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## Ramifications of Incest

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Few subjects in psychiatry elicit more profound, visceral, and polarized reactions than incest—the occurrence of sexual behaviors between closely related individuals—behaviors that violate society’s most sacred and guarded taboos. Furthermore, few circumstances confront the psychiatrist with more complex, painful, and potentially problematic clinical dilemmas and challenges than the treatment of the incest victim and/or the management of situations in which incest has been suspected or alleged by one member of a family, and denied, often with both pain and outrage, by the accused and/or other members of that family.

The study of incest as an actual phenomenon rather than as a fantasy is a relatively recent event. In 1975, an authoritative text proclaimed that the incidence of father-daughter incest in the United States was 1 in a million families.<sup>1</sup> Crucial contributions by feminist authors and traumatologists rapidly sensitized the profession to the frequency and importance of incest and its association with psychopathology.<sup>2-4</sup> By 1986, Russell<sup>5</sup> wrote that some form of father-daughter incestuous activity, ranging from minimal to brutal and aggressive, was found in approximately 1 in 20 families that included daughters and their natural fathers, and 1 in 7 families in which daughters resided with a stepfather. By the early 1990s, feminists, traumatologists, and contributors from the emerging study of dissociative disorders were engaged in a vigorous study of incest and the treatment of incest victims.

However, during this time, there emerged a trend of calling into question the recollections of those who reported incestuous abuse, mounting militant defenses of accused perpetrators. The rising number of incest accusations was attributed to faulty practices on the part of therapists who worked with patients who recalled incest, especially if the recollections had been absent from memory for some time and emerged either in the context of therapy or with the patient’s exposure to certain media, books, and practices. Clinicians were accused of suggesting abuse that had never occurred and of causing their patients’ memories to be contaminated with information and/or ideas that had planted erroneous ideas in their minds. Certain books and media were accused of encouraging false reports.

As a result, for over a decade and a half the study and treatment of incest has been under a cloud of suspicion that has impeded the advancement of knowledge about this devastating form of abuse. Scholars have backed away from even using the word, to the point that it has become difficult to

research unless one searches under more bland and innocuous terms. Between the overall power of the incest taboo and scholars' wish to avoid provoking acrimonious reactions to their work, the term "incest" has been receding from the literature.<sup>6</sup> Even now, researchers rush to deny the frequency of incestuous abuse and to minimize its reality and the damage it can cause.<sup>7,8</sup> However, a careful examination of the literature demonstrates that the arguments that childhood sexual mistreatment is not damaging are seriously flawed.

This is not the format in which to review 2 decades of acrimonious and polarized debate. I will proceed on the basis of what, in my view, are the best data and knowledge now available. That data and knowledge strongly affirm that abusive incest is common, that its consequences are detrimental, and that it usually leaves its victims with considerable psychiatric damage and distress.

The contemporary study of incest and the contemporary treatment of incest victims proceed in the face of profound pressures to dissociate them from the mainstream of psychiatric concern. This avoidance, Courtois<sup>6(p19)</sup> notes, "flies in the face of the fact that research has consistently found that the majority of sexual abuse is perpetrated by someone known to or related to the child, and thus constitutes incest or is incestuous."<sup>9</sup> Furthermore, although not all perpetrators have been victims, many have themselves been mistreated, and avoiding the study and treatment of incest, especially for male victims, bypasses an opportunity to reduce the pool of future sexual offenders.

#### CHECKPOINTS

By 1986, some form of father-daughter incestuous activity, ranging from minimal to brutal and aggressive, was found in approximately 1 in 20 families that included daughters and their natural fathers, and 1 in 7 families in which daughters resided with a stepfather.

Incest often leads to traumatic bonding, a form of relatedness in which one person mistreats the other with abuse, threats, intimidation, beatings, humiliations, and harassment but also provides attention, some form of affection, and connectedness.

There are so many disincentives to revelation that many incest victims will undergo several rounds of psychiatric treatment before they risk revealing this aspect of their histories.

When evaluating a patient, attention must be paid to evidence of dissociation in the patient's history and to the patient's overall symptoms. Appropriate treatment is geared toward each individual patient—not around the problem, the relevant diagnoses, or a particular theoretical model.

#### What is incest?

Courtois<sup>6(p19)</sup> states that "incest is complex, encompassing a wide range of behaviors between individuals of varying degrees of relatedness, with potential effects that are similarly complex and multidetermined." More precise clinical and legal definitions differ widely as to the degree of blood relatedness deemed to constitute incest.

Defining incest is further complicated by the fact that the term is often used in connection with a set of values and assumptions associated with a classic 2-parent nuclear family. In fact, in a society with a high incidence of divorce, blended families are not uncommon. Those who occupy the most crucial and important roles in a child's life and who undertake the roles traditionally filled by blood relatives may not have a genetic relationship to a child, although they are the most consistent sources of that child's nurture and protection.

Courtois<sup>6</sup> distinguishes between consanguineous incest, or sexual contact between blood relatives; sexual contact between a child and individuals who are involved with the child either legally or contractually (marriage to a child's parent, adoption of a child, or serving as a foster parent); and quasi-relative incest, in which there is sexual contact between a child and individuals bound to the child by neither relation nor contract, but who are involved with the child's family and assume a family role associated with caregiving functions and responsibilities. Closely related and similar in their dynamics, although not formally deemed incestuous, are transgressions perpetrated within the context of the relationships of teachers, coaches, clergy, and psychotherapists with those who look to them as safe and positive presences in their lives.

Incest is considered abusive when the individuals involved are discrepant in age, power, and experience. The argument that a younger person may have desired, sought, or given consent is irrelevant. Those very behaviors may have been groomed, coerced, or generated in response to perceived pressure and/or threat from the more powerful person.

It has often been argued that incest between age peers (with neither partner more than 5 years older than the other) is nonabusive, mutually desired, and often consists of nothing more than experimentation. It is dubious whether this generalization will stand up to more detailed scrutiny. While such instances occur, proximity in age need not bring with it equality of power, knowledge, and sophistication. In fact, implied or actual coercion and intimidation play a role in many such situations. Many instances of sibling incest, rationalized as youthful experimentation, are profoundly exploitive. Families often accept that something has occurred between a brother and a sister, but give no credence to the sister's protest that what occurred was forceful, and/or involved the brother's making her available to his friends. And, there are more frequent reports of older sisters who take the initiative in sexualizing younger brothers.

The close relationship between perpetrator and victim complicates the trauma of the incestuous act or acts with both relational trauma and betrayal trauma. Relational trauma, described by Sheinberg and Fraenkel,<sup>10(p197)</sup> leads to "significant loss of trust in others and increased anger, hurt, and confusion about their family relationships, changes in beliefs about the safety of close relationships, changes in beliefs about the safety of close relationships in general, and negative views of the self in relation to others." Betrayal trauma, described by Freyd,<sup>11</sup> encompasses the unique hurt associated with violation by those who have a basic obligation and duty to protect and nurture and extends to those who refuse to believe or help the victim, adding to the victim's traumatization. The threat to attachment needs is so profound that the victim may be impelled to disavow the betrayal that he or she has experienced.

Furthermore, incest often leads to traumatic bonding, a form of relatedness in which one person mistreats the other with abuse, threats, intimidation, beatings, humiliations, and harassment but also provides attention, some form of affection, and connectedness.<sup>12</sup> The victim becomes accustomed to linking mistreatment with a perverse form of caring.

All too often, when incest is revealed, the victim experiences serial retraumatization as a result of being rejected by the family, which often rallies to the side of the accused; because of the interventions of authorities who often treat the victim insensitively, as if she were a liar and/or malefactor; and because of the often excruciating nature of the treatment necessary to address the effects of incest on the victim.

Attempts have been made to describe motivational categories of incest. Maddock and Larson<sup>13</sup> have categorized incest into the following:

- Affection-based: the incest provides closeness in a family otherwise lacking in nurture and affection. There is an emphasis on the specialness of the relationship, within which otherwise unavailable caring is given and received.

- Erotic-based: the family atmosphere is one of chaotic pansexuality, and it is not uncommon for many members to be involved. Its norm is the erotization of relationships. The term “polyincest” is often used to describe such multiple-perpetrator situations.
- Aggression-based: the incestuous acts involve the perpetrator’s sexualized anger. The perpetrator vents his or her frustration and conflicts on a vulnerable individual, and physical mistreatment is often involved.
- Rage-based: the perpetrator is hostile and may be overtly sadistic. There may be great danger to the victim.

It is not unusual for mixtures of these components to be encountered. Many do not think that interactions without actual sexual events should be called incest. When a parent uses a child to serve the parent’s emotional needs and promotes a child to a special and close role, however, that child becomes a surrogate spouse, trapped in a world dominated by the needs of a parent. This type of relationship, which is often simultaneously seductive and critical, is often called “emotional incest.”<sup>14</sup>

Sgroi and colleagues<sup>15</sup> have described a 5-stage process in the sexual mistreatment of children.

In stage 1, engagement, the child is brought into a more intense relationship with the perpetrator. He or she becomes involved in more intense and gradually sexualized behaviors via special attention that engages the child’s emotional needs en route to sexual behaviors that may be normalized and introduced gradually as games or as activities that clearly bring the child desired attention. Some perpetrators use violence or threats to coerce sexual engagement.

In stage 2, the sexual interaction phase, the perpetrator builds on the preliminary grooming of the victim, and the initial sexual involvements escalate, often progressing from exposure and touching to the penetration of one or more orifices.

In stage 3, secrecy, efforts are made to ensure privacy, to reduce the victim’s understanding of the abuser’s accountability, and to set the stage for ongoing sexual activity. The child is made to feel responsible and to understand that revelation would have very bad consequences. This “understanding” involves threats of harm to the child or others. Threats include loss of attachment (because the child will be seen as bad by others or would lose the affection of the perpetrator and others); being told that the child would not be believed; being assured that the child really wanted what was done; being told the child will be rejected by God for not honoring his father, etc. The child often emerges from this brainwashing with profound self-loathing, convinced that he or she is evil, and that any revelation would only confirm his or her badness, and guarantee rejection.

In stage 4, disclosure, the secret gets out, either spontaneously, accidentally, or deliberately. The reaction of concerned others is more likely to be determined by the perpetrator’s role in the family, family loyalty, and shame than by the best interests of the child. Families tend to be most protective of the child when the perpetrator is not a parent or a sibling. Not uncommonly, the family becomes protective and defensive in its anxiety and moves to disavow the severity of the offense and its sequelae and to blame the victim and any authorities or professionals who become involved.

Adopting a shame script of denial toward the acts of the perpetrator, who is defended as “one of their own,” and a shame script of “attack other” toward those seen as shaming the family, the family becomes adversarial toward the victim and involved agencies, authorities, and professionals.<sup>16</sup> Reasonable understanding of the world is turned upside down. Good becomes redefined as what is most likely to

preserve the good name of the perpetrator and the family. Bad is redefined as what might acknowledge and shine an unfavorable light on what has transpired. The loyalty conflicts in which the victim is placed are terrible and can prove more traumatic than the incest itself.

In stage 5, suppression, the community of concerned individuals within and associated with the family moves to suppress the veracity of the child's report, minimizing both the severity of the mistreatment and its consequences. The group does not want to deal with the consequences of the ugly truth and are eager to avoid the shame and inconvenience of dealing with agencies and professionals. Individuals may actively try to discredit the child or pressure him to recant accusations.

Summit<sup>17</sup> summarized many of the adaptations made by victims of incest in his article "The child sexual abuse accommodation syndrome." He described the secrecy that surrounded the abuse; the helplessness and powerlessness of the victims; their entrapment in a terrible situation and their accommodation to it; their delayed, conflicted, and unconvincing disclosure of their circumstances; and the likelihood of retraction. With painful irony, their adaptation to the abuse they cannot avoid leads to behaviors that undermine their credibility if they later complain about their circumstances.

## Sequelae

As with other profound childhood trauma, incest may initiate a complex series of biopsychosocial events that may resonate throughout a person's life. The consequences involve both psychopathology and unhelpful patterns of adaptation. Adaptations that allow one to survive amidst an incestuous family usually prove maladaptive in other areas of life.

Efforts to link particular aspects of incestuous mistreatment with the severity of the symptoms suffered by the victim have often yielded inconsistent results. However, a number of factors generally thought to increase the severity of psychopathology were summarized by Courtois<sup>6</sup> (**Table 1**).

TABLE 1: Factors associated with more severe effects on victims of incest<sup>6</sup>

Longer duration of mistreatment
Frequent mistreatment
Degree of force and intimidation
Onset at a very young age or in latency
Transgenerational mistreatment
Male perpetrator
Closeness of relationship
Passive or willing participation
Having an erotic response
Self-blame and shame
Disclosure did not lead to help
Parental blame and negative judgment
Failed institutional responses: shaming, blaming, ineffectual efforts

## Revelation

Incomprehension, shame, loyalty conflicts, fear of retaliation, and the misperception that the child is to blame for what took place make revelation difficult. In fact, only about 30% of victims, mostly older children and adolescents, reveal their situations. In 43%, the revelation is accidental. The remainder are revealed by eyewitnesses and are inferred from vague or ambiguous comments.<sup>18</sup>

Many adult survivors continue to fear reprisal, believe their silence protects their families, fear the shame and/or stigmatization associated with revealing their experiences, mistrust authorities, and often have had such negative experiences with earlier attempts to make revelations that they are reluctant to disclose again. This is especially true for those who attempted to reveal their situations earlier and suffered terrible consequences. Roesler and Wind<sup>19</sup> found that 51.9% of those who reported mistreatment to a parent were still being abused a year after the disclosure.

The take-home lesson is that there are so many disincentives to revelation that many incest victims will undergo several rounds of psychiatric treatment before they risk revealing this aspect of their histories.

## Symptoms

Incest victims present with a wide range of symptoms and comorbidities.<sup>20</sup> It is well established that trauma increases the likelihood a person will suffer symptoms that include not only the spectrum of posttraumatic conditions and response patterns but also anxiety, depression, and multiple psychiatric and somatic diagnoses.<sup>21</sup> The groups of symptoms most commonly encountered in incest victims involve several clusters (**Table 2**).

TABLE 2: Symptom clusters in victims of incest<sup>6,20,25</sup>

Emotional incontinence: an inability to contain distressing effects and the urges that accompany them
Affective dysregulation: the intrusion of strong emotions and/or their suppression
Dysfunctional self-soothing: use of addictive substances, activities, rituals of self-harm or self-stimulation
Somatoform dissociation <sup>26</sup> : physical expressions of emotional distress
Comorbidity: the effects of trauma-related conditions, physical and mental
Sexual dysfunction: inhibitions, dyscontrol, and reenactment-driven compulsive sexuality
Reenacting and revictimization behaviors: efforts to please, charm, withdraw, defy, place self at risk for further trauma, etc
Failures in relatedness: efforts to play a role pleasing to others, or inoffensive to others, while experiencing mistrust/unrealistic trust toward others; often relationships do not provide either intimacy, nurture, or support, but they are continued

## Treatment issues

The treatment of incest victims must be highly individualized. Victims of incest are found in all walks of life and from all socioeconomic circumstances. Some are alone in the world, some are surrounded by loving and concerned family and friends, and some have support systems that cannot or will not tolerate the burden of dealing with such matters. Some victims suffer numerous comorbid conditions, medical and/or psychiatric, and some have little else disturbing them. Some can afford the luxury of regressing in their treatment sessions and taking hours to restabilize after a difficult session, and some must rush back to their jobs, studies, or families in a stable and functional state. With distance and time, some are able to look at the past from a position of safety, while others remain dependent on those who mistreated them.

Appropriate treatment is individualized to each patient and is not focused around the problem, the relevant diagnoses, or a particular theo-retical model. In general, therapists adopt the overall framework of the 3-stage treatment of trauma<sup>22</sup>:

- Safety: the patient is protected and strengthened
- Remembrance and mourning: recollections of problematic experiences and losses are processed
- Reintegration: the patient has integrated the effects of the past and is helped to be well positioned to move into his or her future as unburdened as possible by the trauma that has been endured

The initial evaluation of the patient must be comprehensive and enable the psychiatrist to identify and prepare to address the full range of the patient's therapeutic needs, including the possible use of psychopharmacology. In this process, attention must be paid to evidence of dissociation in the patient's history and to the patient's overall symptoms.<sup>20,21</sup>

A common error is to assume that if there is a dissociative issue, it will declare itself readily. Such an assumption defies a massive body of information to the contrary. Because dissociation is such a powerful coping tool for the person under sustained and repeated distress, it may well have been mobilized by an overwhelmed victim of incest. A major risk of not assessing for dissociation is the unanticipated flooding of the patient's psyche with painful traumatic material that was not previously within accessible memory because the treatment lowers unrecognized dissociative barriers. Such episodes can be disruptive and life-threatening to the patient.<sup>20,21</sup>

The treatment must be paced in a manner that does not consistently overwhelm the patient, and the trauma work must be understood to be only part of an overall therapeutic effort. At times, other concerns predominate or the patient cannot tolerate dealing with the incest. The relationship that the therapist forms with the patient may prove more crucial than the theories and techniques used in treatment.

### **Special issues**

Patients may bring and develop trans ferences based on relationships with persons who have hurt and betrayed them. The expectation of sexualization and emotional harm from the therapist may be denied on a conscious level but is often revealed in numerous ways, and usually it is finally acknowledged. Many therapists have difficulty with being perceived as someone who may exploit, betray, and reject the patient, but this must be tolerated and explored as treatment progresses. Even if the therapist is not suspected of plans to actually violate the patient, the therapist may be confronted by a patient's accusations of using the accounts of mistreatment as his or her personal pornography. The therapist's kindness may be understood as preliminary seductive behavior—although treatment seems to be going well, the patient lives in fear of the moment when the therapist will show his true colors and exploit, humiliate, and/or reject him or her.

The pervasiveness of shame, guilt, self-loathing, and self-directed disgust experienced by many incest victims cannot be overstated. It is difficult for victims to accept the treatment as well-intended; even if it is, it is difficult for them to accept that it will likely continue to be well-intended as they reveal more deep-seated information. Many incest victims have been so indoctrinated to believe that what happened was their fault and was instigated by their desire, that they have difficulty with talking about relevant issues out of shame and out of fear that their “badness” will corrupt the therapist. This is especially pronounced in incest victims who suffer dissociative identity disorder or closely related dissociative conditions.

One of the major concerns during treatment of incest victims is their ongoing rumination over whether their accusations are accurate or whether what has happened is their own fault. The latter concern is especially prominent in victims of polyincest, who reason that if so many people abused them, it must have been their fault. When patients realize that facing what has happened may confront them with the irretrievable loss of their relationship with one or more family members, and sometimes with the potential loss of their entire families, the pressure to doubt themselves is profound.

The therapist is always on solid ground when he maintains that whatever might have happened was not the fault of the child who has grown into the patient he is treating. Matters are not so clear when it comes to the therapist’s stance in the notoriously difficult area of memory for sexual traumatization, however.

Although this is not the place for a lengthy discussion of this matter (authoritative texts are available<sup>23</sup>), certain principles are useful guides. It is not possible to determine whether a patient’s memory is accurate from any inherent quality of the reported memory. The patient will have to come to his or her best understanding, and the therapist is most helpful in facilitating that pursuit of understanding rather than attempting to be an arbiter of a historical truth unknown to him. Therapists are ill-equipped to distinguish accurate from inaccurate memories on the basis of the information available to them throughout the course of therapy.

Collateral sources are rarely without interests of their own to protect. I was once involved in a forensic case in which the defendant and all members of her family attested that no abuse had occurred in their family. Because an issue of great importance was involved, the FBI, which had found no evidence of abuse in a cursory investigation, did a more exhaustive inquiry. Sixteen witnesses to the abuse of the defendant by members of her family were located, including a former neighbor who could see from her third-floor window the defendant being raped by her father in a second-floor bedroom of the house next door. That observation had been reported to the police but was not acted on. (**Table 3 summarizes study findings.**)

Table 3: Observations drawn from the literature on trauma and memory<sup>23,27</sup>

The details, vividness, and resemblance of a memory to known events do not demonstrate that a memory is accurate or inaccurate

A patient’s conviction that a memory is accurate or inaccurate does not demonstrate that a memory is accurate or inaccurate

Neither a fragmentary quality often associated with traumatic memory nor a quality of narrative completeness sometimes linked to inaccurate memory for trauma demonstrates that a memory is accurate or inaccurate

Neither a dreamlike, unreal, foggy, nor surreal quality to a memory demonstrates that a memory is accurate or inaccurate

The discovery that one memory is accurate does not demonstrate that the patient's memory is generally accurate

The discovery that one memory is not accurate does not demonstrate that the patient's memory is generally inaccurate

The corroboration or noncorroboration of a memory of abuse by others allegedly present at the time is not adequate grounds for validating or for dismissing the memory unless the witnesses can be shown to have no incentive to misrepresent matters

Finally, with regard to memory, it is useful to remind ourselves that although much has been disputed about recovered traumatic memory when matters of incest have been involved, little concern has been expressed about the situations in which memories of other types of trauma return to awareness after having been unavailable. It may be useful to review some of the factors that may lead to memory of a trauma becoming inaccessible or being reported as inaccessible for long periods. Some are noted in **Table 4**, drawn from my practice.

Table 4: Reasons why memories of incest trauma may become inaccessible or be withheld  
Familiar mechanisms of defense

Dissociated storage processes and structures

Conscious coping mechanisms

Guilt and shame

Loyalty to/protection of the abuser

Protection of family members and of the family

Perceived moral or religious imperative to withhold

Bargaining

Confusion about the reality of events and their meanings

Confusion about the source and nature of and misunderstanding of the meanings of available mental contents; obsessing over the reality of mental material

Consequences of obfuscation or gaslighting<sup>a</sup> or promoted reinterpretations of events

Obsessing over the meanings of terms

Deliberate or inadvertent discouragement of reporting by others

Encouragement to doubt or dismiss memories

Contamination<sup>b</sup>

Rationalization

Strategic withholding with goals and objectives in mind

Driven withholding, motivated by higher priorities (personal or cultural, including defending loved ones)

<sup>a</sup> Gaslighting involves providing a person with false information in order to bring that person to doubt his or her perceptions and memories. The term comes from a play and movies about a husband's attempt to drive his wife insane by raising and lowering the illumination in their home and denying that any changes had occurred.

<sup>b</sup> Contamination is information that is not autobiographic but to which one was exposed; it influences memory or may become the basis for a memory with no basis in autobiographic fact.

Bear in mind that the treatment of the incest victim must address not only past problems but current problems as well. Treatment must concern itself with the patient's future. The therapist should assess the patient's ongoing vulnerability and attempt to reduce the likelihood that he or she will be revictimized.

In an article in 1989, I described the "sitting duck syndrome."<sup>24</sup> I studied a series of patients who had been victims of therapist-patient sexual exploitation and was shocked to discover that all of the patients in the series had previously been victims of incest. I postulated a connection between their childhood mistreatment and characteristics that predisposed victims to repetitive victimization (such as exploitation by their therapists). Therapy must free the incest victim of the burden of repetitive victimization by addressing the following 4 areas of problematic function:

- Severe symptoms and problematic traits that render the patient needy, dependent, and pessimistic about achieving recovery—afraid to displease or to be rejected
- Dysfunctional individual dynamics that drive the patient to enact and reenact problematic scenarios
- Pathological object relations and family dynamics, including the toleration of behaviors and interactions that most would protest with vigor
- Deforming of the observing ego/debased cognition

## Conclusion

The treatment of incest victims is often painful and difficult. However, if approached circumspectly, gently, and with patience, the vast majority of those who have experienced incest can experience considerable improvement and enjoy an enhanced quality of life without succumbing to repeated victimization.

Image by slauz

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