DOCUMENT RESUME

ED 310 313 CG 021 889

AUTHOR Gregory-Bills, Therese; Vincent, Ken
TITLE Psychopathology and Incest: A DIPS Code Type Assessment.
PUB DATE Apr 89
NOTE 30p.; Paper presented at the Annual Meeting of the Southwestern Psychological Association (35th, Houston, TX, April 13-15, 1989).
PUB TYPE Reports - Research/Technical (143) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS *Behavior Disorders; Depression (Psychology); *Emotional Disturbances; Emotional Problems; *Incest; Mental Disorders; Neurosis; Personality Assessment; Personality Measures; *Psychopathology; *Sexual Abuse
IDENTIFIERS Beck Depression Inventory; Diagnostic Inventory of Personality and Symptoms

ABSTRACT

The Diagnostic Inventory of Personality and Symptoms (DIPS) was used to examine psychopathology in 30 therapy outpatients with histories of incest. Subjects also responded to the Beck Depression Inventory (BDI). Correlations were used to examine characteristics of the sample and to identify circumstances of their experiences of incest which significantly related to psychological adjustment. More severe psychopathology was found with brother perpetrators (who also used more force and violence) than with father perpetrators. Eating disorders were significantly more common in incest victims who had maintained secrecy about the incest, while disclosure significantly related to the absence of an eating disorder. The sample produced a mean Affective Depressed (AD)-Dissociative Disorder (DD) code type and a mean Neurotic Personality Disorder Cluster Diagnosis. The AD-DD code type was also the actual code type seen in 13 cases. This subsample experienced significantly more severe sexual violation than the remainder of the sample. As the experience of the most severe sexual acts also related to increasing symptoms related to the dissociative disorder, researchers inferred that more severe sexual violation is implicated in the use of dissociative coping strategies. (Author/TE)

PSYCHOPATHOLOGY AND INCEST: A DIPS CODE TYPE ASSESSMENT

Therese Gregory-Bills,

Ken Vincent

University of Houston

Running head: PSYCHOPATHOLOGY AND INCEST

ABSTRACT

The Diagnostic Inventory of Personality and Symptoms (DIPS) was used to examine psychopathology in 30 therapy outpatients with histories of incest. Subjects also responded to the Beck Depression Inventory (BDI). Correlations were used to examine characteristics of the sample and to identify circumstances of their experiences of incest which significantly related to psychological adjustment. More severe psychopathology was found with brother perpetrators (who also used more force and violence) than father perpetrators. Eating disorders were significantly more common in those individuals who had maintained the incest a secret while disclosure significantly related to the absence of an eating disorder. The sample produced a mean Affective Depressed (AD) - Dissociative Disorder (DD) code type and a mean Neurotic Personality Disorder Cluster Diagnosis. The AD-DD code type was also the actual code type seen in 13 cases. This sub-sample experienced significantly more severe sexual violation than the remainder of the sample. As the experience of the most severe sexual acts also related to increasing symptoms related to the dissociative disorder, it was inferred that more severe sexual violation is implicated in the usage of dissociative coping strategies.

Key words: Incest, Dissociation, Eating Disorder, Sexual Abuse, Victimization, Psychological Assessment

INTRODUCTION

Alarming prevalence rates of incestuous abuse of children and adolescents are being found. For example, in a recent survey of 935 women in the general population, 16% reported at least one experience of sexual abuse by a relative before age 18 (Russell, 1986). Furthermore, individuals in psychological treatment are as equally represented by women with histories of incest (30 to 33%) (Gelinas, 1983) as the general population is represented by individuals who are left handed (25 to 35%). It has been suggested that these statistics are not new. They merely reflect a greater greater social awareness of these occurrences because the taboo of adults having sexual relationships with children, is no longer as powerful as it had been in preventing the disclosure and investigation of these issues (Butler, 1978; Forward and Buck, 1978).

Despite these alarming prevalence rates, until most recently, there has been little or no mention of incest in psychology or psychiatry books (Herman and Hirshman, 1977). It is noteworthy also that the Diagnostic and Statistical Manuals of Mental Disorders III (DSM-III) (American Psychiatric Association, 1980), nor any of the earlier versions, does not mention incest or have any separate category for incest (Renshaw, 1982).

Moderate to severe emotional disturbances are being found in children being treated in the immediate aftermath of experiences of incest and sexual abuse (Adams-Tucker, 1982). Many of these children suffer from posttraumatic stress disorder (Goodwin, 1986). In many cases, the negative effects of incest have been found to persist into adulthood. For example, Armsworth (1984) found the reports of 43 women who experienced incestuous relationships as children or adolescents, to be consistent with the criteria for delayed posttraumatic stress disorders. Herman, Russell, and Trocki (1986) describe that in adulthood, the symptoms of this disorder may become chronic and integrated into the victim's personality structure. Many of the common clinical symptoms reported are a consequence of the partial or complete repression of memories about the incest trauma, unbidden thoughts or reminiscences about the experience, or attempts to avoid their

intrusion. According to Herman et al. (1986), the resulting personality is described to be fearful and hypervigilant and the trauma may be reenacted in nightmares, flashbacks, and dissociative states. Attempts to avoid intrusive thoughts about the trauma frequently result in social isolation, drug and alcohol abuse, and eating disorders. Symptoms of depression, anhedonia, dissociation, self-destructive behavior, and suicide attempts are commonly reported (Maltz & Holman, 1987). Also commonly experienced are problems with impulse control, difficulties trusting, problems in sexual functioning, parenting difficulties, periods of promiscuousness, and tendencies towards revictimization (Tsai and Wagner, 1978; Benward and Densen-Gerber, 1975; Justice and Justice, 1979; Meiselman, 1978; Herman and Hirschman, 1977). Even undisclosed cases are identifiable by the uniformity of symptoms that manifest. For example, Gelinas (1983) describes the "disguised presentation" of this undisclosed victim to be a "characterological depression with complications and with atypical impulsive and dissociative elements" (pp.326).

Recent research attempts have been stimulated to find a particular diagnostic entity that would describe individuals who experienced incest in childhood or adolescence. Several investigators have used the Minnesota Multiphasic Personality Inventory (MMPI). These studies are beginning to establish an MMPI typology for individuals with histories of incest. The most common profile identified for this group indicated pathological elevations on Scale 4 (psychopathic deviate (PD)) and Scale 8 (Schizophrenia (Sc)) (Meiselman, 1980; Scott and Flowers, 1988; Scott and Stone, 1986a; Scott and Stone 1986b; Tsai, Feldman-Summers, and Edgar, 1979). In addition to elevations above a T-score of 70 for Scales 4 and 8, Meiselman also found pathological elevations in the mean profile of the 16 adult psychotherapy patients studied on Scale 2 (Depression (D). Other slight deviations from the common 4-8 profile come from a study by Scott and Thoner (1986) whose incest group of 30 females produced mean profile elevations above a T-score of 70 on Scale 8 only. While Scale 4 was second highest in this study, it only approached the critical T-score value of deviance (a T-score of 68). Similarly, Winterstein (1982) found her incest group to be elevated on Scale 8.

Characteristics of individuals who produce the 4-8 profile have been identified. For example, Dahlstrom, Welsh, & Dahlstrom (1972, cited in Meilselman, 1980) interpret this profile pattern to describe individuals who are impulsive and delinquent, socially isolated and possibly prepsychotic. Scott and Thoner (1986) note how coerced participation in incest could explain the Scale 4 characteristics of antisocial and hostile externalizing. Role reversals and ego fusion with the mother are likely contributors to the long-term disturbances in ego identity seen in many individuals who experienced incest and as indicated by Scale 8 characteristics. Tsai et al (1979) describe the 4-8 profile as one that includes a) a history of poor family relationships; b) an early establishment of distrust towards the world; c) poor social intelligence and difficulty in becoming emotionally involved with others; d) sexuality seen as a hostile act through which anger is released; e) low self-concept; and f) a characteristic pattern of choosing men inferior to themselves in their relationships.

Another psychometric measure of psychopathology is the Diagnostic Inventory of Personality and Symptoms (DIPS) (Vincent, 1985). This is a brief test of psychopathology built from the descriptors and criterion of the DSM-III (American Psychiatric Association, 1980) diagnostic categories for Axis I and II.

A large scale study has examined the relationship between the DIPS and the DSM-III classifications. This study developed 16 DIPS code types and 5 personality disor'r cluster diagnoses, and related these to DSM-III Axis I Diagnoses for 316 patients (both males and females) in private mental health settings (Williams et al., 1988). In this study it was possible to obtain separate DSM-III clinical diagnoses from the patients' records or directly from the treating psychiatrist. These were subsequently compared to the DIPS code types and personality disorder cluster diagnoses produced by the same groups. On the basis of this study, the DIPS appears to differentiate among the major DSM-III categories (Williams et al., 1988). The DIPS "hit rate" for the sample (using code type analysis) was 75%. This compares to a diagnostic category hit rate of correct classification for the MMPI of 79% (Vincent et al., 1983). Thus the DIPS appears to be working as well as the MMPI and has

the advantage of brevity. In addition, a system using scales based on Bayesian probability, resulted in correct classification of specific primary diagnosis in a private patient setting of 70% (Vincent and Duthie, 1986).

While research on the DIPS code types has been done for patients in both private and public institutional settings, it has not thus far been used specifically for assessing individuals who were incestuously abused in childhood or adolescence. The purpose of this study then is threefold: a) to assess the utility of the DIPS for identifying individuals with earlier experiences of incest by comparing the sample's profile from this scale with clinical descriptions of psychological adjustment associated with women who have experienced incest in childhood or adolescence; b) to delineate the psychological profile for adult women who experienced incest in childhood or adolescence; and c) to identify experiences of the incest that related to adult psychological adjustment.

METHODS

Subjects

Participants were recruited from mental health agencies, an incest survivors group, and private therapists in the Houston, Texas and its vicinity. A few participants were also obtained from private therapist's in other states who responded to an add in a newsletter which requested assistance in recruiting volunteers. The sample consisted of a clinical group of 30 women reporting experiences of incest in childhood or adolescence. These individuals had been in therapy from 3 months to 20 years. Most reported from 2.5 years to 10 years of psychological treatment (individual counseling, group therapy, and a few hospitalizations). Their ages ranged from 18 to 48 years old, with the majority of the sample (43%) between the ages of 26 and 33. Educational levels ranged from 2 individuals with less than a high school degrees to 2 Ph.D. degrees. Most (37%) had some college or technical training. Common occupations reported were student, registered nurse, homemaker, teacher, and clerk. Three individuals in this sample were diagnosed with

multiple personalities and all three reported the onset of sexual abuse between the ages of 6 months and 2 years. A fourth individual, whose diagnosis was not known, stated that "I feel like I have 2 separate persons or personalities." For their participation, those volunteers who requested, could receive the results of this study.

Materials

The participants provided background information about themselves and about their experiences of incest. Data were gathered on the following variables: present age, occupation, highest degree obtained, length of time in therapy, relatedness to perpetrator, age(s), duration, and frequency of incest, type of sexually abusive acts, whether force or violence was involved, and whether they told anyone about the abuse, and if they did, whether or not the response they received was supportive. In addition, respondents provided information as to whether or not, since the abuse, they had experienced any of the following: battering, rape, panic attacks, memory loss, anorexia, bulimia, and/or obesity (Table 1).

Insert Table 1 about here

Participants also completed the Diagnostic Inventory of Personality and Symptoms (DIPS) (Vincent, 1985). This is a brief (171 item) test of psychopathology. It consists of a 4 item validity scale, 11 scales which correspond to Axis I Diagnostic Categories of the DSM-III (APA, 1980), and 3 Character Disorder Scales corresponding to a collapsed version of the Axis II Diagnosis of the DSM-III (Vincent, 1987a). The 11 axis I diagnostic scales are: Alcohol Abuse (AA), Drug Abuse (DA), Schizophrenic Psychosis (SP), Paranoid Psychosis (PP), Affective Depressed (AD), Affective Excited (AE), Anxiety Disorders (AX), Somatoform Disorders (SO), Dissociative Disorders (DD), Stress Adjustment Disorders (SA), and Psychological Factors Affecting Physical Condition (PC). The 3 DIPS Character Disorder Scales, collapsed from DSM-III Axis II Character Disorders include: 1) The Withdrawn Character (WC) Scale corresponding to the odd or eccentric DSM-III

personality cluster which includes paranoid, schizoid, and schizotypal personalities; 2) The Immature Character (IC) scale corresponding to the dramatic emotional, and erratic personality disorder cluster of DSM-III and includes histrionic, narcissistic, antisocial, and borderline personality disorders; and 3) The Neurotic Character Scale corresponding to the DSM-III personality disorder cluster of anxious and fearful personality disorders, which includes avoidant, dependent, compulsive, and passive-aggressive personality disorders (Vincent, 1987a).

Validity for the DIPS scale was established through content, criterion, and construct validity procedures. Content validity was insured as the scale was made from the description and criterion sections for the various disorders of the DSM-III. Criterion validity was established from comparisons of mean profiles of normal subjects, private patients, and Veteran's Administration patients. These comparisons indicated that the scale was able to differentiate normality from abnormality. Principal component factor analysis was used to examine the construct validity of the DIPS. The 3 factors resulting from the rotation accounted for 70% of the total item variance, which is indicative of an internally consistent instrument. Test-retest reliability for the DIPS scale was .78 indicating that it is able to measure consistently and accurately under varying conditions.

Participants also completed the Beck Depression Inventory (BDI) (Beck and Ward, 1961). The BDI is a 21-item scale of attitudes and symptoms of depression. It was designed to assess the depth of depression in clinically depressed persons. Scores on the BDI range from 0-63. Scores from 0-9 indicate that the individual is "not depressed;" from 10-15 the individual is "mildly depressed;" and from 24-63 the individual is "severely depressed" (Bumberry, Oliver, & McClure, 1978). Split-half reliability for the BDI on 97 psychiatric patients was 0.93. Criterion validity was established from comparisons of psychiatric assessment of depression in 2 clinical samples with their scores on the BDI. The comparison yielded biserial correlation coefficients of 0.65 and 0.67 for each of the samples (N = 226 and N = 183 respectively) (Beck & Ward, 1961). The BDI has been validated with clinical diagnoses of depression, (Beck and Ward, 1961; Bumberry, Oliver,

and McClure, 1978; Reynolds and Gould, 1981; Strober, Green, and Carlson, 1981) and it was used for descriptive and validation purposes, and as an indirect assessment of clinical diagnosis for the present sample in which, in only a few cases, actual clinical diagnoses were available.

Design

Psychopathology was examined by mean "2 Point Code Types" obtained by the 30 participants on the DIPS Scale. These 2 Point Code Types represent the two scales (in excess of a T-Score of 70) from DIPS Scales 1-11, on which the highest scores were obtained. As described above, the 2 Point Code Types also correspond to DSM-III Axis I Diagnosis (APA, 1980). A personality disorder diagnosis was also obtained from mean scores in excess of a T-Score of 70 on DIPS Scales 12-14. These scales correspond to the Axis II Broad Personality Disorder Clusters of the DSM-III (Vincent, 1987a).

Demographic data, circumstances of the incest, and the samples' scores on the BDI and the DIPS were then correlated for 1) the total sample of 30 individuals with histories of incest, and 2) for any sub-sample(s) of greater than 6 cases that produced the same 2 Point Code type (consistent with previous research on the MMPI by Gilberstadt and Duker (1965), Kelly and King (1977), and Vincent et al, (1983)). The following background information was coded for the analysis: a) their present age, b) the amount of therapy they had received, c) their age at onset of the incest, d) its duration, e) the relationship to the perpetrator or, in cases of multiple perpetrators, the primary perpetrator, f) whether or not the incest was disclosed, and if so, g) whether or not the response received was supportive, whether or not the individual had experienced h) rape, i) panic attacks, j) an eating disorder (obesity, anorexia, and/or bulimia), or k) memory loss, and l) the types of sexual acts experienced. The types of sexual acts were collapsed to relate to the degree of sexual violation and were assigned to the following three-category typology defined by Russell (1983): (1) Least Serious Sexual Abuse, including experiences ranging from kissing, intentional sexual touching of the buttocks, thigh, leg or other body part, including contact with clothed breasts or genitals, whether by force or not; (2) Serious Sexual Abuse,

including experiences ranging from forced digital penetration of the vagina to nonforceful breast contact or simulated intercourse; and (3) Very Serious Sexual Abuse, including experiences ranging from intercourse, oral-genital contact, to anal intercourse, whether by force or not.

Procedure

Participants were recruited through mental health agencies and private therapists in Houston, Texas, and its vicinity. These agencies and therapists were contacted by phone and sent letters describing the research and requesting assistance in recruiting volunteers. Those who agreed to help were sent questionnaire instruments. A few participants were also obtained from private therapist's in other states who responded to an add in a newsletter which requested assistance in recruiting volunteers. Questionnaires were subsequently provided to clients and group members who agreed to participate and whose current work in treatment was related to earlier experiences of incest.

The questionnaire was accompanied by a cover letter explaining the project, about the researcher, and their rights as subjects. The participants were requested to complete the questionnaire in their homes and to return it sealed in the envelope provided, within the following week or two. These were subsequently mailed to, or picked up by the researcher.

The DIPS and the BDI were hand scored. The DIPS contains a validity scale and the resulting profiles were screened for validity. All participants produced valid profiles.

Definition

Incest

For the purpose of this investigation, incest subjects were chosen on the basis of the psychosocial definition of incest developed by Sgroi, Blick, and Porter (1982). This definition of incest includes any form of sexual activity performed between a child and a parent or step-parent, extended family member or surrogate parent (common-law spouse,

foster parent). The crucial psychosocial dynamic in this definition is the exploitation of a child's dependency needs by persons in kinship roles.

RESULTS

Background characteristics of the present sample, particularly circumstances related to their earlier experiences of incest, are shown in Table 1. Seventy three percent of the sample was represented by individuals for whom the incest began prior to age 8. Variable abuse durations were reported, ranging from 3 months to 22 years, with one woman, age 28, reporting that "it still happens." Forty percent of the sample experienced incest from 1 to 5 years. Another 44% of the sample experienced from 6 to 15 years of incestuous abuse. Fifty-seven percent of the sample experienced the most severe sexual acts (i.e. their incest experiences fit into the "most severe" category identified by Russell, 1983). The perpetrator in 50% of the cases was the biological father. Stepfathers were the offenders in another 17% of the cases. In 33% of the cases the perpetrator was an older brother. Only 33% of the sample had disclosed the incest while it was occurring. Of these 10 individuals who told, responses to the disclosure were supportive in only 2 cases. One individual was not included with those who disclosed the incest because she did not tell until after it ended and she had moved out. This individual described that she was "begged, then threatened not to tell by the abuser." However, at age 18, after she had moved out, she told her mother and was "not believed." Thirty percent of the sample were subsequently raped as teenagers or adults later in life.

Fifty percent of the sample scored in the "severely depressed" category range of the Beck Depression Inventory (BDI) (Blumberry et al, 1978). Seventeen percent were "moderately depressed," 23% mildly depressed, and 10% not depressed. The correlation between the present sample's BDI scores, and their scores on the DIPS Affective Depressed Scale was significant ($r = 0.73$, $P < 0.0001$).

The sample of individuals with histories of incest produced an overall mean Affective Depressed (AD) - Dissociative Disorder (DD) (5-9) code type on the DIPS (Figure 1). This profile is indicative of persons reporting marked feelings of dysphoria and a significant loss of interest or pleasure. These individuals are likely having very significant depression accompanied by a very significant amount of dissociative phenomena. Feelings of unreality are present and depersonalization is likely. In addition, problems with identity are indicated (Vincent, 1987b).

Insert Figure 1 about here

The mean DIPS Personality Disorder Diagnosis accompanying this sample's Affective Depressed - Dissociative Disorder code type was in the Neurotic Character Disorder Cluster. Significant elevations on the neurotic character scale correspond to the anxious or fearful cluster of the DSM-III personality disorders such as avoidant, dependent, compulsive, and passive-aggressive disorders (Vincent, 1987a). Such individuals are described by Vincent (1987b) to be overconsciencious, sensitive, passive, and rigid. Persons of this profile type are also described to be often negative towards themselves and chronically anxious.

Psychotic disorders, not elsewhere classified, were also represented by 1/3 of this sample. Alcohol and/or drug abuse was seen in 4 of the 30 cases in this study. Eighty-seven percent of the sample reported current or past histories of eating disorders--anorexia, bulimia, and/or obesity. Thirty percent were subsequently raped as teenagers or adults later in life. Battering (57%), panic attacks (70%), and memory loss (57%) were also reported by a sizeable proportion of this sample. While the majority of the sample reported heterosexual preference, 13% reported homosexual preference, 7% indicated a bisexual preference, 7% described themselves as "asexual," and one individual "didn't know."

One code type, represented by greater than 6 cases, was found. This was the Affective Depressed - Dissociative Disorder code type seen in 13 cases and which was also discussed above as the overall mean code type for the entire sample. This subsample of 13 cases

differed from the remainder of the sample in some specific ways. Sixty-two percent scored within the Withdrawn-Neurotic personality disorder cluster. This corresponds to elevations on the "odd" or eccentric cluster (paranoid, schizoid, and schizotypal) and the anxious or fearful cluster (avoidant, dependent, compulsive and passive-aggressive) of the DSM-III. The simultaneous elevations of these clusters indicate a combination of oversensitivity and social withdrawal with anxiety and passivity that is most apt to be seen in individuals with an avoidant personality (Vincent, 1987b). No other personality disorder was found to be consistently represented by this sub-group of 13.

Also significant for those individuals who produced the actual AD-DD code type, is that in almost 1/2 of this sub-group, psychotic disorders, not elsewhere classified, were represented. Six out of the 10 cases found in the total sample were in the sub-group of 13 producing the 5-9 code type. One case from this sub-sample scored above a T-Score of 70 on the DIPS Alcohol and Drug Abuse Scales.

Five individuals produced a "floating" code type. A floating profile is one in which 6 or more of the Axis I scales are greater than a T-Score of 90. Although this represented insufficient cases to be identified as a code type in this sample, it is described due to the clinical relevance of this profile to certain individuals with earlier experiences of incest (Barnard and Hirsch, 1985; Cohen, 1981; Brooks, 1982).

Individuals who produce floating profiles are often seen as borderline personality disorders who are evidencing either an extreme adjustment disorder or a brief reactive psychosis. Substance abuse is also often part of the clinical picture (Vincent, 1987b). Indeed, 3 of the 5 individuals producing a floating code type also abused drugs and/or alcohol (produced a T-Score > 70 on the DIPS Alcohol and/or Drug Abuse Scales). Three of the 5 floating code types also produced significant elevations on all three of the character disorder scales, namely: Withdrawn Character, Immature Character, and Neurotic Character. These correspond to elevations in all three of the personality disorder clusters of DSM-III: "odd" or eccentric; dramatic, emotional, or erratic; and anxious or fearful. A personality disorder cluster such as this is likely indicative of a borderline personality

disorder (Vincent,1987b). The remainder of the floating code type cases produced a Withdrawn-Neurotic personality disorder cluster described above.

Correlational Characteristics of the Sample

Correlations were used to 1) examine characteristics of the total sample, and 2) to identify circumstances of the sexual victimization which were different for the sub-sample producing the 5-9 code type from the remainder of the sample. The circumstances examined were: a) the age of onset of the incestuous abuse, b) its duration, c) the degree of sexual violation, d) the relationship to the perpetrator, e) whether or not the abuse was disclosed, and if so, f) whether or not the response received was supportive, g) whether or not the individual was subsequently raped as teenagers or adults later in life, and h) the amount of therapy received. Some of these correlations follow:

The younger the child at the onset of the incest, the more likely the father was the perpetrator ($r = -0.36$, $p = 0.05$). Fathers were also involved in longer durations of the incest ($r = 0.38$, $p = 0.03$). More severe symptomatology on the DIPS Affective Depressed, Dissociative Disorder, and Schizophrenic Psychosis Scales was found when the brother was the perpetrator ($r = 0.38$, $p = 0.03$; $r = 0.39$, $p = 0.03$; and $r = 0.44$, $p = 0.01$ respectively). While there were no significant differences, between the severity of the sexual acts perpetrated by fathers versus brothers, 75% of the brothers were reported to have been forceful and aggressive as opposed to 16% of the fathers.

The younger the child at the onset of the incest the more neurotic symptoms manifested ($r = 0.55$, $p = 0.001$). Panic attacks and reports of memory loss were also significantly related to younger ages at onset of the incest (-0.47, $p = 0.009$ and -0.45, $p = 0.01$ respectively).

Correlations between the BDI and Not Disclosing the incest indicated a tendency towards more severe depression as an adult if the incest was maintained a secret ($r = 0.34$, $p = 0.06$). Eating disorders were also significantly more common in those individuals who had maintained the incest a secret ($r = 0.39$, $p = 0.03$), while disclosure significantly related to the absence of an eating disorder ($r = 0.43$, $p = 0.01$). All but 4 individuals in

this sample reported having an eating disorder (anorexia, bulimia, and/or obesity) in their backgrounds. These same 4 without histories of eating disorders, also disclosed the incest while it was occurring. Tetrachoric correlations between the BDI and a history of an eating disorder, and the Affective Depressed Scale and a history of an eating disorder, also suggested that depressive symptoms were more severe if the individual also had an eating disorder ($r = 0.35$, $p = 0.05$ and $r = 0.36$, $p = 0.05$ respectively).

Depressive, withdrawn, and neurotic symptoms decreased with increasing duration of therapy ($r = -0.35$, $p = 0.01$, $r = -0.35$, $p = 0.01$ and $r = -0.43$, $p = 0.0016$ respectively). The amount of therapy received by the 13 sample members who produced the actual AD-DD code type and the remainder of the sample however, were not significantly different ($.95t29 = 1.699$ which is $> .864$).

Subsequently examined were differences in the experiences of the incest of those 13 sample members who produced the actual AD-DD code type and the remaining 17 sample members. Only one circumstance of the incest, the Severity of Sexual Violation, significantly differentiated the groups ($r = 0.38$, $p = 0.03$). Those individuals producing the AD-DD code type experienced, on average, significantly more severe sexual acts than the remainder of the sample. This group also reported dissociative symptoms more commonly than the remainder of the sample. Furthermore, the severity of sexual violation related to increasing usage of dissociative coping strategies ($r = 0.25$, $p = 0.05$). The full symptom cluster of the Withdrawn Personality Disorder was also more likely if the individual experienced the most severe sexual violation ($r = 0.32$, $p = 0.02$).

Discussion

The diagnostic information obtained from the DIPS for 30 therapy outpatients with histories of childhood or adolescent incest was remarkably similar to the clinical impression identified by Gelinas (1983). She described the disguised presentation of the undisclosed incest victim, to be that of "a characterological depression with complications

and with atypical impulsive and dissociative elements" (p. 326). Similar to this clinical description, our sample produced an Affective Depressed-Dissociative Disorder Code Type.

The chronic depression seen in many individuals with histories of incest is related to long term low self-esteem, unresolved feelings of shame and guilt, experiences of helplessness, hopelessness, and powerlessness, and unexpressed anger. Dissociation is described to have been a coping mechanism learned during the abuse. Maltz and Holman (1987) describe that "they create a mind-body split so they do not have to stay mentally present and fully experience the discomfort or pain of the abuse" (p. 34). However, this method of coping frequently persists long after the abuse has terminated. In many cases, dissociation can become a general and automatic response to other situations in which strong emotions are evoked (Maltz & Holman, 1987; O'Brien, 1987). However, because dissociation frequently blocks a significant experience from conscious memory, Maltz and Holman described that the survivors are sometimes left not feeling fully themselves in many other situations. There is a general sense of feeling unconnected within themselves and with life.

Despite the significance of dissociation to the clinical symptoms found in many individuals with histories of incest, it has received relatively little empirical attention. This is because, to date, the DIPS is the only standardized instrument available that contains a measure of dissociation. Another reason is that the MMPI has been the most popular instrument to assess psychopathology in individuals with histories of incest. However, the MMPI does not directly tap dissociation. The closest measure of dissociation contained in the MMPI is a 3-8 (hysteria-schizophrenic) profile. However, dissociation is only found in 9.5% of the individuals who produce this profile. The findings of this study, and the growing body of clinical literature addressing the significance of dissociation to this population, suggest that the DIPS may be an important scale to assess psychopathology in individuals with histories of incest.

Because the Affective Depressed - Dissociative Disorder profile found for the present sample coincided with that predicted from clinical observations, an attempt was made to understand how the 13 individuals who produced this actual code type, differed from the remainder of the sample. Specifically examined was whether the experiences surrounding the incest for those who produced the 5-9 code type, were any different than the experiences of the remainder of the sample. One circumstance was found to differentiate the groups. Those who produced the actual Affective Depressed - Dissociative Disorder code type experienced the most severe sexual acts, while the remainder of the sample, on average, experienced less serious sexual violations. As dissociative symptoms increased with increasing severity of sexual violation, it is suggested that dissociative coping strategies will be more commonly found in individuals with experiences of incest that involved the most serious sexual violations than in those individuals whose experiences of incest involved less serious sexual acts.

The 13 cases that produced the actual Affective Depressed - Dissociative Disorder code type were also different from the remainder of the sample in that they reported symptoms of the Withdrawn Character Disorder while the remainder of the sample did not. As withdrawn symptoms also increased with increasing severity of sexual violation, it is suggested that, not only is the Affective Depressed - Dissociative Disorder (Axis I) diagnosis affected by differences in the experiences of the incest, but so is the personality disorder (Axis II) diagnosis.

Symptoms of the withdrawn character disorder found in the sample may be related to the disruption of emotional and social development precipitated by experiences of incest. Ganzarain and Buchele (1986) note that "incest marks the end of childhood and the beginning of a pseudo-adult sexual life" (p. 552). Their existence in a household with blurred boundaries as well as their premature sexual experiences, cause them to feel isolated and different from peers. Feelings of shame, guilt, low self-esteem, and knowledge results in further isolation. As they withdraw, the peer group is lost as a resource for their emotional growth and for connecting with themselves and with others. It

is likely that increasing severity of the types of sexual acts experienced, played a role in augmenting feelings of shame, guilt, low self-esteem, and of being different, thereby intensifying the need to withdraw. This may explain why symptoms of the withdrawn character disorder were more commonly found in those individuals who reported experiences of the most severe sexual acts. Similar to the generalizing effect of dissociation, coping by withdrawal tends to persist into adulthood. Not only are the social skills lacking, but unresolved feelings of shame, guilt, and low self-esteem perpetuate the need to withdraw.

The finding that more severe pathology resulted when the brother was the perpetrator as opposed to the father is not as frequently found in the literature. More commonly, studies have identified more serious impact when the incest was perpetrated by the father (Finkelhor, 1979; Herman et al., 1986; Russell, 1986). However, in the context of the present sample, this finding may be quite relevant and a discussion of this is warranted. In this regard, Forward and Buck (1978) describe that sibling incest that is harmful most commonly occurs in one of two situations: 1) with an older brother who either takes advantage of a younger sister's naivete to satisfy his sexual cravings, or 2) to cope with various unconscious conflicts. As an example of the latter, a brother may sexually abuse his little sister as a means of acting out his aggression toward his mother. Because of the aggressor's hostility, this form of incest is often violent. They further argue that the greater the age difference between siblings, the more violent the incest tends to be. Also, they note that the more violent the sibling incest, the more destructive the trauma. Similarly, Gelinas (1983) points out that sibling incest may have greater potential for rivalry and unrestrained viciousness than incest by a father figure whose paternal role itself, and the greater impulse control of the adult, may protect the child victim somewhat.

The aggressive psychodynamics of sibling incest may be relevant to this sample, thus accounting for the finding of greater psychopathology when the incest was perpetrated by a brother as opposed to a father. Although brother perpetrators did not dominate the total sample, nor significantly differentiate the subgroups, 63% of the total number of brother

perpetrators were in the sub-sample who produced the actual AD-DD code type and who also experienced significantly more severe sexual violation than the remainder of the sample. Furthermore, the use of force and/or violence was more commonly reported when brothers were the perpetrators (63%) as opposed to when fathers were the perpetrators (16%) and more of the brothers who used violence and force (4 of 5) were in the sub-sample than in the remainder of the sample (1 of 3). (Data presented on perpetrators, describes 8 of the 10 brother abusers and 19 of 20 father abusers, representing the cases in which the brother or father was the main perpetrator.)

An additional characteristic of this sample which may further account for more severe psychopathology found when the brother was the perpetrator as opposed to the father is that in this sample, only 5 of the 20 cases of father perpetrators were step-fathers. Finkelhor (1984) describes that natural fathers, as opposed to step-fathers, have more built in restraints and feelings of protectiveness because of their blood relatedness to their daughters. Consequently, natural fathers are less likely than step-fathers to use force or violence.

Maintaining the incest a secret, or disclosing the incest, regardless of whether or not the response received was supportive, did not appear to strongly influence psychopathology in this sample. However, eating disorders were significantly more common in those individuals who had maintained the incest a secret, while disclosure significantly related to the absence of an eating disorder. Current or past histories of anorexia, bulimia, or obesity were surprisingly prevalent in this sample. A later study will examine eating disorders in the context of earlier experiences of incest.

Limitations

Certain limitations of this study should be acknowledged. It cannot be said with certainty that the levels of psychological adjustment found in this sample were caused by their earlier sexual traumas. It is possible that the development of psychopathology in these women was completely unrelated to their histories of incest. In addition, the true picture of psychopathology may have been obscured by the high incidence of current or past

histories of eating disorders reported in this sample. It may be that the eating disorder, and its impact on personal and interpersonal functioning, as well as the psychological effects secondary to starvation or binging, altered the representation of psychopathology that was related to the incest. Alternatively, psychopathology related to experiences of incest may have precipitated the eating disorder. The eating disorder would then be a symptom of the psychopathology, thereby completing the picture rather than obscuring it. One way or the other, given the increasing number of reports of eating disorders being found in individuals with histories of sexual victimization (Root & Fallon, 1988; Wooley & Wooley, 1986; Oppenheimer et al., 1985; Gregory-Bills, 1989), it is unlikely that other studies have not unwittingly had this confounding factor associated with their samples of individuals with histories of incest. Furthermore, women who volunteer might not be representative of incest history patients in general. The data were obtained through self-report. This fashion of data collection is always subject to conscious distortion and/or memory deficit. Moreover, the defensive structure of the respondent may invalidate or distort self-evaluative data. Nevertheless, it is also important what an individual believes they experienced. Even if distorted and flawed, these self-perceptions are an important determinant of current psychological adjustment.

Completely definitive conclusions regarding what really "caused" the psychopathology evident in many individuals with histories of incest, can never really be drawn from one study alone. Ex post facto research, in which what is being measured has already occurred, can never result in cause and effect interpretations. Not only is there no control over all the factors from youth to adulthood that may have produced a vulnerability to psychological maladjustment, but it is also extremely difficult to control for all the extraneous variance associated with being human. We do not perceive experiences nor respond uniformly to any condition. Even more complexly operating to prohibit precise understanding of what caused what, are all the ways different factors interact to influence an outcome.

Nevertheless, we have addressed the purpose of this investigation despite the limitations addressed above. Considering the commensurate diagnostic findings of this study with clinical interpretations, the DIPS appears to be a useful measure of psychopathology for individuals with histories of incest.

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TABLE 1. Characteristics of Clinical Sample of Women with Histories of Intra-Familial Sexual Abuse (N = 30)

Characteristic	N	%
PRESENT AGE		
18-25	4	13
26-33	13	43
34-41	8	27
42-48	5	17
EDUCATION		
Less than high school	2	7
Highschool	6	20
Some college or technical school	11	37
Bachelors degree	6	20
Some graduate work	2	7
Masters degree	1	3
Ph. D. degree	2	7
AMOUNT OF THERAPY		
3 mo. - 6 mo.	5	17
7 mo. -11 mo.	1	3
1 yr. - 2 yr.	3	10
2.5yr.- 5 yr.	8	27
6 yr. -10 yr.	11	37
11yr. -15 yr.	1	3
16yr. -20 yr.	1	3
AGE OF ABUSE ONSET		
0 - 3	10	33
4 - 7	12	40
8 - 11	7	23
12 - 15	1	3
16 - 17	0	0
DURATION		
Once	0	0
3 mo. - 11 mo.	1	3
1 yr. - 2 yr.	7	23
3 yr. - 5 yr.	5	17
6 yr. - 10 yr.	8	27
11 yr. - 15 yr.	5	17
16 yr. - 20 yr.	2	7
21 yr. - 28 yr.	2	7

TABLE 1 (continued)

Characteristic	N	%
DEGREE OF VIOLATION		
1	2	7
2	11	37
3	17	57
INVOLVEMENT OF VIOLENCE AND FORCE		
Father	3	16
Brother	6	75
PERPETRATOR[a]		
Father	15	50
Step father	5	17
Brother	10	33
Uncle	7	23
Grandfather	3	10
Step Grandfather	2	7
Cousin	5	17
Mother	1	3
Brother in law	1	3
TOLD VERSUS SECRET		
Told	10	33
Secret	20	67
SUPPORT VS NO SUPPORT		
Told and supported	2	18
Told and not supported[b]	8	80
EATING DISORDER HISTORY	26	87
Anorexia	4	13
Anorexia with Bulimia	10	33
Bulimia	4	13
Obesity	8	27
No eatng disorder	4	13

TABLE 1 (continued)

Characteristic	N	%
OTHER EXPERIENCES		
Battering	8	57[c]
Self-mutilation	6	38[d]
Memory loss	17	57
Panic attacks	21	70
Suicide attempts	5	31[d]
Rape	9	30

a) In most cases, data represents multiple abusers.

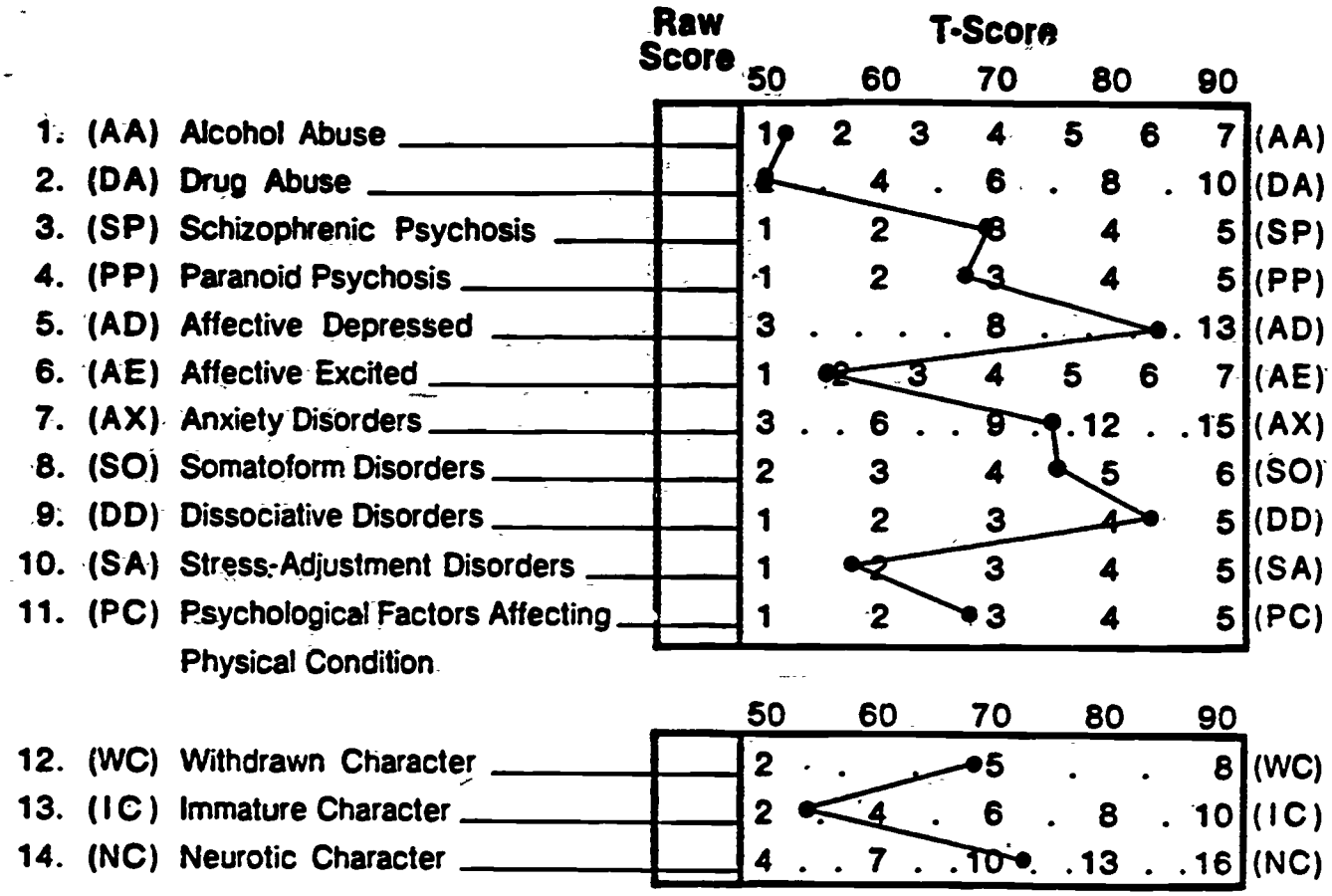
b) Blamed, not believed, sent away, ignored and no follow up, told to keep it a secret.

c) Information on 14 of 30 cases.

d) Information on 16 of 30 cases.

Figure Caption

Figure 1. Mean DIPS profile for incest sample.


Raw Score
T-Score
50 60 70 80 90
1. (AA) Alcohol Abuse
2. (DA) Drug Abuse
3. (SP) Schizophrenic Psychosis
4. (PP) Paranoid Psychosis
5. (AD) Affective Depressed
6. (AE) Affective Excited
7. (AX) Anxiety Disorders
8. (SO) Somatoform Disorders
9. (DD) Dissociative Disorders
10. (SA) Stress-Adjustment Disorders
11. (PC) Psychological Factors Affecting Physical Condition
12. (WC) Withdrawn Character
13. (IC) Immature Character
14. (NC) Neurotic Character