

Ethical Aspects of Competence for Sexual Relationships: A Case of Adult Sibling Incest

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A case of adult sibling incest serves as the occasion to review relevant literature and discuss issues related to competence to consent to sexual relations between adults. The case was presented at ethics rounds at the Massachusetts Mental Health Center (Boston, MA), and the resulting discussion is analyzed as to the decision making with which the treatment team is faced. The relationships among competence and competence assessment, autonomy, morality, and countertransference issues are also considered in this provocative case.

Sieglinde:

Sieglinde bin ich, die dich ersehnt:
die eigne Schwester gewannst du zu
eins mit dem Schwert!

Siegmund:

Braut und Schwester bist du dem Bruder,
so bluhe denn Walsungen-Blut!

(Sieglinde:

I am Sieglinde who longed for you:
you have won both sword and sister as
well!

Siegmund:

Wife and sister you shall be to your
brother,
So let the Volsung blood increase!)
*Die Walkure*¹

Incestuous siblings have been part of our consciousness throughout history from

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ancient mythology to German epic poetry and contemporary fiction. In Greek mythology, Zeus dethroned his father Kronos (the latter himself incestuously wed to Rhea) and then married his sister, the Titan Hera. In a more contemporary example from *The Holcroft Covenant*,² Ludlum describes a sibling pair in which the brother, an elusive international assassin, has a sexual relationship with his sister, because as a blood relative she is the only one he can trust not to murder him during sex.

He loved [his sister] as few men on earth loved their sisters; in a way that the world disapproved of because the world did not understand. She took care of his needs, satiated his hungers, so that there were never any outside complications. (p. 205) . . . [it was] a secret ritual that had kept him pure and unentangled since he was a child. (p. 209)

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In Wagner's opera *Die Walkure*, Siegmund and Sieglinde, fraternal twins separated since childhood, find one another. After Siegmund rescues Sieglinde from an enslaving husband, he plans to marry her and perpetuate their distinguished family, presumably by conceiving a child with her. Here, sibling incest follows the rescue of a sister from a tyrannical husband who had kidnapped her from her father's house.

After a brief discussion of adult sibling incest, a clinical vignette will illustrate one possible sibling relationship and the ethical dilemmas it created for the therapist and the treatment team. Ethics rounds served to illuminate the issues.

Background

In the psychiatric literature, little attention is paid to sex between *adult* siblings, in contrast to the extensive coverage of both the long and short term effects of parent-child incest and sibling incest when one or both partners are minors. Although the latter pairings seem immediately familiar to mental health professionals, they may inaccurately predispose our thinking to conclude that all incestuous pairs involve a relationship based on a power imbalance or the use or threat of emotional or physical force, as does in fact occur when the pair involves an adult and a child; in the latter case, power differentials are unavoidable, and the ethical prohibitions are unambiguous. Problematic dyads include parent-child, grandparent-child, or aunt/uncle-child, where the pairings are mixed in gender; and pairs composed of the same gender, a pairing

infrequently observed, perhaps because of under-reporting.

The ethical issues may become less clear-cut for siblings of a similar age. In fact, despite legal statutes prohibiting incestuous relationships among all first-degree relatives, patterns of prosecution may vary across jurisdictions. An assistant district attorney in the child abuse bureau of a major East Coast city revealed that, in legal practice, cases of incestuous siblings are rarely prosecuted when the age difference is less than two or three years, assuming that one or both minors are approaching majority.³ Two studies of undergraduate populations found that self-reported sibling sexual experiences in childhood or adolescence may have either neutral or even positive effects when the age difference between the siblings is less than five years and the encounter does not involve force or threats.^{4, 5}

Incest *per se* is rarely prosecuted when both siblings are considered adults. Although the reasons for such practice may be unclear, one inference may be that these cases are difficult to prosecute because it may be hard to prove that adults lack the ability, outside of gross mental impairment, to resist or reject such relationships. Operationalized, this line of thought may lead to the following question: what role does competence to consent play in cases of incestuous relationships between adult siblings?

The legal system has already begun to describe the importance of competence to consent in cases of criminal prosecution of persons with normal intelligence who are charged with having sexual relations

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with persons allegedly incapable of consenting due to mental impairment. In their article on sexual behavior and the mentally retarded, Sundram and Stavis,⁶ both lawyers, describe the need to consider whether or not mentally impaired people are also competent or incompetent to make decisions about sex; conviction of the perpetrator may rely on the ability to determine if the alleged victims *were* competent to consent and then did so, or if their mental impairment left them *unable* to do so.

In a study of professionals' attitudes toward sex between psychiatric inpatients, Commons *et al.*⁷ surveyed treaters regarding six factors that might influence staff attitudes. The authors found that only the form and the location of patient-patient sexual activity proved to be determinative; that is, the study subjects indicated highest approval of consensual, heterosexual relationships that occurred in a traditional environment, such as a bedroom. The competence of the patient to engage in the activity and the degree of consent in or consensual nature of the sexual relationship, although central to the legal view of such activity, were treated as nonsignificant by staff subjects.

Clinical Case

Ms. A. was a 40-year-old, unmarried, childless woman with a long history of chronic schizophrenia. Prior to the subject admission to a local mental health center, she had been found wading into the harbor, requesting money and asking for "an operation to give me a penis and motor" in order to function sexually. The treatment team requested a medicolegal

consultation from the Program in Psychiatry and the Law after the patient confided to her therapist that she was involved in a sexual relationship with her brother.

About two years into the present hospitalization, Ms. A. began to tell her therapist how her brother would help her bathe when she went home on pass and on at least one occasion told her therapist that they had had sexual intercourse. She denied that this was a result of physical or emotional force, but she seemed fearful that passes to visit her brother and plans to return to live with him after discharge might be jeopardized by her confession. On further interviews, she seemed to change her answer so often that it seemed unclear whether such a relationship existed or not.

The initial consultation question was whether there was a duty to report this allegation to the Department of Mental Health (DMH) or some other agency as a case of potential abuse. In fact, the treatment team felt so strongly about this that they had notified DMH even before the consultation was even completed. Consultation added a second question: did Ms. A. have the capacity to make a competent decision to be involved in a sexual relationship with her brother?

At the time of the consultation, little was known about Ms. A.'s premorbid life. She had never had children and there was no known history of pregnancy. There was also no known history of childhood abuse, by brother or any other family member, nor of rape or any other traumatic sexual experience.

Upon hearing the reason for the con-

sultation interview, Ms. A. was eager to describe why she was in the hospital. She said, "When women reach a certain age, their motor burns out down there, and I came into the hospital so I could get my motor looked at and fixed or get a new one. But they haven't done that at all." When asked what she meant by motor she stood up and insisted, despite the consultant's request otherwise, on pulling down her pants, showing a severe vaginal rash and saying simply, "This is what I mean, my motor is here." Ms. A. was told that unless she pulled up her pants the interview would have to end and, with the chaperoning nurse's help, she agreed to do so.

She correctly identified her location as a hospital but denied that she had any psychiatric illness. Her response to why she agreed to take medication was that the doctors offered it and "Maybe it will help with my motor." She was not able to describe the potential risks and benefits of taking the medication or identify other aspects of her treatment in a meaningful way.

Asked about the events leading up to this consultation, specifically the allegations of a sexual relationship with her brother, she denied completely that such a relationship currently or ever existed in the past. She said, "He does help wash my hair" and started to demonstrate how he did this. Asked in general about sexual relationships between brothers and sisters or between other immediate family members, she said that she "did not see anything wrong with that," but that most people might not see it that way. "Anyway," she insisted, "nothing happened so

just don't ask me about it anymore." When asked if she ever felt forced or threatened to do something she didn't want to do by anyone in her family, as a child or as an adult, she responded irritably, "No, never. That never happened to me."

To the question of what lay ahead for her, she answered, "I'm getting out of here soon, and I want to go live with my brother." Asked if she planned to continue with treatment at the Center, she said she wasn't sure if she needed any and couldn't say how she'd feel later.

Ethics Rounds on the Case

Because of these interesting questions, the case was presented in two ethics rounds, one on the treatment ward and one in grand rounds format, moderated by the authors. The practice of ethics rounds⁸ is a particularly useful format for clarifying ethical tensions in clinical cases. Such tensions, in this case, might be the competing relative good of supporting the patient's right to make autonomous decisions, if competent to do so, versus the relative good of protecting the patient from the potentially negative consequences of certain decisions. Our goal in ethics rounds was to deepen staff awareness of the personal values latent in their decision making.

Despite the uncertainty of the central allegation, staff in both settings initially placed their focus on the external rules and regulations of reporting requirements; such external focus seemed to draw on the staff's own uncertainty regarding the inconsistency of the patient's report and their discomfort in containing

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the anxiety that such a controversial topic produced. Minimizing these difficult feelings may have been an important motive for pursuing legal requirements, especially when it may have been difficult for individual team members to identify, voice, and process their own feelings about adult sibling sex. Certainly, the involvement of the outside agency effectively foreclosed further discussion and processing of the matter by the unit staff. In the nonjudgmental format of ethics rounds, however, team members had a place to share their different views regarding this subject.

Many staff members felt that the connotations of childhood incest were so strong and contaminating that it was hard to imagine that this adult patient could be involved in an incestuous relationship without there being a significant power differential or threat of force by her brother. Others felt that mental illness must have so impaired the patient's judgment that she was unable to choose a more appropriate sexual partner and, consequently, she may have regressed to a childlike way of thinking about sex and sexual partners. Consequently, some staff members reasoned, the allegation itself might even be reportable in a manner comparable to mandatory reporting of child abuse.

Still a third group felt the situation was more complicated and sought an expanded view (indeed, one function of ethics rounds would be to foster just such a more complex perception). They noted that if both partners were mentally ill, or if the gender of the partner with the mental illness were changed to male, the pres-

sure to invoke reporting requirements seemed to decrease; when the issue involved the protection of a woman with mental illness from a man presumably without mental impairment, it was difficult to view the woman's decision making outside of the traditional abuse dyad. A more equal or symmetrical hypothetical situation (e.g., both mentally ill) led discussants to place more weight on each individual's competency to choose such a relationship.

A small subset of both groups (unit staff and grand rounds audience) insisted on viewing the issue in black and white terms. One side felt that the good of protection unambiguously outweighed the relative good of supporting the patient's autonomy, particularly around questions of sexual behavior and other issues seen as somehow external to therapy. The opposing group dissented, stating that sex might be viewed as a fundamental right, like the right to nutrition or to conduct other essential physical functions, and may not even be any business of treaters when the patient is competent to make autonomous decisions. Some went further and suggested that competency around sexual behavior might be superfluous; consider that treaters do not routinely assess competence around other physical functions such as choosing a certain diet.

Overall, the trend in both settings was a gradual move toward support of the patient's autonomy to make decisions regarding sex, if competent to do so; a subgroup believed that this issue lay outside a psychiatric purview. "Freed" from externally imposed reporting requirements through the ethics rounds exercise,

clinicians explored their own ethical values and conflicts, considered multiple factors that affected their own decision making, and arrived at a position that placed a higher priority on the patient's autonomy and competence to make decisions than on their own personal value systems. In contrast, upon preliminary anonymous notification, the agency called said it *was* a reportable issue; the treating clinician then called back to make the formal report, thus foreclosing any opportunity to discuss the issues further within the team or with the patient to determine the appropriateness of such a disclosure in the real world.

Conclusions

In conclusion we underscore the need to consider competence to consent to sexual relationships when evaluating a mentally ill person's decision making regarding sexual behavior. In this case example, the staff initially seemed to place little importance on competence and competence assessment, and their thinking reflected more conventional moral views (as defined by Kohlberg) toward sexual activity.⁹ As staff decision making deepened through the ethics rounds exercise, a more complex point of view emerged, consistent with professional norms and, consequently, with the increased importance of assessing the individual's capacity to give informed consent.

The capacity to give consent may be an important factor too often overlooked when considering sexual behavior of those with mental illness. When some—perhaps even many—seriously mentally ill persons appear to lack competence to

consent to sexual relations, staff may assume that *all* patients with major mental illness do not have sufficient competency to make such decisions. Such a generalization may lead staff to act solely according to their own views of sexuality, unless they are given the chance to explore those attitudes in conjunction with a full exploration of the patient's ability (competence) to make decisions about sexual behavior.

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