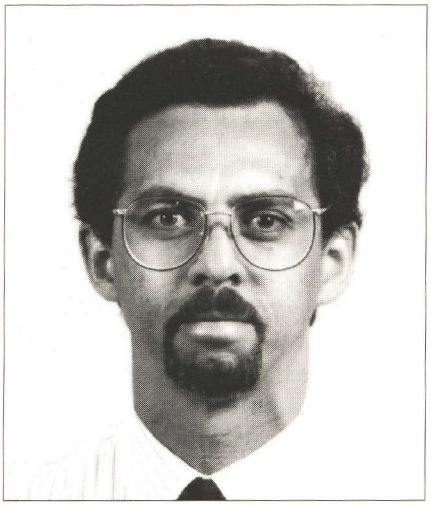
ORIGINAL ARTICLE

Helping Victims of Incest: A Challenge to Family Practice — Graham Bresick



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Curriculum vitae

Graham graduated in 1980 at UCT (MBChB) and did his internship at King Edward V111 in Durban. He spent quite some time at various departments of anaesthetics, but returned to the Cape to Red Cross Hospital and obtained a DCH from the College of Medicine. After general practice work, he joined the SACLA Health Project at Crossroads (Cape) for three years. In 1988 he joined the Primary Care/Family Practice Unit at UCT, where he is presently involved in student teaching, the development of undergraduate curriculum in Family Medicine and clinical work in a community primary care clinic. He is busy doing the MPrax Med through Medunsa, and his medical interests are the application of the philosophy, principles and practice of family medicine in primary care service, and the doctor-patient relationship as an opportunity for enabling personal growth and development. Graham is married to Jenny who works in a pastoral care team.

Summary

Two patients disclosed their secret of incest in a family practice setting, when three aspects of family medicine were put into practice: patient-centredness, a therapeutic relationship and continuity of care. This made the author sensitive to the problem, and by reporting these patient studies, he wants to make family physicians aware of the size if the problem and how well they are placed to care for these patients.

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Physician, Family; Incest; Physician-Patient Relations; Case Report

Patient-centredness, building a therapeutic relationship and continuity of care – these important dimensions of the family practice – enable victims of incest to disclose their 'secret'.

An account of two disclosures is presented and the implications for family practice discussed.

My first contact with JD, age 52, was during a routine visit to the day hospital for her anti-hypertensive medication. Previous history included treatment for a peptic ulcer and depression at a tertiary hospital.

During the consultation she revealed a stressful relationship with her brother. At the end of a follow-up consultation regarding the stress, and while on her way to the door, she expressed the desire to discuss another matter at a subsequent visit. An appointment was made for the following week. She related this story:

While watching a TV documentary on rape, she became aware of feeling intense discomfort but could not understand why. The following day she was visited by an uncle whom she had not seen for 20 years and immediately recalled an incident that had occurred at age 7 years. He had fondled her and threatened that if she told her parents he would deny it and that her father would punish her. The incident was never disclosed.

She expressed feelings of anger and of feeling 'dirty' and questioned whether this incident could have been a factor in her depression, and whether she had been to blame.

DC, a 27 year old woman, presented with intermittent backache, chest pain and sweating. These symptoms had been present for a few weeks and occurred mainly at work. She had consulted many doctors for similar complaints and had received symptomatic treatment.

An inquiry regarding stress revealed a history of rape (for which she had had 6 months of psychotherapy) the previous year. Her work situation was stressful and included demands for sexual favours by her employer.

This disclosure clearly embarrassed DC but she seemed to need to talk about it – even though it was my first

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contact with her. She experienced guilt and inner conflict which she felt accounted for some of her symptoms.

As this was a longstanding and complex problem, I offered her a further consultation and expressed a willingness to help. She expressed relief at having had the opportunity to talk openly and accepted the offer.

Subsequent consultations revealed that she had had a number of admissions to 3 different tertiary psychiatric hospitals from age 17. She was not able or was reluctant to say what diagnosis had been made but revealed a history of 3 overdoses.

She expressed disillusionment with past treatment and was unwilling to consider referral. I therefore decided to establish a therapeutic relationship and provide continuity of care as a basis for further management. A number of sessions went by before she began to respond more openly. Although she was willing to attend, she was reluctant to talk. There was clearly more to her story than had been offered. During this time she was clinically depressed.

Initially she was unwilling to discuss her childhood. When pursuing this at a later stage, she disclosed that she had been the victim of incest perpetrated by two older brothers from age 8 years to 14 years. She had never disclosed this before and doing so was obviously difficult for her and unsettled her for several days afterward.

> Incest occurs far more often than is commonly thought

Discussion

1. The size of the problem

Incest is defined as sexual intercourse or other sexual activity between persons so closely related that marriage between them is legally or culturally prohibited.[1]

Recent reports indicate that incest occurs far more frequently than is commonly thought and that most cases remain hidden. Accurate statistics are not available in South Africa but estimates of child sexual abuse[2] give some idea of the prevalence:

* 80% of abusers are known to the child, most of whom are family members. 20% were found to be the child's natural father.

* approximately one in three girls is sexually abused in some way by age 18 years.

These estimates correlate with American studies: 930 women were interviewed in a random sample of San Francisco households. 38% had been sexually abused before they were 18 years old and 16% had been victims of exploitative incest, ie involving force.[3]

> 80% of abusers are known to the child, often family members

A survey of 796 American college students showed that 28% were victims of incest – half involved siblings – and that 19% had been exploitative.[4]

2. Long-term effects

The presence and severity of long-term effects are related to the degree of force used, the extent of the physical intrusion and the length of the period during which incest occurred.

50% of female victims in a community-based (non-clinical) sample believed that the abuse had significant long-lasting effects on their lives. A clinic-based sample showed much higher rates of long-term effects and greater morbidity.[5]

> About one in three girls is sexually abused by age 18

* very low self-esteem: evident in both the patients presented.

* chronic traumatic neuroses: repetitive thought, emotional and behavioural intrusions eg nightmares, flashbacks, panic attacks, recurrent obsessive ideas, promiscuous behaviour. Patients commonly re-experience the frightening and painful elements of the actual abuse after disclosure and show an exacerbation of their symptoms. Disclosure unsettled DC, requiring more frequent

consultations. JD was destabilised when her memory was triggered and required psycho-emotional support.

* continuing relational imbalances: difficulties with relationships hinder the development of character, a sense of self and maintaining positive relationships. DC has a poor sense of self and has difficult relationships with her family and has no meaningful friendships.

* other long-term effects include depression, anxiety, substance abuse, self-destructive behaviour including suicide, sexual maladjustment.[1] DC periodically abuses alcohol and has taken several overdoses.

Victims of incest in childhood were found to have a higher prevalence of virtually every psychiatric disorder other than anorexia nervosa, mania, pathological gambling and schizophrenia. They also had a higher number of psychiatric diagnoses than comparison subjects.[1]

The two accounts presented differ markedly in terms of the degrees of force used, the duration of incest and the extent of physical intrusions. JD showed a few of the long-term effects and her symptoms resolved quickly. DC required longer-term and more experienced help.

3. Help-seeking pattern and presentation

Most victims do not present with complaints of having been abused. The majority seek help for psychiatric symptoms or interpersonal problems. DC presented with somatisation hiding and underlying depression. In earlier care, the absence of continuity and continuing care probably contributed to this pattern.

JD repressed the memory of the original stressor. Many victims are known to present with the sequelae and the history of incest will only be obtained if memory is triggered.[6]

In both these patients incest remained undisclosed for many years despite repeated contacts with primary, secondary and tertiary services – including psychiatry.

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4. The apparent failure of the services

Both JD and DC had had psychiatric treatment but the incest was never disclosed. DC's treatment included a number of admissions as well as being treated as an outpatient.

Researchers have found that incest victims are generally unlikely to receive benefit from mental health institutions.

"... the underlying negative effects do not emerge in any recognisable form until after disclosure, but incest victims very rarely disclose spontaneously and therapists don't ask. Instead, former victims present for treatment with a characteristic 'disguised presentation'. If this becomes the focus of treatment, the history remains hidden and the effects are not available for treatment."

The result is frustration and failed therapy. Experienced workers have found that although patients do not disclose spontaneously, they will 'almost invariably disclose after specific inquiry ... patients have broken silences of up to 56 years.'[6]

5. Implications for Family Practice

Points to note:

* Incest is a common problem with often serious sequelae.

* Most of the problem is hidden and presents in a disguised manner.

* Facilitating disclosure is the first step in the healing process.

* Experienced workers agree that it is treatable and that much can be done in primary care.

* The size of the problem outweighs specialist services available.

Questions raised:

* can the family medicine approach contribute toward earlier recognition and treatment?

* what attitudes, knowledge and skills are required to help patients in the family practice setting?

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* what treatment is appropriate in family practice?

* what preventive strategies could be applied?

6. Toward assisting (adult) victims of incest in Family Practice

Raising our level of awareness: by reading, speaking to experienced workers and attending seminars, etc. I was sensitised to the problem and its extent through the encounter with two patients who were willing to risk disclosure and become my teachers. They highlighted a gap in my knowledge and experience and stimulated learning.

Identifying victims and facilitating disclosure: aspects of the family medicine approach may enable the identification of victims and facilitate disclosure:

- attention to the therapeutic relationship, person-centredness and continuity of care.

- an understanding of help-seeking patterns which may point to a hidden problem.

- a systems approach to understanding and helping families.

Direct questioning of adults with longstanding psychiatric symptoms is advocated.

In the two accounts given, a patient-centred approach, continuity of care and a therapeutic doctor-patient relationship facilitated disclosure.

Management

'An experienced general clinician is usually able to provide excellent treatment ... given knowledge of the underlying negative effects.'[6]

Both supportive and insight psychotherapy are commonly used in general practice[7] and given a knowledge of incest, the same principles and techniques can be applied.

JD required brief insight and supportive therapy (2 sessions) to restore equilibrium after disclosure.

I found it helpful to set aside an afternoon per week for counselling – it prevents disrupting clinical demands and helps maintain a more appropriate mindset.

DC required more intensive and skilled therapy. This is being done in conjunction with a psychotherapist.

Practical points: I have found it helpful to set aside an afternoon a week for counselling. It helps avoid the disruption of other clinical demands and enables the shift into a more appropriate mind-set. The need for confidentiality has required a separate, confidential patient record.

Referral

Available services depend on the area and should be discussed with a local social worker, psychologist or psychiatrist. Referral should be to someone with experience in dealing with victims of sexual abuse.

All victims of ongoing incest and sadistic incest require referral to a specialist.[6]

7. Prevention – the real challenge

i) In the clinical setting

Incest is a family problem. Family physicians have a concern for the individual within the family context and are therefore well placed. The following should be noted:

* a raised index of suspicion. The hidden nature and high prevalence means that we see (and misdiagnose) many of the victims and potential victims without being aware of it.

* identifying children/families at risk.

The family at risk is one where the mother is emotionally and physically exhausted and the father is demanding and emotionally needy because of a deprived childhood. The daughter begins to fulfil some of her father's emotional needs. Known as the parentified child, she is one who, at an early age, does more than merely help her mother (often a parentified child herself) in the home, but will actually assume responsibility for domestic activities such as cooking, cleaning and caring for siblings etc. If the mother leaves home for a while (eg for a confinement) and the father is angry that his wife is not available, the parentified daughter is at risk of being used to fulfil sexual needs as well.

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** Other risk factors:*
- the disinhibiting effect of alcohol.

- after the emotionally needy father has suffered an important relational loss e.g. the loss of a parent.

- family history: women who are untreated victims of incest are at risk of becoming the mothers of incest victims and the wives of offenders. The parentifying process leads them to choose men who are emotionally deprived and in need of caring. The cycle is then repeated.

Informed history taking and assessing family function may elicit these risk factors. Early attempts to support the family and/or referral for family therapy may be important preventive interventions.

ii) Beyond the clinical setting – Rape Crisis publication[2]
* promoting children's rights.

* working toward improving the status of female children and adults in a male dominated society.

* promoting respect for children.

* educating children to recognise situations/actions which place them at risk and how to respond in such situations.

* altering the perspective that sex and violence are two sides of the same coin.

* campaigning for a more appropriate Child Care Act.

Conclusion

While some may consider treatment of incest victims by family practitioners to be inappropriate, the size and seriousness of the problem demand the following:

- an awareness of the nature and extent of the problem.

- an ability to recognise a victim and someone at risk.

- an ability to facilitate disclosure and manage the immediate post-disclosure phase sensitively.

- knowledge of available resources for help and referral.

Research in the family practice setting could make a significant contribution to understanding and treating the victims of incest – many of whom have significant morbidity. The size of the problem suggests that the rate of mis-diagnosis and inappropriate treatment results in significantly prolonged suffering and wastage of resources.

Help should be more readily available for victims in the community, eg community health centres should have a trained person who can provide a primary level of care and collaborate with other workers.

Prevention provides the biggest challenge. Much of our work is '...often like pulling drowning people out of the river, never having the time to go upstream and stop whoever is pushing them in.'[8]

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