister agreed to testify in criminal court against her father and he was sent to jail. The mother in the family was so angry with this daughter that she would not allow her to return home. In the first year after her report the child ran away from 13 different placements.

Working with this family gave me ample opportunity to contemplate the various meanings of running away. Running away was certainly this family's principal strategy for coping with problems, although this flight was usually accomplished by denial, psychosis, or intoxication rather than literally by running with the feet. Also, in this family the child's admission of the incest was treated as a running away, as an abandonment of the family. The only way to undo this was to run away again. Furthermore, with her father in prison, it seemed that the younger daughter was unwilling to let herself become more comfortable in a placement than was her father. In fact, when he was injured in a fight in prison, the daughter attempted suicide. It was as though she felt, like Camus, that if her friend were in prison, she too should be sleeping on the floor.[16] Another process which seemed to be taking place was that this child was growing so rapidly during the year in which she had her first opportunity to live with normal families, that she would outgrow a placement quite rapidly. With each new placement, her behavior problems decreased and her strengths increased, so that each new set of parents could begin by treating her more as a normal adolescent. It was almost as though she had substituted the question, "Where will I be?" for the more usual adolescent question, "Whom will I become?" As with many adolescent incest victims, the storm seemed to ease after exactly 1 year. She chose a rather Spartan placement supervised almost entirely by peer counselors, completed the program there, and is now working . Her solution seemed to satisfy her need for a prisonlike

existence and for a placement in which she would not betray her parents further by substituting better parents for them.

Our Western mythology tells us that incest victims wander. Oedipus wandered out into the desert. Hippolytus, after being sexually approached by his stepmother, got into his chariot and fled so blindly that his journey ended in his being trampled under the feet of his horses.[12] Saint Dymphna set sail from her home without knowing how to navigate or steer (see Appendix III).

If one looks at Weinberg's cross-cultural sample, banishment is the incest punishment most commonly prescribed for both perpetrator and victim. In the 11 cultures described by Weinberg, seven mentioned banishment.[1] Ostracism can substitute for banishment in some cultures. This review is a reminder that when we speak about an incest taboo, we are using a word which means "to set apart."

American social workers seem to be following in the grand tradition of banishment and ostracism of incest participants. A typical case plan involves banishing the offending father to prison, banishing the child to a foster home, and banishing the mother and the remaining children to a wasteland of poverty and ostracism.

What is remarkable is that even when social institutions make every effort to keep families together and integrated into the social system, individual family members manage to taboo, ostracize, and banish themselves. Other cultures do not make a distinction between perpetrator and victim. Whoever breaks the taboo is punished, regardless of sex or age. Clinically, in our society children and adolescents who have been involved in incest can at times attain for themselves, through suicide attempts and runaways, a punishment equivalent to that meted out to the offender.

An extreme example of this is the Cinderella syndrome, a pattern of simulated neglect in children who had previously experienced actual abuse. Several years ago, we observed two cases in which 9-year-old incest victims dressed themselves in rags, claimed they had to do all the chores, and that their adoptive parents favored their siblings.[17] Because of this extreme behavior, these children were referred to a protective service agency and eventually had to be placed in another home. Both of these girls had been physically and sexually abused in their original homes. Instead of being banished, however, they had been taken in by relatives dedicated to parenting them.

It is instructive to recall that the fairytale *Cinderella* is closely related to the series of tales such as *Thousandfurs* and *The Legend of Saint Dymphna* (see Appendix III), which describe the flight of a daughter from her incestuous father who had chosen the daughter to replace her dead mother. Almost inevitably this heroine, although rescued by a prince who marries her, encounters a new series of problems with a stepmother or mother-in-law who treats her like a criminal or witch, often threatening

to have the heroine burned at the stake.[18] These difficulties with the new mother-figure always precipitate a new cycle of running away by the heroine (see Appendix IV).

Despite the best efforts of the incest victim and of the adoptive parents, the banishment prescribed in the old myths took place in the Cinderella syndrome cases. Banishment took the form of the child's Cinderella fantasy, which brought about literal removal, and severe scapegoating of the child, which created a psychological banishment.

One of the principal dynamics at work in these cases was the child's need to preserve a good image of the original parents despite the physical and sexual abuse. These children displaced their anger and hurt from the past into the present in order to cling to the image of an idealized past mother. This seemed necessary in order for them to hope for something good in the future. The price they paid was that they had to keep running from the frightening parental figures that their displacement created in the present. The Cinderella child abandons her new family in a blaming way, just as she imagines that her original mother abandoned her by dying. By recreating and justifying the event, the child avoids feeling the hurt and the loss of that abandonment.

In my clinical examples both patients who produced Cindrella syndromes had experienced the death of a mother, in addition to incest. Like Oedipus with his father, they suffered the anxiety that their sexual experiences had somehow contributed to the mother's death. The treatment for these children was to complete their mourning for the lost mother. In both of their adoptive families, certain family members had been so jealous or ashamed of the child's original mother that the child had not been allowed even to speak of this person.[17]

In the Grimms' version of the Cinderella story, Cinderella waters a tree with her tears each day as she mourns for her dead mother. It is this tree that ultimately produces dresses and shoes for the prince's ball and the other attributes necessary for Cinderella to form successful relationships.[2]

Watering a tree with one's tears may be the most apt metaphor for the kind of therapeutic grieving necessary in any incest victim who runs away. Like other melancholics, the teenage incest victim who runs away is often making a symbolic statement that it is she who has committed the crime of abandonment, not the parents who are guilty of abandoning her. By simulating neglect, the younger Cinderella runaways are coming closer than do the adolescent runaways to stating that they are running away in order to find the good parenting that they need. However, the Cinderella child is usually unaware of how her own psychological flight from grieving for the dead mother and from feeling grief about the frightening incest experience have perpetuated her difficulty in forming the new attachments which would provide the mothering she seeks.

HOW INCEST OPERATES AS A DEFENSE AGAINST LOSS

The phenomenon of runaways in incest victims becomes even more puzzling when one becomes sufficiently familiar with incest families to understand that separations are avoided and viewed as highly dangerous in these families.[19] These are families in which daughter-victims are not allowed to date, mothers are not allowed to have jobs outside of the home, and children who run away almost inevitably allow themselves to be caught in a way that binds them even more tightly to the home.[20]

In fact, one of the clinical interpretations of the runaways which occur in these families is that they are counterphobic; that is, the family fears of separation are so extreme that the child is too afraid to take the usual gradual steps to leave home and so, like Hippolytus, must blindly run.

Since separation is the major fear in these families, many clinicians have felt that the incest itself must be functioning to abate that fear of separation. It is clear that in some families an incestuous relationship acts directly to prevent divorce in the parents. In more than one half of incestuous families the mother is refusing sex to her husband at the time the incest starts.[21] The incest relationship provides a sexual outlet for the husband while at the same time binding him more closely to his wife because he feels he has to atone for his guilty secret. The wife's discomfort may be eased as her daughter moves into a more mothering role.

These families are not only wary of the daily separations and losses that are the normal human circumstance, but they become panicked when they must face a real threat of death. Again and again one hears in the family history that it was an accident, an illness, or a death in the family which immediately preceded the initiation of incest. I have seen three families in which the incestuous relationship began after a child had been seriously injured in an automobile accident. In two of these cases, the parent began sexually fondling the child while the child was ill in the hospital. Another very typical family history is that the sexual abuse began immediately after the mother's hysterectomy or the father's vasectomy. Again, it is common for sexual abuse between father and daughter to begin while the mother is still in the hospital recovering from the hysterectomy.

Western mythology and folklore give us some clues that a family tragedy can precipitate incest. In the biblical story of Lot and his daughters, that family had just experienced the loss of their home and their city, plus the turning of the mother into salt.[22] In Grimms' fairytale, *Thousandfurs*, the king asks his daughter to be his wife after her mother dies tragically.

When we look at the cross-cultural data, incest emerges more concretely as a literal antidote against death. The Murngin of Australia say that the corpses of incestuous progeny do not rot.[1] The Malawi of South Africa say that if one has intercourse with one's sister, one becomes bulletproof.[5]

Another South African tribe allows a father to have sexual relations with his daughter only immediately before he goes out to hunt the dangerous hippopotamus.[23] Among the Dierri in Australia, incest is allowed only immediately before battle.[5] In black America, one sometimes hears the belief that incest will cure venereal disease; in the Middle Ages incest was thought to be a cure for bubonic plague.[6]

What is at work here? How is incest a remedy for death and other kinds of loss? It has been postulated that the continuing lure of infanticide for human beings has to do with the fact that infanticide undoes the aging process.[24] Hercules, for example, killed his wife and all his children in the process of attaining heroic powers. As soon as one has children, one is confronted with the fact that someday one will be dead and one's child will be living in one's place. By killing one's children, one makes a symbolic statement that no such replacement will be required. Infanticide was often performed ritually in ancient times to ensure the undying strength of the parental generation: The walls of Jericho were strong because the bodies of the king's first- and last-born sons were part of the foundation; until the 1600s, dikes in Europe were similarly strengthened.[25]

Is it possible that incest could provide another symbolic opportunity to turn back the clock? It is said that Cardinal Richelieu sucked milk from his daughter's breast in order to prolong his life.[5] His death at age 57 is a dubious advertisement for this technique, although given the lethality of his physicians, as documented by a contemporary patient, Molière, Richelieu may not have fared too badly.

However, there is a certain logic to the idea that if one has sex with one's own daughter, one will never move into the older generation. No one will ever leave the family of origin to seek a mate, so the father will never be reminded by an empty nest that he is getting older and closer to death. There will never be a need for the entry of a young son-in-law to challenge the father's authority or to remind him that there exists a younger generation. If the father continues to conceive children with his daughter, even after his wife's menopause, he need not be reminded that time is passing and that he needs to reassess his priorities as he moves into a new developmental stage.

In mythology there are several legends, such as the myths about the house of Tantalus, in which incest is linked with the ritual killing and subsequent cannibalism of children. In the New Guinea Arapesh, shamans boast that they have experienced both incest and cannibalism.[26] One anthropologic theory suggests that incest became taboo because it was part of a magical ritual leading to immortality that was not allowed to ordinary persons.[27] This primordial resurrection rite may have prescribed ritual incest between adolescent brother and sister followed by ritual murdering and cannibalism of the male, with the subsequent child of the brother-sister mating representing the magically revived king. The Isis/Osiris myth is only

one of many African beliefs that link the practice of incest to the attainment of immortality. Isis retrieves the fragments of her brother/husband's body and restores him to life. It has been suggested that the epidemic of brother-sister marriages in Egypt during the Roman occupation in the first two centuries after Christ was connected with the democratization of embalming, which stimulated even commoners to attempt the Pharaonic recipe for immortality: Brother-sister marriage followed by the embalming rituals after death.[28]

In one way these are logical conclusions. The Navajo, however, would say they make as much sense as a moth's flying into a flame. Mythology and fairy tales are an unending source of good advice about the folly of both infanticide and incest as techniques for attaining immortality. They consistently remind us that rearing a healthy child is the only route to immortality that exists in reality.

SUBSEQUENT FAILURE OF MOTHERING IN THE INCEST VICTIM

In a survey of 100 abusive mothers, I and my coworkers found that 24% of these women had been incest victims in childhood[29] versus a 3% prevalence of prior incest in 500 normal women in the same community. Mothers of sexually abused children were no more likely to have experienced incest than were mothers of physically abused children.

Children who have been sexually abused often express overt worries that they will somehow fail as mothers. Asked if they will ever have children, the usual answer is no. Often they go on to say that they are worried that something was broken inside them by the incest so that they cannot have children. It seems that these same children, as adults, reproduce at higher fertility levels than the general population.[30] Perhaps this occurs in part because they are challenging their own fears about sterility.

Two of the 11 cultures reviewed by Weinberg predicted sterility and the inevitable extinction of the family as sequels of incest.[1] The Mojave Indians say that such a family will inevitably become extinct. The Tikopia of Melanesia say that incest offenders will become barren or their offspring will die. The Tanala of Madagascar also say that incest will lead to sterility.[31]

There are some indications from Western mythology that incest participants do not reproduce efficiently. In the Oedipus story, his sons slay each other and his daughters are condemned to death for insisting that the bodies of their brothers be buried. Legends in South America and Borneo describe how brother and sister must mate to populate the earth; however, the first child born to the couple is a dog.[27,32] Many stories in the *Thousandfurs* or *Catskin* cycle tell how the young incest victim is falsely accused of having borne a "monster" and is then condemned to death.[18]

Often in folklore the fertility and prosperity of the entire land is endangered by a breach of the incest taboo. The Ashanti of Africa say that unless incest participants are killed, crops will refuse to bear fruit and children will cease to be born. It is only after his kingdom is struck by a plague that Oedipus realizes that his marriage to Jocasta is incestuous. French peasants say that horses will die, orchards will become barren, and flocks will be devastated by disease if the taboo is violated.[27] In the King Arthur legend the kingdom of Camelot is destroyed by Mordred, Arthur's son/nephew, born of an incestuous mating between the king and his sister.[6]

A clinician observes many obstacles to successful reproduction for the incest victim. She cannot reproduce if she dies, either from perineal damage secondary to premature intercourse, from complications of a premature pregnancy, or from suicide. Since 40% of incest victims become promiscuous, the risk of venereal disease which might impair fertility is increased. Frigidity, homosexuality, and psychosomatic disorders have all been reported as sequels to incest. Any of these might impair fertility by interfering with mating (see chapter 14). Twenty percent of incest victims have been reported to have experienced severe depression.[33] It this occurs postpartum, the depression could interfere with the maternal nurturing necessary to the survival of the child. Our data indicate that the incest victim is at higher risk for battering her child. Four of ten mothers of children who had died from physical abuse were incest victims.[29] This is still another kind of reproductive failure. Genetic obstacles become a factor if the incest victim conceives by a consanguineous partner. The offspring of such a first-degree mating has less than a 50% chance of surviving and being normal. The "animal" children of folklore, born of incestuous matings, may represent deformed children.

It is likely, however, that the psychological obstacles to mothering have been most often observed in incest victims in different cultures. In medieval incest legends like Manekine (see Appendix IV), the heroine's children are often described as in grave danger of being killed or abandoned.[18] Incest victims may not have experienced good mothering because of the neglect that usually precedes the incest event. They also have difficulty allowing themselves to experience the physical sensations that accompany sexual and maternal love. As many as 85% of incest victims react to the incest experience with aversion to sexuality and with frigidity.[30] The mothers who batter their children often complain that the experience of breast-feeding and physical contact with the young infant is overwhelmingly close to sexual feelings. One such woman actually became convinced that her newborn son was trying to seduce her when he had erections while urinating.[29] The early sexual exploitation, which has made sexuality unmanageable, can also make mothering an intolerable experience which the mother turns off by becoming full of rage and physically abusive.

Some incest victims do not themselves abuse their children, but rather

fail to protect the child from abuse by a husband or boyfriend. This failure to protect the child is linked to an inability to protect herself. More than one third of women who have been multiply raped are incest victims.[34] Case examples are extreme. One incest victim literally froze when an intoxicated stranger began fondling her breasts; after struggling for weeks with the problem of what she might have done to stop him, she decided that she might have crawled under a table. The nonverbal techniques for signaling a sexual negative seem to be undeveloped in these women. Most victims still rationalize at some level the bizarre, exploitative, tyrannical actions of their fathers, and have difficulty even in recognizing, much less in resisting, such behaviors in current sexual partners who are abusive.[29]

The Kalahari Bushmen of South Africa provide an instructive contrast to these sexually abused mothers who neglect, batter, and fail to protect their infants. In two decades of intensive anthropologic studies of several hundred Bushmen, no instance of child abuse has been found. Infanticide of deformed infants is practiced. This is neither sociologically nor psychologically classifiable as child abuse. The Bushmen provide an almost absolute contrast to the abused and abusive parents who have unrealistic expectations of their children (based on their own memories of having themselves been prematurely thrust into a parental role), who lack any support from their parents or other adults, who have forced themselves into early pregnancies to prove their fertility, and who have experienced violence and incest in their own childhoods.

The Bushmen believe that children are incapable of even the simplest constructive activity and discourage children from any action that might be construed as work—gathering nuts, carrying them, cracking them. Girls are never asked to care for younger children.[35] In Bushman culture, social pressure would make it impossible for a girl to assume a maternal role. A number of adults are always closely present monitoring the activities of the children. Mothers are often heard to repeat a common Bushman idiom, which translates loosely as, "Get this child off my hands." At that point, a nearby adult assumes responsibility for the child. Low lean body mass, which delays menarche and suppresses later menstrual cycles during times of stress, and prolonged breast-feeding, allow women to economize maternal investment. The average interval between children is over 4 years. There is a strong cultural sanction against the physical expression of aggression which extends to children as well as to adults. Children are neither spanked, threatened, nor isolated. Misbehaving children are removed from the situation and distracted. Scolding is reserved for emergencies. Tantrums are ignored.[36]

What is also pertinent to this discussion is that secret sexual liaisons are an impossibility among these groups of Bushmen. The Bushmen live in open huts, clustered very closely together. They are all expert trackers, so that any couple who tried to sneak away from the settlement would leave

behind signs which could be read like an open book. Genetic studies indicate that all children in these groups were fathered by the socially recognized father (Henry Harpending, personal communication, 1981).

One way to interpret this analogy between Bushman culture and our own society is that if we are to eliminate child abuse, we may need to give up our unrealistic expectations of children, provide constant support for parents, find ways to economize maternal investment, and develop strong sanctions against violence. It may also be necessary to eliminate the incestuous acting out that can lead to subsequent impairment of mothering in the victim.

Many parents and pediatricians come to me saying that they suspect that a child has been sexually abused, but that they are afraid to talk with the child about it directly. Some are afraid of "putting ideas into the child's head." They have been conditioned by the myth of the prevalence of false accusation (see chapter 2) to believe that children cannot distinguish incest fantasies from an actual sexual experience.[37] Others have tried to talk with the child about a possible sexual contact, but have found the child most unwilling to discuss sex and not possessing an adequate vocabulary to do so.

Some therapeutic stories have been written about incest, movies have been made, games have been invented—all in the effort to provide tools for talking with children about sexual abuse.[38]

What seems to have been forgotten in this effort is the incredible wealth of incest stories to be found in the mythology and folklore of our own and every other culture. Montaigne suggested that these folk tales contain the best arguments ever devised against incest.[39] In this chapter I have already mentioned Oedipus, Phaedra, Lot, Isis and Osiris, and the fairy tales of the *Thousandfurs* cycle. I have recently retold in English the story of the seventh-century Belgian saint, Dymphna, who rejected her father's proposal of marriage and was beheaded by him after having made a valiant attempt to run away. This story, and *The Story of the Princess of Hungary* or *Manekine*, based on legends from the twelfth and fourteenth centuries, are included as appendices to this book (Appendices III and IV, respectively).

Incest stories which have survived for centuries provide multiple metaphors about the incest experience. Not only do these stories open up the topic of incest in a simple and nonthreatening way, but they communicate the variety of responses to the sexual abuse experience. The story of Oedipus describes the willingness to sacrifice all to save the family, the suicidal despair, the sexual guilt, the self-banishment, the episodic violence, and the fear of reproductive failure that haunt the incest victim. The story of Phaedra's attempted seduction of Hippolytus illustrates the special incestuous temptations of stepparents and the dangerous blind panic that characterizes the runaways of incest victims. The story of Lot illustrates the importance of castastrophic loss, paternal alcoholism, and family isolation as precipitants of incest. The fairy tale, *Thousandfurs*, catalogues

the techniques that incest victims use to defend themselves from further sexual trauma: The victim runs away, pretends to be a beast, and tests her prince, tempting him to reject or abuse her.[2] The story of Dymphna, which focuses on the victim's determination to save her own mind and to heal her demon-possessed father, shows how this becomes transformed into an identification as a healer (see Appendix III). This legend is also helpful in providing, in the person of the monk Gerebernus, a model for the therapist working with an incest victim. Other related tales, such as Manekine (*The Story of the Princess of Hungary*), and *Cinderella*, show how the incest victim projects her resentment of her neglectful mother onto other women and how this can lead to repeated runaways unless the girl allows herself to feel the hurt at being abandoned by her parents and can resolve this. Stories in this cycle usually end with the heroine later meeting the incestuous father accidentally and forgiving him. Stories of this type also show how self-mutilation is attempted by the victim in an effort to discourage the father's sexual interest. For example, Manekine cuts off her hand so her father would not kiss it (see Appendix IV). In these stories is also the fear of having a monster-child who must be destroyed, which persists as long as the heroine has not resolved her guilt about the incest experience. The heroine may be struck dumb so that she literally cannot speak about what has happened; some stories end with the heroine's powers of speech being restored at the same time as her dead children are returned to her (see Appendix IV). The speechlessness and mannequinlike qualities of these heroines recall the clinical descriptions of incest victims trying to function despite massive posttraumatic numbing and occasional dissociation.

Many different strategies can be used to integrate these folk tales into the treatment of victims. For example, one preadolescent girl was preoccupied with negativistically refusing school and had refused to talk about her father-daughter incest experience. She finally disclosed that she was afraid that if she went to school a particular classmate would tear out her eyes. "There is a story about that," I said, and told her the story of Oedipus. As we tried to understand why Oedipus would have plucked out his own eyes, she began to talk for the first time about her feelings of guilt about the sexual relationship with her father.

With younger children one can simply offer to tell a story during a play therapy session and the child can then act out with puppets or make drawings about parts of the story. Sometimes children will bring in their own story material which can be used in this way. A 7-year-old whose mother had disbelieved her accusations of incest played out repeatedly in play sessions with her mother the story of Jesus healng the blind man. At times she healed her mother's blindness; at other times she reversed roles and asked her mother to heal her.

Reading *Thousandfurs* can be a helpful exercise for use in groups of adolescent and adult incest victims. In this tale the princess runs away from

her incestuous father, disguising herself in a coat made of many furs. She is tracked down by the hunting dogs of a neighboring prince whom she eventually marries. Incest victims who read this story predictably misunderstand it as follows: They believe that it is the girl's father who has tracked down the heroine, and that it is this incestuous father who eventually succeeds in carrying out his wish to marry the daughter. This misunderstanding of the story is a helpful way to begin group discussion of the continuing impact of the incest experience on current relationships with men.

Can such stories be used in prevention and case identification? Appendices III and IV are brief versions of two medieval legends in the *Thousandfurs* cycle: *The Legend of Saint Dymphna* and *The Story of the Princess of Hungary*. We are beginning to use these stories both in treatment groups for incest victims and in rape prevention sessions for grade school and for junior high school children.

SUMMARY

It is likely that most professionals in our culture know less about incest than the average Navajo. In our culture the suppression of sexuality, the patriarchal emphasis, and the supreme value placed on privacy have led to a "conspiracy of silence" about incest. Clinical experience, tradition, and cross-cultural data indicate that incest may lead to a relatively fixed set of symptoms which have been observed in many different cultures and times. Informants have been telling anthropologists for centuries that the reason for the incest taboo is that incest does not work out well.[40] Anthropologists have tended to reject this explanation as simplistic and to search for deeper meanings to the incest taboo. However, clinical data from our own culture support this simple contention. These clinical data also lead us to believe that incest between first-degree relatives is common enough so that each generation in each culture will have the experience of a new series of disasters which will confirm the wisdom of the incest taboo.

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REFERENCES

1. Weinberg SK: *Incest Behavior*. New York, Citadel, 1955.
2. Manheim R (trans): *Grimms' Tales for Young and Old*. New York, Doubleday, 1977.
3. Goodwin J, Zouhar M, Bergman R: Hysterical seizures: A sequel to incest. *Am J Orthopsychiatry* 49:698–703, 1979.
4. Standage K: The etiology of hysterical seizures. *Can Psychiatr Assoc J* 20:67–73, 1975.
5. Maisch H: *Incest*. New York, Stein & Day, 1972.

6. Brewster BW: The incest theme in folksong. *Folklore Fellows Communications* 80:1–36, 1972.
7. Temkin O: *The Falling Sickness*. Baltimore, Johns Hopkins, 1971.
8. Proskauer S: Oedipal equivalents in a clan culture: Reflections on Navajo ways. *Psychiatry* 43:43–50, 1980.
9. Ginsberg EL, Hebeler J: Counter-violence counseling. Read before the Third International Congress on Child Abuse and Neglect, Amsterdam, April 21–25, 1979.
10. Silber A: Childhood seduction, parental pathology and hysterical symptomatology: The genesis of an altered state of consciousness. *Int J Psychoanal* 60:109–116, 1979.
11. Goodwin J: Suicide attempts in sexual abuse victims and their mothers. *Child Abuse Neglect* 5:217–221, 1981.
12. Aldington R, Ames D (trans): *New Larousse Encyclopedia of Mythology*, ed 13. London, Hyman, 1977.
13. Fine S: The teaching, service and research components of a university sexual medicine clinic for children. Read before the Third International Congress on Child Abuse and Neglect, Amsterdam, April 21–25, 1981.
14. Kempe CH: Sexual abuse, another hidden pediatric problem. The 1977 C. Anderson Aldrich Lecture. *Pediatrics* 62:382–389, 1978.
15. McCormack A, Janus MD, Burgess AW: Runaway youths and sexual victimization: gender differences in an adolescent runaway population. *Child Abuse Neglect* 10:387–395, 1986.
16. Camus A: *Notebooks, 1935–1942*. Thody P (trans). New York, Modern Library, 1965.
17. Goodwin J, Cauthorne C, Rada R: The Cinderella syndrome: Children who simulate neglect. *Am J Psychiatry* 137:1223–1225, 1980.
18. Cox MR: *Three Hundred Forty-Five Variants of Cinderella, Catskin and Cap o' Rushes*. London, Folk-lore Society, 1892.
19. Bethscheider JL: *A Study of Father-Daughter Incest in the Harris County Child Welfare Unit*, thesis. Sam Houston State University, Houston, 1972.
20. Gutheil T, Avery NC: Multiple overt incest as a family defense against loss. *Fam Process* 16:195–116, 1977.
21. Kroth JA: Family therapy impact on intrafamilial child sexual abuse. Read before the Second International Congress on Child Abuse and Neglect, London, Sept 1978.
22. Rosenfeld AA, Nadelson CC, Krieger M, et al: Incest and sexual abuse of children. *J Am Acad Child Psychiatry* 16:327–339, 1977.
23. Forward S, Buck C: *Betrayal of Innocence*. New York, Penguin, 1978.
24. Muslin H: On the resistances to parenthood. Read before the Michael Reese Hospital Dept of Psychiatry Conference on Parenting as an Adult Experience, Chicago, March 7–8, 1980.
25. Montag BA, Montag TW: Infanticide. A historical perspective. *Minn Med* 62:368–372, 1978.
26. Tuzin D: *The Voice of the Tambaran: Truth and Illusion in Ilahita Arapesh Religion*. Berkeley, Calif, University of California, 1980.
27. Lord Raglan: *Jocasta's Crime: An Anthropological Study*. London, Methuen, 1933.
28. Middletown R: Brother-sister and father-daughter marriage in ancient Egypt. *Am Sociol Rev* 27:603–611, 1962.
29. Goodwin J, McCarty T, DiVasto P: Prior incest in abusive mothers. *Child Abuse Neglect* 5:1–9, 1981.

30. Meiselman KC: *Incest*. San Francisco, Jossey-Bass, 1978.
31. Kardiner A: *The Individual and His Society*. New York, Columbia University, 1939.
32. Canal Feijoo B: *Mitos Perdidos*. Buenos Aires, Compania Impresora, 1938.
33. Lukianowicz N: Incest. *Br J Psychiatry* 120:301–313, 1972.
34. Miller J, Moeller D, Kaufman A, et al: Recidivism among sex assault victims. *Am J Psychiatry* 135:1103–1104, 1978.
35. Draper P: !Kung women: Contrasts in sexual egalitarianism in foraging and sedentary contexts, in Reiter R (ed): *Toward an Anthropology of Women*. New York, Monthly Review Press, 1979, pp 77–109.
36. Draper P: The learning environment for aggression and anti-social behavior among the !Kung, in Montagu A (ed): *Learning Non-Aggression*. New York, Oxford University Press, 1979.
37. Goodwin J, Sahd D, Rada R: Incest hoax: False accusations, false denials. *Bull Am Acad Psychiatry Law* 6:269–276, 1979.
38. Holley KC: *Sexual Misuse of Children: Tools for Understanding*. Tacoma, Wash, Pierce County Rape Relief, 1978.
39. Montaigne M de, cited in Lord Raglan: *Jocasta's Crime: An Anthropological Study*. London, Methuen, p 79.
40. Burton RV: Folk theory and the incest taboo. *Ethos* 1:504–511, 1973.

21

Obstacles to Rulemaking about Incest: Social and Historical Contexts

Jean Goodwin

"Cinderella, dressed in yellow
Went upstairs to kiss a fellow,
Made a mistake and kissed a snake.
How many doctors did it take?
One, two, three. . . ."

—American jump rope rhyme

This brief rhyme, which can be heard in most American schoolyards, exemplifies the power of folkloric materials to bring us to the center of the human, clinical issues surrounding childhood sexual abuse. The rhyme reminds us, for example, that present-day fairy tales in the Cinderella cycle are based on older tales in which the heroine's flight from her incestuous father is an explicit theme. The jump rope rhyme also conveys the hopefulness of the deprived and depressed child who anticipates approval and affection from an encounter which so suddenly transforms into sexuality and humiliated intimidation leaving her feeling guilty as well as betrayed. The rhyme then reminds us of the multiple layers of damage that can result from such an event, damage that often does require the intervention of many different doctors over many years.

Folkloric materials of this sort—rhymes, jokes, riddles, fairy tales—provide the clinical examples and cautionary tales that accompany each culture's version of the universal incest taboo. This chapter describes these folkloric materials and reviews anthropologic analyses of the incest taboo. Given the prevalence of father-daughter incest in the general population (4%)[1] and the evidence that molestation by a trusted caretaker is one

of the most damaging forms of childhood sexual abuse,[2–4] it is remarkable that so little clinical use has been made of these materials. In 1912 Otto Rank[5] provided a comprehensive review of the clinical implications of folkloric materials; his book is as yet untranslated. The classicist Lowell Edmunds has recently provided a new review of Oedipus themes in folklore and a casebook.[6, 7]

Previously, I used these materials (chapter 20) to illustrate the psychological harm caused by incest. Today there is some consensus that incest is in fact harmful.[8, 9] The problem now is how to develop an acceptable system of response which minimizes rather than exacerbates the traumatic effects of this kind of abuse. The disarray in our social and legal response to incest has been well documented elsewhere.[10] Although legal experts consistently recommend criminal prosecution in these cases,[11, 12] population studies indicate that fewer than 5% of cases result in criminal conviction[1] (see chapter 19). The majority of incidents are unreported. Finally, this chapter proposes a five-part analysis, illustrated by clinical, folkloric, and historical examples, of the conceptual obstacles which must be understood if we are to develop an acceptable and workable system.

OBSTACLES TO RULEMAKING ABOUT INCEST: COMPLICATING ATTITUDES AND VALUES

Feminists explain our failure to develop a system to control incest as a result of the excess privilege accruing to men in our society and the inferior status of women; misbehaviors involving primarily men as perpetrators and females as victims tend to remain underreported, underpunished, and underprevented.[13–15] There are many data to support this hypothesis including my own experience, that in over 500 cases of alleged parent-child incest, the only one which resulted in criminal conviction of a falsely accused parent was also the only case which alleged mother-son incest.

Other difficulties have been documented including the multiple practical obstacles to productive involvement of child victims in our criminal justice system.[16–20] These were illustrated with clarity in the recent Jordan, Minnesota, sex ring cases. Here, the techniques intended to render the child witnesses more competent to testify—isolation from family and friends, repeated questioning, long time to prepare—led to decompensation in the children and confusion in the legal process.[21]

Review of cross-cultural and historical materials relating to incest suggests that still other aspects of social politics complicate our efforts to design a consistent and effective rule system. When communities—or individuals, or families—make rules about childhood sexual abuse, they are simultaneously taking positions along at least five axes of beliefs and attitudes: (1) preference for informal controls versus preference for formal

legal controls, (2) a view of the child as parental—mainly paternal—property versus a view of the child as an autonomous individual, (3) the need for inviolate family privacy versus the need for community oversight of child rearing, (4) a view of the child as sensuality expert versus a view of the child as virginal innocent, and (5) a view of sexuality as dangerous and secret versus a view of sexuality as harmless and natural.

An initial example will illustrate how consensus on these issues affects a society's handling of incest accusations. One hundred years ago Freud and his contemporaries employed informal rather than formal sanctions against seducers of children. Children were viewed as "belonging" in an absolute way to a patriarchal estate which was essentially immune to outside oversight.[22, 23] Children's sensuality was viewed as dangerous until the psychoanalytic movement successfully convinced the intellectual world that neither sexuality nor its presence in children was unnatural. Today feminists operate along several of these axes at poles opposite to Freud's. They advocate the preferential or exclusive use of formal legal controls in incest cases with routine separation of the sexually abused child, viewed as an autonomous being with individual rights, from one or both parents (when the father is the perpetrator) and with community oversight of the child's care. They find themselves often in uneasy alliance with conservative fundamentalist groups whose advocacy of aggressive investigation and maximum penalties stems from positions on axes (4) and (5) that are not necessarily shared by feminists, that is, a perception of any sexual behavior by a child as dangerous and pathologic, and a conviction that all sexuality must be strictly regulated.

Today, with 100 years of hindsight, it is easy to see how Freud's reluctance to confront his patients' fathers and his tendency to focus on the patient's sensuality rather than her wounded innocence limited his ability to remain in the center of the clinical material brought to him by sexually abused women.[22] This chapter uses folkloric and cross-cultural materials to contend that, since each pole of each of the five axes contains much that is valuable and true, the center of this conceptual landscape is the most useful place to be. Many of the most heated, fascinating, and unresolvable debates about sexual abuse represent attempts to declare a single extreme position ultimately true and right, while rejecting as illegitimate the interests represented by the opposite pole of that axis. This discussion argues that child victims and their families fare best when they are helped to avoid the hazards of extreme positions and to integrate the positive values along each axis. Informal sanctions, formal sanctions, parental rights, children's rights, family privacy, community oversight, respect for the child's sexuality, respect for the child's innocence, caution about sexuality, acceptance of sexuality—all are necessary for effective treatment and for effective rulemaking in this area. Folkloric materials, like detailed unbiased clinical materials, are helpful beacons guiding us to the humanistic center of these debates.

NATURE AND VALUE OF FOLKLORIC ARCHIVES

Stith Thompson's *Motif Index of Folk Literature*[24] lists more than 20 categories of incest folk tales including: incest punished; misshapen child from brother-sister incest; child of incest exposed; father, feigning death, returns in disguise and seduces his daughter; flight of a maiden to escape marriage to father; father casts daughter forth when she will not marry him; suicide to prevent brother-sister marriage; God born from incestuous union; new race from incest after world calamity; loss of magic power through incest; incest unwittingly committed; enigmatic statement betrays incest; incest accidentally averted; lecherous father wants to marry daughter; girl got with child by intoxicated father; lustful stepmother; aunt seduces nephew.

Some argue that incest rules do not apply to intrafamilial sexual abuse. Psychoanalysts say the taboo functions only to interdict oedipal fantasies, and some anthropologists contend that the taboo simply provides a structure for choosing marital partners.[25] However, clinicians treating families entangled in intrafamilial child sexual abuse will find much in these incest motifs that they recognize. Some of us have even written case reports that can be categorized quite precisely into a particular motif.[26] When anthropologists witness incest, the problems of family isolation and deviance are described in terms remarkably similar to those used by clinician observers.[27] Folk tales often incorporate historical data,[28] and some famous tales, like the story of Dymphna, may be the product of centuries of revision and embroidery in the telling of an actual clinical case history (see Appendix III).

THE INCEST TABOO: THE NEED FOR PROHIBITION

Every culture has developed a prohibition against incest. Anthropologists explain this universal phenomenon in various ways. Structuralists like Levi-Strauss[29] explain the incest taboo as arising from the human need for allies to assist in times of famine, war, or other catastrophes. Groups are at a survival disadvantage without the kinship and friendship ties forged by the practical exigencies of exogamy—courtship, weddings, the interactions engendered by the existence of two sets of grandparents for each child.

Psychological anthropologists hypothesize that the survival disadvantages of incest relate to the stress, disruption, and confusion caused by the muddling and overlapping of roles within an incest family.[30, 31] They note the havoc that incest inflicts on even relatively simple structures, such as kinship terminology. For example, a cautionary riddle from the late Middle Ages describes a chance meeting between a cleric and the woman who long before bore him in incestuous union with her father. The woman,

recognizing her son, says "I greet my brother; he is my father's son; he is my father's grandson; his mother is his father's daughter." More complicated versions of this riddle involve a subsequent marriage between the incest progeny and his mother-sister and question how the progeny from that union would address his then mother-aunt-grandmother and his father-brother-uncle.[5]

Lindzey[32] and other anthropologists have asked if there is a genetic basis for the folkloric incest motif, "misshapen child from brother-sister incest." Recent surveys of progeny from first-degree mating in humans indicate that only half of pregnancies result in the live birth of a normal child[33] (see chapter 14). Nonspecific mental retardation, double recessive disorders, polygenetic disorders, increased stillbirths, and increased spontaneous miscarriage contribute to the poor outcome. The brother-sister marriages of the Pharoahs have been used to illustrate the supposed absence of fundamental genetic contraindications to incest. However, recent reexamination of these lineages indicates that only two of the Ptolemies, one Hawaiian ruler and one Inca, were actual progeny of a brother-sister union.[34–37] It is likely that, as in African kingdoms which survived into the nineteenth century, the brother-sister marriage was a formal entity only; the king's unrelated wives, not the sister-wife, were designated for sexuality and procreation.

Anthropologists interested in these genetic problems link the incest taboo to the Westermarck phenomenon in other animals, also called "stranger preference."[38–40] Animals are observed to show decreased sexual preference toward nuclear family members or other conspecifics who have related to the individual since infancy. This phenomenon has been used to explain the rarity of marriages between kibbutz dwellers raised in the same nursery.[41] Insofar as this phenomenon is part of the human apparatus, one might speculate[42, 43] that children of divorced parents would experience higher rates of incest because they reach sexual maturity among relations who were not in the household during their infancy. Indeed, Diana Russell's data,[1] drawn from a population-based sample of California women, indicate that women with stepfathers had almost an eightfold increased risk of incest victimization.

In chapter 20, I reviewed clinical and folkloric data which support the concept that the taboo developed because of the interpersonal stresses which surround the incestuous act. Suicidal acts, runaways, and hysterical symptoms are major clinical problems among incest victims. As many as half of the difficult patients we call "borderline" have been sexually abused.[44] Folklore provides numerous illustrations of extreme symptoms in incest victims; one recalls Oedipus gouging out eyes, Hippolytus being trampled by his chariot horses in his panicked flight from his seductive stepmother Phaedra (who later hangs herself), and Cinderella-cycle heroines such as Manekine who lose the function of limbs or their speech under the stress of a "marriage" offer by the father. Those behavioral symptoms that

intrude on later parenting abilities—for example, none of the children of Oedipus survived to procreate—may have been observed in other societies and may have contributed to the decision that incestuous behavior, although tempting, is too interpersonally expensive to be condoned. As Freud said, "Incest is antisocial—civilization consists in this progressive renunciation."[45]

FORMAL LEGAL CONTROL VERSUS INFORMAL SANCTIONS

Some incest myths like the Navajo Moth Way chant suggest that formal rules against incest are necessary primarily because incest is such a tempting solution to universal conflicts. In this story, the Moth People are delighted when they realize that if they marry their daughters to their sons, families will never have to part or change and they can be together forever. The Moth People become so excited at this discovery that they all fly into the flames and perish. How economically this story describes the paranoid intolerance of separation, change, and aging that characterizes some incest families as well as the associated tendencies toward immaturity and impulsive self-destructiveness.

The Navajo maintain their very strict prohibition of incest through a series of informal sanctions: Incest participants are said to fall into fires (a common accident in hogans), to have seizures, and to become witches. Even today these sanctions are powerful enough to create serious difficulties for Navajo epileptics, who are automatically assumed to have committed incest and to be at risk for becoming a witch.[46] (see also chapter 20).

In cultures with formal sanctions against incest, these are severe, with death and exile being the most common.[47] Under formal rules governing incest, both parties are punished. The extreme severity of these formal rules and their disregard for power differentials between partners is reminiscent of our own legal system. In our system as well as in others, there has been a tendency for informal systems to develop which divert the majority of cases into more workable pathways.[48] For example, in India where the formal punishment for incest is exile, reinforced by folkloric predictions of earthquakes, leprosy, blindness, and sterility, what actually happens is that the accused father "eats his way back" into the community by giving a feast.[49]

Public acknowledgment of incest characterizes many informal religious and tribal sanctions. English Puritans affixed to the offending father a sign describing his sexual misbehavior, a practice similar to the punishment for adultery described in *The Scarlet Letter*. In Africa, such an offense against a female would be reported to the woman's society who would gather at the man's hut and sing loudly all night about the details of his misbehavior.

The story of Manekine, the Princess of Hungary (see chapter 20, Appendix IV) illustrates the healing potential for the victim of informal sanctions which emphasize public confession and apology by the offender.[50] Here the battered heroine, on overhearing both her father and her husband express remorse for having abused her, regains miraculously both the severed arm and the dead child which their abuse had cost her.

A problem with the informal system is that it requires unified action by a functioning community and an offender capable first of feeling shame or guilt and second of using that feeling to modify aggressive and sexual behaviors. The medieval legends about Judas testify that this is not always the case.[51, 52] Judas is described as another Oedipus abandoned at birth because of prophesies describing his future atrocities. He is taken in and raised by a group of nuns, all 500 of whom he rapes and kills. Judas then takes a job for Pontius Pilate in Jerusalem where he kills a man and is required by Jewish law to make informal restitution by taking the widow as a wife. When she discovers he is her son, she sends Judas to Jesus for more informal sanctions. We all know how this intervention ends. The tale reminds us metaphorically that family violence is not a private affair; someone who rapes a family member may rape others; someone who starts by killing his own father may end by killing everyone's father. Like Judas, the antisocial or paranoid offender and the compulsive pedophile may be poor candidates for informal sanctions.

In current clinical practice, conflict around this polarity occurs most often between professionals attached to the formal criminal justice system and those attached to the more informal therapeutic protective service system. The conflict may be exacerbated if the advocates of the formal approach, emphasizing questions of justice, are males and if females are emphasizing the need for informal agreements about caretaking responsibilities. Carol Gilligan[53] has provided many examples of males and females failing to understand each other when males focus on issues of justice and females on issues of care.

An increasingly common kind of case, which illustrates how both formal and informal sanctions can fail, involves inappropriate sexual behaviors by a divorced father during visits with his children. In such a case the care-focused professional usually identifies multiple problems in the family, but may perceive the father's impulsive, paranoid, and/or sociopathic patterns as the most disruptive influence, and may suggest that the mother seek to restrict visitation.[54] The worst case occurs if a judge, relatively uninterested in the informal system's attempts to restore adequate caretaking, focuses narrowly on the issue of whether the situation meets formal definitions of rape. If it does not, the judge may be so offended at the mother's "false" accusation and "disregard" for justice that he awards custody to the disturbed father.[55]

CHILD AS PARENTAL PROPERTY VERSUS CHILD AS AUTONOMOUS INDIVIDUAL

Folk tales from the Western Christian tradition acknowledge the difficulty in protecting disenfranchised children from parents who have rights not only as full citizens, but also as owners of the children. Nicholas of Myra, a fourth-century bishop, became the patron saint of children largely because he tried to even this balance of power. When a parishioner announced plans to sell his three daughters into prostitution, Nicholas discretely dropped three golden balls down the family's chimney. The balls landed in the girls' stockings "hung near the chimney to dry" and the world gained a Christmas tradition.[56] What the girls gained was the power and autonomy to choose their own mode of sexual expression; they used the gold as their marriage dowries.

Much later, in the fifteenth century, the Baron Gilles de Rais, after serving as one of Joan of Arc's captains, devoted himself to capturing latency-age boys, then torturing them, and finally sodomizing each boy after hanging him and slitting his throat in a witchcraft ritual. Fragments of the dismembered bodies of about 200 victims were found in the Baron's moat. Gilles de Rais is the real-life prototype for the fairy tale character Bluebeard. The fairy tale translates into a child's terms the entrapment tactics used by some narcissistic and grandiose offenders. Bluebeard gives his young wife the key to a secret room but orders her not to open it. When curiosity overwhelms her and she finds in the secret room the dismembered bodies of his previous wives, Bluebeard is able to frame his long-planned sadistic attack on her as "punishment" for her curiosity. With family and religious support, the wife in the story copes and survives, but the victims of the actual baron were so disenfranchised, as peasants as well as children, that they had no defense. The baron's friends helped him chase down these young human prey on horseback. Only after intervention from another compassionate bishop and the Inquisition was this macabre hunt halted.[57]

However, children are children and cannot be made equal to adults simply by wishing them so. History tells us that children who escape from inadequate parents often go from the frying pan into the fire, falling into the hands of brothel keepers, gang leaders, or cult religious groups. Goldstein et al[58] and others[17–20] have discussed at length how a child's legal rights to court protection and removal from parents can lead to years of shifting foster homes and permanent loss of developmental potential. To go back to the Saint Nicholas story, our system seems able at times to protect children against being sold into prostitution by parents, but we have much greater difficulty supplying the golden balls—the advocacy and validation—which could guide victimized children into their own chosen futures.

Current controversies which develop out of this polarity include issues of enforcing parental custody or visitation on children who are violently

opposed to the interaction. This culminates in the difficulties which surround terminating parental rights. In one case a father, convicted for sexually penetrating his children, almost succeeded in obtaining a court order to require his 2-year-old son to visit him in prison. There had been physical and spouse abuse in the home as well as sexual abuse. The child was to be transported by the paternal grandfather, who had a varied record of felony convictions and inpatient hospitalizations for psychosis. The court's task was to balance the developmental hazards of the proposed visits against the risk that without visits the child might lose forever his tie with his paternal family. Loss of such a tie, even in the face of massive disturbance in a family, is viewed by courts as terribly serious. In another case, police were called because of a 4-year-old girl's screams when left off for a visit with her father. She had complained to relatives and therapists that she was afraid of the father's physical and sexual abuse, but the judge in the custody case saw the mother's manipulativeness as the major problem. Visitation was court-ordered, so police were forced to leave the child screaming in the hands of the father.

Such inexorable tightening of the abuser's control despite reasonable complaints is a recurring theme in folklore as illustrated in the legend of Saint Dymphna. Dymphna is a princess whose father asks her to marry him after the mother's death. The young princess seeks help from her confessor, the monk Gerebernus, who finds a boat. Despite the monk's inability either to steer or navigate they somehow manage to land in Belgium. (I have often thought Gerebernus should be the patron saint of therapists working with incest victims.) However, the father meanwhile has organized an army of searchers who track them down to their forest refuge. Bystanders actually help lead the abusive father to the refugee victim because they disbelieve her tale of incest; they appreciate the credibility of the victim too late, after witnessing the father behead her and Gerebernus (see chapter 20; Appendix III).

THE FAMILY'S NEED FOR PRIVACY VERSUS THE COMMUNITY'S NEED TO OVERSEE CHILD REARING

Odd things happen in even the most functional of families. Western civilization has evolved in the direction of giving families as much privacy and latitude as possible. A Renaissance story illustrates this laissez-faire attitude. The painter Vasari was decorating the bedroom ceilings in the Medici Palace. One morning when Vasari climbed up to his scaffolding to paint, he saw the young princess Isabella, still asleep in her bed. A few hours later he saw her father, Cosimo de Medici, enter the room. Vasari could not see either the bed or the two Medicis from his post but he could hear the unmistakable sounds of intercourse. He waited very quietly until both had left the room, and then he, too, crept away. He told friends that

he did not feel like painting any more that day.[59] Some have questioned the authenticity of this story. What is well documented is that Isabella ended her life as a victim of family violence; she was strangled to death by her husband.[60]

Our excessive embarrassment and caution about interfering in family matters stands in contrast to the attitude of the Kalahari Bushmen of southern Africa. These desert dwellers live in small groups. They are expert hunters and trackers who sleep within view of each other in circumstances which make sexual secrets impossible. Group members who break the incest taboo do so under the intense scrutiny and teasing of the community and are swiftly dissuaded by these informal sanctions.[61]

In our culture, groups like VOCAL (*V*ictims of *C*hild *A*buse *L*egislation) argue that community oversight does more harm than good. Such groups point to the high rate of unsubstantiated reports of child abuse and neglect, saying that even a negative investigation stigmatizes innocent parents. However, overreporting is necessary in order to net a high enough proportion of actual cases to reduce morbidity and mortality (see chapter 19). Perhaps someday it will be possible for our culture to provide community support for parents which is not stigmatizing. The Bushmen have a single expletive that translates as "Take this child off my hands." Parents use this expletive many times each day without fear of guilt or stigma, and children are always in the arms of an attentive, caring adult.

Currently the medical model responds to incest from the privacy pole of this axis while the criminal justice model emphasizes the need for community oversight of family behaviors. A recent study[62] indicates that physicians actually report to protective services only 42% of the incest cases they confirm. Other surveys indicate that this is not because of ignorance of what the law requires[63] but because of mistrust of the protective service system and because of a tendency to underestimate the seriousness of sexual abuse including the likelihood of physical damage and of involvement of other children. A preventive medicine model, analogous to that used in infectious disease, has been proposed to help physicians balance their duty to protect a patient's privacy with the duty to protect the family and the community.[10] The development of specific protocols, such as used in reporting venereal disease, has been helpful in allowing physicians to integrate the need for investigation as part of their medical role as diagnosticians and public health advocates, so they do not feel so much like prying policemen when they collect a complete family violence history.

CHILD AS VIRGIN INNOCENT VERSUS CHILD AS SENSUALITY EXPERT

Therapeutic wisdom in the past decade recommends telling child incest victims that they have done nothing wrong and that there was nothing they could have done to prevent the adult's misbehavior.[64] This position is

stated more completely and poetically in a Polynesian myth. After a terrible catastrophe, a brother and sister find themselves the only survivors. For weeks they take turns searching their island for another human being. Months pass. At last they decide they must mate to try to repopulate their world. A malformed child is born. More months pass. At last a large party of survivors led by an old man discovers the sibling pair. The brother and sister are overcome by guilt and remorse. However, the old man, after listening carefully to their story, tells them "There was nothing else you could do."[65] This therapeutic model is apt for sibling incest survivors seen clinically. These victims often blame each other bitterly, failing to take into account the magnitude of the family catastrophe with which they were coping.

However, other folkloric materials portray the child not as an innocent, but as an expert in sensuality and evil. A medieval English mystery play describes a girl who seduces her father, kills her mother, kills her baby born of the incestuous union, kills her father, and then repents and is forgiven.[66] This tale mirrors the picture of the victim often painted by the incestuous father. "What man could have resisted her?" complained one stepfather who had begun fondling his child when she was a preschooler. However, some victims, too, adopt this seductress self-representation, rejecting the suggestion that their role was passive. I recall one adult incest survivor who had successfuly resisted years of therapeutic attempts to tell her she had done nothing wrong. She finally revealed her secret. Years after her father had stopped initiating intercourse with her, the patient, then a young woman, had sought him out, and successfully seized sexual control. Shortly after they had intercourse "for the last time," her father died of a stroke; she had always blamed herself. Like many victims she had learned to identify with the aggressor, and had also learned, long before puberty, to seek the pleasures of coital orgasm. Even though in this case the perpetrator was dead at the time treatment began, he still had to be dealt with as an introject within the patient. As long as she was protecting her therapists from this part of her experience, treatment made no impact on her patterns of guilty self-punishment and low self-esteem.

Therapists working in this area repeatedly argue about whether the focus should rest on the interpersonal situation or on the victim's inner life. Extreme situationalists may err in tending to view the incest victim as a tabula rasa shaped only by external events. They may forget that more than a third of normal children have learned to masturbate by age 1 year.[67, 68] and that the sexual aspects of incest, while important, are only one factor in its traumatogenesis.[3] Extreme inner-world proponents may err, as did Freud, in losing touch with the character of the perpetrator and the needs of other family members.[23, 69] In real life, of course, the two approaches cannot be separated. If the therapist will listen, the more the survivor can recall and explain about the situation, the more he or she reveals about inner experience and conflicts and vice versa.

SEXUALITY AS DANGEROUS AND SECRET VERSUS SEXUALITY AS HARMLESS AND NATURAL

Even the most sexually knowledgeable and tolerant societies design and enforce an incest taboo of some kind. The ideal of Rene Guyon[70]—relatively indiscriminate sexual partnering between children and adults—seems not to exist in nature. However, cross-culturally, parent-child nudity, communal sleeping arrangements, and tolerance for masturbation and peer sex play in children coexist with stringent incest taboos. The incest taboo regulates not child sexuality itself so much as the impingement of uncontrolled sexual impulses on parenting roles and on the child's own future role performance. Sexual behaviors performed openly according to community sanctions seem not to be experienced as abusive. For example, mothers in many cultures use genital manipulation to soothe and pleasure infants. Some cultures prescribe the deflowering of pubertal girls by an adult male or by the father. This is not experienced as incest, although incest can occur in these cultures, as in one case where the father continued having intercourse with his daughter secretly after the public ritual. There may be as yet unstudied sequelae even of sanctioned sexual practices with children older than age 4 to 6 years. In most cultures this is an age at which children move toward more personal and sexual privacy.

While sexually permissive cultures may overload children with sexual experiences, the sexually puritanical cultures have different kinds of difficulties maintaining the incest taboo. Here secrecy and fears about sexuality can create a climate in which incest fathers can easily seduce their naive prey and where normative inhibitions about sexuality conceal and perpetuate the abuse. Many incest fathers justify their activities as "sex education." The father's own sex education is sometimes so terribly limited as to preclude the possibility of finding an adult sexual partner outside the family. An Indian folk tale expands this concept. In this story the father, on the occasion of his son's wedding, wants to tell the young man and his bride about sex. However, the father's own knowledge is so tenuous and incomplete that he cannot convey in words what must be done, so he ends by deflowering the bride himself.[71] Once such an event occurs, the victim's own lack of sexual knowledge and terminology can render her unable to complain. Those who find extreme the current educational emphasis on the sexual self-protection of children should remember that this effort is filling an enormous vacuum. Before *Thousandfurs* was reinstated in collections of Grimms' fairy tales in the late 1970s, after years of suppression, children in our culture had little opportunity to hear and discuss explicit incest tales. As one African folk tale grimly reminds us, "If parents don't teach their children about sex, life will teach them."

CONCLUSION

Previous discussions of our current problems in enforcing the incest taboo have focused on our culture's tendency to overvalue male needs and ignore female needs and on our judicial system's tendency either to treat child witnesses as adults or to exclude them from the legal process. The present discussion lists five additional sets of problems: (1) insistence on exclusive use of either formal or informal sanctions, (2) refusal to acknowledge either the child's rights as an individual or his natural dependency, (3) excessive exaggeration or minimization of the importance of family privacy, (4) refusal to acknowledge either the child's innocence or her sensuality, and (5) excessive exaggeration or minimization of the dangers of sexuality. In a 1979 article on the pitfalls of investigating sexual abuse allegations, we suggested that professionals examine their own biases before engaging in such evaluations.[72] The present discussion provides a beginning listing of those problematic biases. Forensic evaluators are particularly at risk for losing perspective, because our adversarial legal system tends to split apart truths, forcing each side toward whichever extreme yet partial position favors one particular side of the argument. Disturbed victims also gravitate toward extreme positions, sometimes taking the therapist with them. For example, victims who dissociate into multiple personalities may produce alters who advocate opposing extremes; one alter may be a virgin while another is hypersexual; one alter may be pursuing criminal charges against the father while another keeps the secret faithfully. Folklore provides an antidote to this fragmentation, telling us stories in which opposing polarities can be integrated. In stories, as well as in reality, the needs of both females and males in the family make empathic sense; victims wish to protect as well as punish family members, and children are simultaneously as sensual as they are innocent. Folklore also provides cautionary examples of the problems that arise when extreme positions prevail, and its cross-cultural origins tend to free us from culture-bound perspectives.

Social history tells us that making the incest taboo work is an inevitable human chore. Folklore tells us that it may be possible to carry out this chore with some measure of creativity, good humor, and even wisdom.

REFERENCES

1. Russell D: *Sexual Exploitation.* Beverly Hills, Calif, Sage, 1984.
2. Briere J, Runtz M: Post sexual abuse trauma: Data and implications for clinical practice. *J Interpers Viol* 2:367–379, 1987.
3. Finkelhor D: Child sexual abuse: Two models. *J Interpers Viol* 2:348–366, 1987.
4. Peters SD: Child sexual abuse and later psychological problems, in Wyatt GE, Powell GJ (eds): *The Lasting Sexual Abuse.* Beverly Hills, Calif, Sage, 1988.
5. Rank O: *Das Inzest-Motif in Dicntung und Sage.* Leipzig, Franz Deuticke, 1912.

6. Edmunds L *Oedipus: The Ancient Legend and Its Later Analogues.* Baltimore, Johns Hopkins, 1985.
7. Edmundo L, Dundes A: *Oedipus : A Folklore Casebook*. New York, Garland, 1984.
8. Friedrich WN: Children from sexually abusive families. *J Interpers Viol* 2:391–402, 1987.
9. Goodwin J: Developmental impacts of incest in Noshpitz J, Berlin I, Call J, et al (eds): *Handbook of Child Psychiatry*, 1987, pp 103–110.
10. Surgeon General's Workshop on Violence and Public Health: *Report.* Washington, DC, Health Resources and Services Administration, DHHS No. HRS-D-MC 86-1, 1986.
11. American Bar Association National Legal Resource Center for Child Advocacy and Protection: *Innovations in the Prosecution of Child Sexual Abuse Cases.* Washington, DC, American Bar Association, 1982.
12. American Bar Association National Legal Resource Center for Child Advocacy and Protection: *Child Sexual Abuse and the Law.* Washington, DC, American Bar Association, 1984.
13. Rush F: *The Best Kept Secret: Sexual Abuse of Children.* Englewood Cliffs, NJ, Prentice Hall, 1980.
14. Herman J: *Father-Daughter Incest.* Cambridge, Mass, Harvard University Press, 1981.
15. Brickman J: Feminist, nonsexist, and traditional models of therapy: Implications for working with incest. *Women Ther* 3:49–67, 1984.
16. Goodman G: Children's testimony in historical perspective. *Social Issues* 40:9–31, 1985.
17. Terr L: The child as witness, in Schetky D, Benedek E (eds); *Child Psychiatry and the Law.* New York, Brunner-Mazel, 1980.
18. Terr LC: The child psychiatrist and the child witness: Traveling companions by necessity if not by design. *Am Acad Child Psychiatry* 25:462–472, 1981.
19. Rosenfeld AA, Newberger EH: Compassion vs. control: Conceptual and practical pitfalls in the broadened definition of child abuse. *JAMA* 237:2086–2088, 1977.
20. Terr LC, Watson AS: The battered child rebrutalized: Ten cases of medical-legal confusion. *Am J Psychiatry* 124:1432–1439, 1968.
21. Satterfield S: The legal child abuse in the Jordan, Minnesota, sex ring case. Presented at the Annual Meeting of the American Academy of Psychiatry and the Law. Albuquerque, NM, Oct, 1985.
22. Erikson EH: Reality and actuality: An address. *J Am Psychoanal Assoc* 10:451–474, 1962.
23. Masson JM: *The Assault on Truth.* New York, Farrar, Straus & Giroux, 1984.
24. Thompson S: *Motif Index of Folk Literature.* Bloomington, Ind, Indiana University Press, 1955–1958.
25. Cohen Y: The disappearance of the incest taboo. *Hum Nature* 72–78, 1978.
26. Goodwin J: Persecution and grandiosity in incest fathers in Pichot P, Berner RW, Thaw K (eds): *Psychiatry: The State of the Art.* New York, Plenum, 1985, vol 6, pp 309–322.
27. Wilson PJ: Incest: A case study. *Social Econ Studies* 12:200–209, 1961.
28. Blong RJ: *The Time of Darkness. Local Legends and Volcanic Reality in Papua, New Guinea.* Seattle, University of Washington, 1982.
29. Levi-Strauss C: *Les structures élémentaires de la parentes.* Paris, Presses Universitaries, 1949.
30. Whiting BB: *Six Cultures: Studies of Childrearing.* New York, John Wiley & Sons, 1963.

31. Stephens WN: *The Oedipus complex: Cross-cultural evidence*. Glencoe, III, Free Press, 1962.
32. Lindzey, G: *Handbook of Social Psychology*. Boston, Addison-Wesley, 1954.
33. Adams MS, Neel JV: Children of incest. *Pediatrics* 40:55–62, 1967.
34. Shepher J: *Incest: a Biopsychosocial View*. New York, Academic Press, 1983.
35. Bixler RH: Incest avoidance as a function of environment and heredity. *Curr Anthropol* 22:639–643, 649–654, 1981.
36. Bixler RH: The incest controversy. *Psychol Rep* 49:267–283, 1981.
37. Bixler RH: Comment on the incidence and purpose of royal sibling incest. *Am Ethnologist* 9:580–582, 1982.
38. Westermarck E: *The History of Human Marriage*. New York, Allerton, 1922, vol 2.
39. Bateson P: Sexual imprinting and optimal outbreeding. *Nature* 273:659–660, 1978.
40. Fox R: *The Red Lamp of Incest: An Enquiry into the Origins of Mind and Society*. Notre Dame, Ind, University of Notre Dame, 1983.
41. Spiro ME: *Children of the Kibbutz*. New York, Schocken, 1965.
42. Finkelhor D: Sexual abuse: A sociological perspective. *Child Abuse Neglect* 6:95–102, 1982.
43. Finkelhor D: *A Sourcebook on Child Sexual Abuse*. Beverly Hills, Calif, Sage, 1986.
44. Steele B: Notes on the lasting effects of early child abuse throughout the life cycle. *Child Abuse Neglect* 10:283–291, 1986.
45. Freud S: Extracts from the Fliess papers [1905], in *Standard Edition*, Strachey J (trans-ed). London, Hogarth, 1963, vol 1, p 257.
46. Neutra R, Levy J, Parker D: Cultural expectations versus reality in Navajo. Seizure patterns and sick roles. *Cult Med Psychiatry* 1:255–275, 1977.
47. Weinberg S: *Incest Behavior*. New York, Citadel, 1955.
48. Grollig FX: Anthropological perspective on incest, in Renshaw D (ed): *Incest: Understanding and Treatment*. Boston, Little Brown, 1982.
49. Elwin V: *The Baiga*. New York, AMS Press, 1939, pp 188–194.
50. Trepper TS: The apology session, in Trepper TS, Barrett MJ (eds): *Treating Incest: A Multimodal Systems Perspective*. New York, Haworth Press, 1986, pp 93–102.
51. Reider N: Medieval oedipal legends about Judas. *Psychoanal* 29:515–527, 1960.
52. Tarachow S: Judas, The beloved executioner, in Coltrera, JT (ed): *Lives, Events and Other Players: Directions in Psychobiography*. New York, Jason Aronson, 1979, pp 77–99.
53. Gilligan C: *In a Different Voice: Psychological Theory and Women's Development*. Cambridge, Mass, Harvard University Press, 1982.
54. Benedek EP, Schetky DH: Allegations of sexual abuse in child custody and visitation disputes, in Schetky DH, Benedek EP (eds): *Emerging Issues in Psychiatry and the Law*. New York, Brunner-Mazel, 1985, pp 145–158.
55. Armstrong L: Incest—In the age of no-fault abuse. *Workshops Non-violence* 19:11–13, 1983.
56. Thurston HJ, Attwater D: *Butler's Lives of the Saints*. Maryland, Christian Classics, 1981, vol 4.
57. Bataille G: *Le procès de Gilles de Rais: Les documents*. Paris, G de Laval, 1965.
58. Goldstein J, Freud A, Solnit A: *Beyond the Best Interest of the Child*. New York, Free Press, 1980.
59. McCarthy M: *The Stones of Florence*. New York, Harcourt, Brace, Jovanovich, 1963, p 178.

60. Micheletti E: *I Medici a Firenze*. Florence, Becocci Editore, 1979, p 67.
61. Draper P: !Kung women: Contrasts in sexual egalitarianism in foraging and secondary contexts, in Reiter R (ed): *Toward an Anthropology of Women*. New York, Monthly Review Press, 1978, pp 77–109.
62. James J, Womack W: Physician reporting of sexual abuse of children. *JAMA* 240:1145–1146, 1978.
63. Attias R, Goodwin J: Knowledge and management strategies in incest cases. *Child Abuse Neglect* 9:527–533, 1985.
64. Sgroi SM: *Handbook of Clinical Interventions in Child Sexual Abuse*. Lexington, Mass, Lexington Books, 1981.
65. Dixon RB: *Oceanic Mythology*. Boston, Marshall Jones, 1916, vol, 9, p 165.
66. Wells JE: *A Manual of Writings in Middle English, 1050–1400*. New Haven, Yale University Press, 1916.
67. Kestenberg J: Outside and inside, male and female. *J Am Psychoanal Assoc* 16:456–520, 1968.
68. Rutter M: Normal psychosexual development. *J Child Psychol Psychiatry* 11:25–283, 1971.
69. Ross JM: Oedipus revisited; Laius and the "Laius complex." *Psychoanal Study Child* 37:169–200, 1982.
70. Guyon R: *The Ethics of Sexual Acts*. New York, Octagon, 1974.
71. Elwin V: *Myths of Middle India*. Oxford, Oxford University Press, 1931, p 285.
72. Goodwin J, Sahd D, Rada R: Incest hoax: False accusations, false denials. *Bull Am Acad Psychiatry Law* 6:269–276, 1979.

Appendix I

Structured Questionnaire for Recognizing Dissociative Symptoms in Abused Children

I. Constitutional

Who were the important people around you while you were growing up?

Have you ever worried about the mental state of either of your parents? Of any other important caretaker?

Did any of the adults you grew up with believe or do things which would be hard for you to explain to an outsider? Did you ever think that one of your parents might have a problem with alcohol or drugs? With sex? With temper? Was either of them ever in trouble with the law?

Do you believe that either of your parents might have had an unhappy childhood? Your grandparents?

II. Somatic

When you were growing up were there arguments or fights in your family?

Was anyone ever hurt? Badly enough to go to a doctor or hospital?

Did anyone in your family die while you were still a child?

Were you ever hospitalized as a child? List the hospital name, location, and date.

As a child what problems or worries did you have about your sexuality or about your sexual organs? Did you ever talk with a doctor about such worries?

Did you have your own doctor as a child? List doctors you saw before age 18. Did your family have its own routine or remedies for sickness or injury? What was the most frightening illness or injury you had as a child? Do you recall any frightening treatments?

As a child, were there ever times when you seemed to have less pain than expected? Did you ever have severe pain or any other kind of body response that no one could explain? Did you ever faint or have a seizure? Did you sleepwalk?

As a child, did you ever feel there was something fundamentally "wrong" about your body? (such as "too big," "too small?")

III. Family and Social

As a child, how were you punished when you did something wrong?

As a child, were there ever times when you thought you might die or be killed?

Was there anyone you were especially afraid of? Why?

As a child, did anyone ever do anything to you that was sexual that made you feel upset?

Was there some one person in your family who made *all* the decisions?

As a child, did you notice certain things that you were not allowed to do but that other children your age were permitted to do ? Were the jobs that you did at home different from chores done by your friends? Looking back, do you now believe that any of those chores were too hard for a child?

Were there any special rules in your family about eating, sleeping, or going to the bathroom?

Did your parents do things that you felt were unfair? Describe the most extreme examples.

Were you allowed to stay overnight with a friend? To bring a friend to stay overnight with you? Were there ever any problems with such visits?

Were there any secrets in your family that you were forbidden to tell anyone?

Was there any activity that was very important to you as a child that your family forbade or interfered with?

Did your parents teach you things that you later learned were false? Give the most extreme examples.

Did you ever feel that one of your parents was too demanding of attention? Were there times when you wanted to be left alone but were not? Were there times when you needed help from a grownup but couldn't get it? What were your first experiences with alcohol? Or with any similar kind of drug that changes mood or alertness?

As a child were you ever accused of something you didn't do? Were you ever accused in a way that made you feel terribly guilty? Were you ever accused of something that you didn't remember doing but finally decided you must have done?

As a child, did you have nicknames that you disliked? Were you ever called names?

As a child, were you ever told by an adult to do something that you later learned was wrong?

List the schools you attended between kindergarten and 12th grade.

When you were 6, whom did you confide in? When you were 10? When you were 16?

IV. Psychological

List your grade school teachers from grade 2 to grade 6.

Did you ever have problems at school? Describe.

Describe any imaginary companions you had as a child.

Describe any daydreams from childhood that you recall. Describe any creative work that you did before high school (as a story or poem or performance).

As a child, did you have any strange experiences that could be described as occult or mystical?

Describe any memories you have from childhood of times when your behavior got you in trouble (as fights, sexual experimentation, acting younger than you really were).

Did you ever run away from home? At what age(s)? Describe.

Did you ever think about or try to kill yourself? At what age(s)? Describe.

Have you ever had very frightening or recurrent nightmares? Describe.

As a child, were you ever seen by a psychiatrist, psychologist, or social worker? List name, location, and date.

Appendix II

The Sexual Stress Questionnaire

We would like to have you take a few minutes of your time to fill in this form. Its purpose is explained on the next page.

Some of you may not have experienced the kinds of upsets we are asking about. However, please feel free to fill in the following pages if you would simply like to comment on these kinds of upsetting experiences.

There is no requirement that you fill out this form and you may refuse to do so simply by leaving it blank and returning it; however, any information you can give us will be helpful.

We are trying to understand more about the kinds of upsetting sexual events which happen to children. This study will help us to treat children who have been sexually victimized by helping us to understand how children cope with sexual events.

We would like you to describe any incident from your childhood that you thought was sexual that happened to you because as a child you had to give in to someone bigger. We are interested in any experience that happened before age 18 that either bothered you at the time or has left some sort of lasting memory. Examples are: being followed, being touched sexually, being asked by a grownup to undress, being "flashed" (someone exposing themselves to you), "peeping Toms," obscene phone calls, being raped, or being beaten (in a sexual way).

All information is *anonymous* to ensure confidentiality.

(Please fill in the blank or check the appropriate box.)

1. Your age: _____ Sex: Male _____ Female _____
2. Ethnicity: Anglo _____ Spanish-American _____ Indian _____
   Black _____ Asian _____ Other _____
3. Marital Status: Single _____ Divorced _____ Married _____
   Widowed _____
4. Highest grade completed: _____
5. Religion: Catholic _____ Protestant _____ None _____
   Other _____

6. What is your job? _____
7. Before age 18 were you ever in a sexual kind of situation as described above? Yes _____ If yes, please continue on the next page.
   No _____ If no, please return this form to the survey-taker.

EVENT NUMBER _____

7A. First, describe the event.

1. How old were you? _____
2. What happened? _____
3. Where did it happen? _____
4. Who did it? _____
5. What time of day was it? _____
6. Was anyone drinking or drunk? _____
7. What happened afterward? _____
8. Did you tell anyone? _____

7B. Check the box that best decribes how you feel or felt.

	How upsetting was the event immediately afterward?	How upsetting is the event to you today?	If this event were to happen again, how upsetting would it be?
Not at all upsetting			
Mildly upsetting			
Upsetting			
Quite upsetting			
Highly upsetting			
Extremely upsetting			

Appendix III

The Legend of Saint Dymphna

Once upon a time a beautiful princess lived on an island where her mother and father were queen and king. The name of this princess was Dympha, and from her birth she had been an amazing child, in beauty, sweetness, and cleverness.

Dymphna's father, King Coninck, was a cruel man and a pagan. As Dympha grew older, she understood that the queen disagreed with the king about many things. For one thing, the queen was a Christian, and Dymphna too began to learn Christianity from the hermit Gerebernus who lived in a hut in the forest.

One day the queen became ill. On Christmas Eve, just before she died, she called Dymphna and Gerebernus to her and said, "My daughter, I am no longer able to keep you under my protection. You must make your own decisions now. Gerebernus, try to guide her, with God's help." After that, the queen died.

On losing his queen, King Coninck sank into a black chagrin, becoming more and more cruel and more strange than ever. His counselors, trying to cheer him, suggested that he seek a new queen. And so he sent his soldiers throughout the land searching for someone worthy to be his queen, someone as beautiful, as sweet, and as clever as was his dead wife. Alas, no such person could be found. When his messengers returned, the pagan king's mood became even blacker. Then a demon spoke to him. "What you seek is near you," said the demon. King Coninck, glancing up, saw his daughter, Dymphna. "There is the living image of your dead wife," the demon said. "She alone is worthy to be Queen of Ireland."

The next day he asked Dymphna to be his wife. When she refused he thought, "She says this because she is shy, still a young maiden. She will come around to my view soon enough. It is the only reasonable thing we can do, now that the queen is dead."

Each day Coninck made his proposal anew, at times stroking her body and using sweet flattery, at other times explaining why his way was right, and at other times shouting, threatening, and waving his sword in a rage.

At last Dymphna could bear it no longer, and went to the hermit Gerebernus for advice. "I wish my mother were here," she said. Gerebernus thought for a long time and, at last, he said, "There is no way out except to run. All I can offer to do is run with you." The hermit told Dymphna that to gain time, she should ask the king to give her 40 days in which to make up her mind about the marriage.

When Coninck heard this, he was overjoyed. He showered Dymphna with presents, and gave her dozens of fine silk dresses. "I will often be away from the castle," she told him. The king imagined that she was preparing for the wedding feast. In reality, she was preparing to fly.

One day she went out on her white horse and did not return. She met Gerebernus and an old couple who had been friends of her mother. They ran their horses as far as the sea where Gerebernus had a boat ready. "My princess," he said, "I do not know how to navigate, so I cannot tell you where this boat will take us. Do you still want to go?" Dymphna nodded and got into the boat. It was very cold and the sea was full of storms.

It was not until several days had passed that the servants in the castle dared to tell Coninck that his daughter had disappeared. First, he had his soldiers search for Dymphna throughout his own kingdom. When he found that Gerebernus too was missing, Coninck decided that it was Gerebernus who had caused all of his troubles. "This hermit turned my wife against me, and probably poisoned her in the bargain. Now he has turned my dear Dymphna against me, and has taken her away." Coninck gathered a large army and began to search for Dymphna through all Ireland and then across the seas.

Miraculously, Dymphna's boat reached shore at the busy port of Antwerp, in Belgium. People came to stare at the old hermit and at the beautiful princess who wore torn, sodden, silken rags. She bought food for her friends with the Irish coins she had with her. Because she was beautiful, merchants "sold" her the food, even though her Irish coins had no value in Antwerp. "Let us keep going," said Gerebernus. "There are too many people here."

They walked for many days into the forest. After a long while, they came to a shrine dedicated to Saint Martin in a lonely place with only 15 houses nearby. The village was called Gheel (or Geel, pronounced like a *gale* of wind). Gerebernus liked Saint Martin, so they stopped and built a hut near the shrine. They lived there in peace for about 3 months.

Meanwhile Coninck and his soldiers searched for Dymphna, moving out in ever-widening circles from Ireland. In Antwerp, the King heard of the beautiful girl and the hermit who had arrived in a boat. Coninck sent his men to comb the countryside for more news.

It was Coninck himself who sat down to dinner one night at the inn at Gheel. "Oh, I cannot take this kind of money from you," said the woman who had served him. "I take these from the girl who lives with the hermit in the forest, but only because she is mad. I do it out of charity. Mad as a hatter she is, but lovely. Why, she says her father wants her to be his wife. She imagines it all, of course. She tells me that we must keep all this a secret. Poor girl. She believes, in her madness, that her father is still searching for her."

Coninck drew his sword and ran toward the hut in the forest. His soldiers followed. The woman at the inn was left holding another one of those strange unlucky coins.

It was the end of May now, and warm and light in the evenings. Gerebernus saw the soldiers coming and went to the door, hoping to shield Dymphna from them.

"You are the enemy," said Coninck, seeing Gerebernus. "I will kill you and be free."

Dymphna came to stand at the side of her confessor. "Please, for the love you have for me, do not kill him."

"And what will you do for me if I spare your friend?" Said the king, reaching out to fondle her breasts. "What little favor will you do for your father then?" Gerebernus pushed the king away. "The time has come to speak plainly, my king. No pacts with the devil are allowed. What you have proposed violates all rules of man and God."

The king spoke again. "Will you have me, Dymphna? In exchange for his life?"

"Never," said the princess. King Coninck nodded, and a dozen spears pierced Gerebernus at the same moment.

"Now, my daughter," said the king, "Will you be Queen of Ireland now?"

"Never," said Dymphna.

As always, the passionate lust of the king was very near to becoming a passionate rage. "You will be Queen of Ireland, or you will die," he said.

"My father," she answered, "I simply cannot."

He nodded as before, but this time no soldier moved. He lifted his chin, his eyes blazing. Still, nothing happened. At last, one soldier walked over to Dymphna. He raised his sword. Then he let it fall again. He could not kill her.

Coninck strode over to where she stood. With his own sword, he cut off the head of his daughter.

Dymphna was surprised to find that after all of that, she was still thinking. Coninck had done all he could to stop her thinking, but even this last had not succeeded. She was going upward, very fast, and Gerebernus was with her. She stretched out her arm to hug her mother. "Dear mother," said Dymphna, "Soon we will be together, but now I must find a way to bring father with us."

Dymphna pointed down to where her father, the king, was trampling and hacking at what he could see of Dymphna and of Gerebernus. His demon had now gained possession over his self. Coninck slavered and howled, trotted in circles, and kept spinning his sword above his head. His soldiers backed away from him in horror.

Dymphna, who was learning to fly with more control now, glided down to hover behind the woman at the inn. "What have I done?" The woman began to think. "I thought she was just a mad, silly girl, but she was fighting for her life. How can I make up for what I have done?" Just then King Coninck came wandering in. Coninck howled at the door, then fell to the floor and settled down to writhing like a snake, and hissing. The woman at the inn went to him. "Perhaps I can care for this poor creature. He is guilty of much, but so am I. I will try to give him the care that I did not give to his child. This one I will treat as one of my own family, not as someone to ridicule or to point the finger at, but as someone who truly belongs with us."

Dymphna saw clearly now the demon riding upon her father's back. It looked like a small dragon with horns. She was amazed that she had never seen it before. She took the sword from her father's hand. The demon knew that she had recognized him and ran to hide under the bed. Coninck collapsed into the arms of the innkeeper. Dymphna kept stalking the demon. She hunted him for nine days before she caught him and stabbed him to death with her father's sword.

All this happened almost 1300 years ago. Still today, if you see a picture of Saint Dymphna, she will be holding her father's sword and standing on the head of a vicious-looking demon. Gerebernus became a saint too, and now he has long conversations with his friend, Saint Martin, every day. In memory of Saint Dymphna, today the families of Gheel still take in those who are possessed or deranged and help them to get well. Dymphna still helps to heal such people, as she healed her father. It is said that madness can be cured if one stays for nine days in Dymphna's

church. Today, fathers still make passionate, demonic proposals to their daughters, and the daughters must try to find a way to say no. This is about as easy as sprouting wings. Dymphna and Gerebernus still wonder if they could have found a simpler way to do it.

SOURCES

Bogaerts Felix: *Dympne d'Irlande. Legende de septième siècle.* Antwerp, LJ de Cort, 1840.
Janssens G: *Sainte Dimphne. Patronne de Gheel.* Lierre, J Van In, 1894.
Geel: A Changing Tradition, 16-mm film, Berkeley, University of California Extension Media Center, 1973.

Appendix IV

The Story of the Princess of Hungary

Once upon a time there was a princess so bonny and bright and gay that she was called Joy. Everyone said she was the exact image of her good mother.

One day the princess's mother, the queen, became ill. The king stayed by the queen's bedside and swore that he would never leave her. As the queen lay dying, she made him promise that he would never remarry unless it was to someone who had the queen's own golden hair, the queen's own sea-blue eyes, and the queen's own flame-red lips. The king promised, and the queen died. However, he was so overcome by grief that he did not even think of marrying for many months. Then his barons began to mutter that the king had no son. The barons insisted that he take a wife. However, the king could find no one in the land as beautiful as his dead queen, and he was determined to keep his promise.

One day, while Joy was playing chess with her father to cheer him, the king looked at his daughter in a new way. He saw that she had the queen's own golden hair, and the queen's own sea-blue eyes, and the queen's own flame-red lips. He caught up her small hand, kissed it, and begged his daughter to marry him. Joy replied by taking up her father's sword with which she cut off her own left hand even as the king held it to his lips.

Enraged, the king tossed Joy's severed hand over his shoulder, where it fell into a stream. He ordered that his daughter be burned at the stake immediately. However, the court jester loved Joy and could not bear to see her hurt any further. So he made a mannequin or dummy so that it looked exactly like the princess. He tied the mannequin to the stake to be burned, and he spirited the real princess away to a small boat. The princess had lost her power to speak, and her eyes held only a cloudy emptiness. As the court jester set her adrift in the cold sea, he said, "I am afraid it was Joy that was burned today. I fear it is only the mannequin that I have saved." From that day, the princess was called Mannequin or Manekine.

When her boat cast her up on the coast of Scotland, everyone who saw her

was struck by her sad loveliness. The King of Scotland came to see for himself this silent, one-handed beauty, and he fell in love with her at once. Despite the muttering of his mother, who was sure that Manekine was a witch, the king and the castaway were married. However, before their child was born, the king had to leave on a crusade.

Manekine had a beautiful baby boy and wrote to the King of Scotland to tell him of their joy. However, her mother-in-law intercepted her letter, and replaced it with one saying that the witch-queen had borne a monster and that both must be burned at the stake. The king was troubled when he received this letter but wrote back saying that he would come back immediately and that nothing should be done until his return. However, Manekine's mother-in-law intercepted this message too, and replaced it with a letter that ordered that Manekine and her son be burned at the stake.

Now Manekine had been burned at the stake once before, so she remembered how it could best be done in order to survive. She made two mannequins, one to resemble herself, and one to resemble her baby; she tied them to the stake, and she fled with her baby out to sea in a small boat.

This time the sea took them to Rome. There Manekine became a begger to get food for her starving baby. Despite all her struggles, the baby died of hunger.

One day Manekine was sitting in her rags beside a fountain. On a balcony above her, she heard two men talking as they ate. Both were pilgrims who had come to Rome asking forgiveness. The older man was doing penance for having desired his own daughter for his wife and for having killed her when she refused him. The younger man was asking forgiveness for having abandoned his young wife to the cruelty of his mother. He had not been able to return in time to prevent his mother from killing his wife and child, but he had had his mother burned at the stake when he learned the truth.

Suddenly, Manekine realized who these two men were. Her voice was restored to her and she uttered a shout of recognition. Her father and husband came running down; they recognized her at once because of her missing left hand. Then the two men knew each other as well, for Manekine had never told her husband that her father was the King of Hungary, and her father had never dreamed that his daughter would be married to a king. "I forgive you both," said Manekine, and with those, her first words since her father's unnatural proposal, a miracle occurred. Her left hand flowed into the fountian and flowed up to Manekine where it joined smoothly to her arm. The hand must have been flowing down from Hungary from that first moment when her father threw it into the stream. Then Manekine heard splashing sounds from the fountain. She turned around to see her young son, no longer a baby now, but standing in the water and holding out his arms to this mother.

SOURCE

Cox MR: *Cinderella: Three Hundred Forty-five Variants of Cinderella, Catskin, and Cap o' Rushes.* London, Folk-lore Society, 1892.

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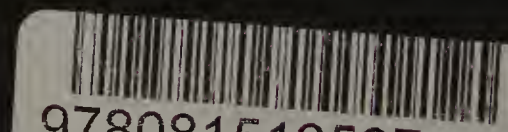

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