

Adolescent Pregnancy and Incest: The Nurse's Role as Counselor

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The incidence, victim symptoms, and characteristics of incestuous families are highlighted. A case history of incest that led to an adolescent pregnancy is presented. Nursing implications and specific intervention strategies that successfully establish patient trust, build rapport, and lay foundations for further interactions are described.

Media reports of sexual abuse are at an all-time high, especially for cases of incest. When adolescent pregnancy is a result of an incestuous relationship, the victim may withdraw or demonstrate hostility. Such behavior is a warning sign often overlooked by the nurse giving care. The nurse must be intuitive, supportive, and non-judgmental when caring for incest victims. These attributes can positively influence the welfare and development of the pregnant adolescent.

DEFINITION

Incest, from the Latin word *impure* or *soiled*, is defined by Warner as "inappropriate sexual behavior among surrogate family members."¹ This includes sexual contact from an adult to a child, such as rape, genital fondling, or oral-genital contact. Sexual contact be-

tween nuclear or extended family members—either biologic or step-relations—is included in the definition of incest, because it is not permitted by law and social norms.¹

Incest is an ultimate, universal taboo in most cultures. The existence of the taboo is felt to have evolved out of the human need to safeguard the integrity of the family, in that sexual competition promotes family disruption.² This taboo originated in the Judeo-Christian heritage. Law against incest is based, in part, on the elaborate definition of incest set forth in the Bible (Leviticus, chapter 18).³

Since suspected incest cases must be reported to the police according to child abuse laws in all 50 states of the United States, nurses need to know the legal definition of incest in their particular states. Sexual misconduct does not have to be committed in an aggressive or forcible manner to qualify as incest. Indeed, in many instances, the minor is a consent-

ing, sometimes willing, participant. The basis for the legality is similar to that with statutory rape: the inappropriate use of power by an adult over a minor is illegal.¹ Furthermore, the reporting of sexual abuse of minors takes precedence over nurse-patient confidentiality when the abuse is a continuing threat.⁴

INCIDENCE

In the American culture, incest appears in a variety of forms. The most frequently reported cases occur between an older male and a younger female, such as father-daughter incest. Sibling incest is the next most common type.⁵ An estimated 100,000 cases or more of incest occur per year. Twelve to twenty-four percent of the female victims become pregnant. Simens reports that 20 to 35% of all adult women surveyed were sexually molested as children. Nurses who work in schools, public health, pediatrics, obstetrics, and emergency

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rooms are in excellent positions to identify victims and intervene strategically. To help victims, nurses must be aware of the signs and symptoms that the incest victim displays.⁵

SIGNS AND SYMPTOMS

Following incest and sexual abuse, adolescents may experience these physiologic problems: rectal fissures; poor sphincter control; perforated anal and vaginal walls; gonorrhea tonsillitis; chronic, unexplained pelvic pain; excoriation in the perineal area; migraines; stomach ailments; bed-wetting; uncontrollable crying; and skin disorders. Sociologic and psychological problems may include interrupted education, reduced economic opportunities, isolation from families and peers, lowered self-esteem, guilt, depression, psychosis, self-destructive behavior, and sexual dysfunction.^{5,6}

CHARACTERISTICS OF INCESTUOUS FAMILIES

Nurses in pediatric, school, public health, emergency room, and maternity care settings must be aware of the characteristics common to incestuous families. Viewed by an outsider, the family may appear to be well adjusted and functioning without problems. Family members who are involved in incest may maintain a facade to keep peace and harmony within the family unit and community. A stressful event or crisis such as disease, death, accident, unemployment, or economic failure may precipitate the onset of incest.⁷

Family Member Roles

To comprehend the psychodynamics of an incestuous relationship, the roles of the family members need to be understood. Family dynamics differ depending on who is involved; father-daughter, brother-sister, father-son, or

mother-son dyads each have different dynamics and require different interventions.

In nuclear families that experience father-daughter incest, two patterns are most commonly observed: 1) closed, rigid, enmeshed families, in which family members give little nurturance and support to one another but, because of insecurity, are extremely dependent on one another; and 2) chaotic, multiproblem families in which family life is characterized by a series of crises and acting-out behaviors.⁸ Incest in the rigid family may be difficult to detect, since the family may appear normal to an outside world that values close-knit family systems. Even families with children who are involved in the school system, attend church, or show other outward signs of community relatedness can be considered closed-system families if the only valued and acceptable sources of information, relationships, and stimulation come from within the family. Therefore, in the apparently normally functioning family, the nurse must fully assess the situation when incest symptoms, however subtle, are present.^{8,9}

In families in which father-daughter incest occurs, the marital relationship may have ceased being emotionally and sexually satisfying. The husband often has a history of inadequate nurturing or may be overwhelmed by situational stressors. Alcohol often contributes to incest because it causes the father to lose his inhibitions and impulse control. Following episodes of intoxication, the father is shocked at his behavior. Attributing it to alcohol, he vows never again to imbibe, yet the cycle repeats itself because of the alcohol addiction.¹⁰

The Father

Sociologists offer varied descriptions of the incestuous father.

He is categorized as being emotionally immature and strives to control the lives of all family members by whatever means found effective. Unable to meet his emotional needs with a wife or outside lover, the father misuses the power he has in the family by dominating his daughter. The choice of his daughter as a sexual object is a stress-related regression from normal sexual development.^{7,10} To justify his behavior, the father often cites teaching his daughter the facts of life or protecting her from outsiders as reasons for incest.¹¹

Other characteristics incestuous fathers may exhibit are low self-esteem, depression, anger, loneliness, and a history of sexual abuse as a child. However, in studies of fathers who were imprisoned, these characteristics were present in both the abusing and nonabusing groups.¹² The major difference determined in one study was that nonabusing fathers reported participating significantly more in feeding, diapering, and caring for their daughters during the children's first three years of life than the abusing fathers.¹³ Perhaps fathers' participation in caretaking provides a protective function against incest through strengthening the parental bond.

Incest behavior between the father and daughter is usually initiated well before the daughter's pubescence. Inappropriate sexual behavior, such as "romantic" kissing and genitalia fondling, is instigated by the father. The relationship progresses to masturbation, cunnilingus, fellatio, and intercourse.^{5,7}

The Mother

According to the "maternal collusion" theory, mothers in incestuous families have two characteristics in common. The mother 1) relinquishes her maternal role and delegates those responsibilities to her daughter, consciously or un-

consciously, and 2) backs out of her sexual role as a wife.⁷ Feminist psychology, however, disputes this theory and states that such myths only promulgate the abusive power of fathers. Mothers in incestuous families often report active sexual relationships with their husbands while the incestuous relationship is occurring.¹⁴

The mother in an incestuous family may be frightened that exposure will force her husband, on whom she is emotionally and/or economically dependent, to leave. By using denial as a coping strategy, the mother may not realize that she too has a role in maintaining the father-daughter dyad.⁹ This denial is evidenced by a range of behaviors, including indifference to condonation of her husband's actions, submissiveness, and depression.

The mother often feels ambivalent toward her parents because of neglect and deprivation. She too may have been a victim of childhood sexual abuse. The nurse needs to be sensitive to the psychodynamics of the maternal role in father-daughter incest and should not blame the mother who seems to have ignored or even encouraged the father's abusive behavior.^{9,14}

The Daughter

Since adolescence represents a wide developmental age range, summarizing the list of daughter characteristics that contribute to the problem of incest is difficult. A major developmental task of adolescence is achieving sexual identity. This task is associated with growth and development of the adolescent's body image.⁵

In many instances, the sexual relationship between the daughter and her father may satisfy her need for physical affection and closeness. Typically mature for her age, the daughter has usually assumed many household responsibilities.

Her mature behavior is the result of a role reversal with her mother. The incestuous relationship can be a means of expressing revenge against her mother, who psychologically abandoned her—that is, the child can excel her mother in both the kitchen and the bedroom.

Emotionally isolated, the daughter is unable to share her secret sexual experiences. She is bitter toward her father for using and betraying her and toward her mother for not offering protection. Often, the daughter can forgive her father but has a great deal of hatred toward her mother for allowing the incest to happen. The daughter feels worthless and powerless and has an overwhelming sense of guilt for having participated in the incest.⁵

Siblings

By the age of 10, children usually have a good idea about what is happening in the home. Yet, parents say that their other children know nothing about the incest—an example of the closed-system family's rule of silence.¹ In the literature, the role of siblings is rarely mentioned.

CASE EXAMPLE

Background

The case study chosen for review is an example of a chaotic, multi-problem family with a father-daughter incest dyad.* Family life in this case was characterized by a series of crises, each building on the other and escalating into the problem of incest.

K. is a 16-year-old, Caucasian, high-school freshman, gravida one, para zero, who is six months pregnant. She was referred to a non-profit maternity home in a large

* Details of the case have been altered slightly to protect the confidentiality of the patient.

city by a public health nurse. K.'s pregnancy is the result of an incestuous relationship of two years' duration with her father. K. lives in a poverty-stricken, socially isolated county located in the northern United States. Her mother died of cervical carcinoma two years before K.'s pregnancy. Since that time, K. has done all of the shopping and housecleaning. Her maternal grandmother, in her eighties, and her father, age 54, run the household. Her father is unemployed and has a history of alcohol abuse. Also living in the home are K.'s two brothers, ages 18 and 25, and five sisters. The 19-year-old sister has had two children, both the result of incest, but it is not known if father or brothers were involved. These children are living in the home and are being reared by the grandmother. The family is currently under investigation by child protective services.

Before admission to the maternity home at 24 weeks of pregnancy, K. had no prenatal care. During her fifth month of pregnancy, she began skipping classes at school. K. was tested for pregnancy during a visit to the health unit with a chief complaint of weight gain. Initially, she denied missing her menstrual cycle or being sexually active. K. had all of the normal childhood diseases, and her review of organ systems was normal with the exception of multiple dental caries. She stated no particular religious preference.

Nursing Intervention

A maternal-child nurse who counsels adolescents was contacted by the social services agency where K. was living. An appointment was made for a mutually agreed on time, and a contract was made for intensive weekly sessions.¹⁵ A written contract was made to help K. understand what the problems were and also realize that they could be realistically re-

solved. After the initial interview, a review of K.'s case history, and input from the caregivers at the maternity home, established objectives were to

1. Explain reasons for nurse's involvement and role as a nurse counselor by the end of the first session;
2. Provide privacy and confidentiality at each session, and explain the reason for reporting sexual abuse of minors to proper authorities by end of first session;
3. Encourage K. to ventilate her feelings and become actively involved at all sessions;
4. Give K. information about available options and legal rights concerning childbirth by the end of second session;
5. Provide health education on sexual identity, reproductive anatomy and physiology, sexually transmitted diseases, nutrition, growth and development during pregnancy, prenatal care, prepared childbirth, labor and delivery, and contraception;
6. Serve as an advocate for K. by establishing a referral network for obtaining prenatal care and related services at the state-funded hospital at which delivery would occur; and
7. Plan for life following childbirth in regard to home, family, safety, school, and support.

The counseling intervention strategies that successfully established trust, built rapport, and laid the foundation for further interactions were based on Johnson's five-part approach for the nurse to incorporate into the plan of care⁶: clarification of values, establishment of trust and rapport, development of interviewing skill, provision of nursing treatment and information, and laying the foundation for future interaction.

Clarification of Values

The first step in incest cases is for the nurse to clarify her/his attitudes and values as an individual and professional.⁶ This is important because the patient's circumstances may be quite different from the nurse's. This was the case with K. The nurse had to remind herself not to make value judgments or be maternal in an inappropriate way.

The nurse avoided the urge to rescue K. from her situation by considering that completion of developmental tasks and decision making by the patient would lead to satisfaction and success with later tasks.¹⁵ Initially, the nurse remained emotionally detached to be nonjudgmental.

K. chose adoption. The nurse supported her in the decision-making process and then endorsed the final decision K. made. The ramifications of K.'s choice were discussed and reviewed often, to reduce her stated guilt and insecurity.

Trust and Rapport

The second step in counseling is to lay a foundation for treatment by establishing trust and rapport.⁶ The nurse must put the patient at ease to get past formalities. In the beginning, the nurse shook K.'s hand and asked to be called by her first name. K. felt comfortable doing so and asked the nurse to do likewise. The nurse told K. about her clinical background as a nurse and offered her services as a resource person. The nurse came from behind the desk and sat down next to K. to decrease the physical distance. The nurse told K. she was concerned and wanted to help in any way she could. K. immediately began asking questions about childbirth and the public hospital where she would go for delivery.

While such questions identified an important area of needed knowledge for K., the questions

were also a nonobtrusive start to a therapeutic relationship. The patient knows that such questions are safe topics for the counselor, and questions give the nurse counselor a chance to demonstrate an ability and willingness to help. Indeed, K. was receptive to the nurse's presence and to her taking such a personal interest in K.

Interviewing Skill

The development of interviewing skills is a third counseling step.⁶ The nurse erroneously assumed that K. understood her own body functions. By actively listening to K. talk about her menstrual cycle, the nurse found that K. lacked accurate information about the consequences of her sexual activity. The nurse then was able to plan future sessions that provided K. with the health education she needed. Using proper medical terminology in the discussion elicited little response from K. Although the nurse was uncomfortable using lay jargon to describe sexual activities, K. readily understood and offered information once she comprehended the language.

At this point in the counseling, the nurse discussed the right of each individual to body privacy and to choice making. Only then did K. profess ignorance of the fact that sexual intercourse was the way that infants were created. Through use of therapeutic silence, and humanistic, open communication skills such as reflection and clarification, K., by the third visit, was able to discuss her sexual relationship with her father. K. was very protective of her father, and she did not view the relationship as unusual. She also did not know or value the information that she had a right to refuse sexual activity. This is often the reaction to incest in a young adolescent.

In enmeshed families, the adolescent may not be aware of what healthy family life is about, since

outside friends and visits to other homes are discouraged. All needs of individual members are expected to be met from within the family unit. Thus, within the realm of experience gained from the immediate family, incest may be unconsciously regarded as a normal part of life.^{9,11}

Treatment and Information

A helpful fourth approach is to provide maximum nursing treatment and information while the adolescent is accessible.⁶ K. faithfully came to the weekly sessions armed with a list of questions. In a reassuring voice, the nurse answered K's questions at her level of understanding. K's questions dealt with aspects of prenatal care, body changes during pregnancy, sexual response, and birth control. For those questions the nurse could not answer, she contacted other professionals in the community and then quickly relayed the answers to K.

Sexual decision making was practiced by communication role playing, with K. and the nurse taking turns as the male and female. During counseling, emphasis was placed on taking responsibility for choices made by looking at the effects that follow particular behaviors.

While sexual decision making was understood by K., she was not certain that she would be able to employ it within her family situation. Even though her father had left the family home to escape the legal system, she was not sure if she would be able to refuse submission if her father reentered the family. K.'s aunt, who K. was to live with after delivery, knew about the incestuous relationship and was noncommittal concerning her role as protector. For these reasons, K. requested and received birth control pills.

Some sessions with K. were more formal for the purpose of teaching.

For example, the nurse used colorful posters on good eating habits, movies, pamphlets, overhead projections, and informal discussions. Positive encouragement of K.'s strengths was given while proper prenatal care was taught. The nurse acknowledged K.'s good habits and made suggestions for further improvement, instead of showing disapproval.

On two of K.'s prenatal visits, the nurse assisted with fetal monitoring for a nonstress test and accompanied K. for a diagnostic ultrasound. This link between the community and the hospital by means of a familiar face offered reassurance and support.

Future Interaction

The final suggestion Johnson made was to lay the foundations for future interactions.⁶ For K., this was of crucial concern. The immediate problem of incest was resolved. However, because of K.'s limited sexual coping experience, a link back into the legal and health-care network was important, since she was at risk for further abuse. The nurse gave K. and her community social worker home and work telephone numbers. The nurse reassured K. that she would follow K. closely through the pregnancy, and should K. have questions she could call on the nurse. The nurse told K. that she had the freedom to make her own choices because she had to live with those choices. Demonstration of appropriate behavior was rewarded with praise and positive feedback.

Follow-up

The intervention strategies discussed were implemented with K. and resulted in successful counseling sessions and a good maternal-fetal outcome. Without complications, K. was delivered of a viable male infant, at 37 weeks' gestation, weighing 6 pounds, 8

ounces. K. followed through on her decision to relinquish the infant to a private agency in the city. At three weeks postpartum, the nurse had a last session with K. during which closure took place. K. was coping well with her decision and was making plans to complete her high-school education. She verbalized understanding of the use of her birth control pills. K. was then released to the custody of her aunt, who was aware of the situation and lived in another city. K.'s father, who had vacated the family dwelling while she was in the hospital, could not be located by the authorities for further questioning. Her brothers were traveling outside of their home state, and her sisters were left to be cared for by her grandmother.

SUMMARY

Epidemiologic studies on incest, based on reported cases, produce a figure of 100,000 cases a year. Unreported cases of incest increase that figure considerably. When pregnancy is a result of such sexual abuse, the adolescent may exhibit behaviors such as withdrawal or hostility. To have a positive influence on the pregnant adolescent's welfare and development, the nurse giving care must have a nonjudgmental attitude and be caring and supportive.

Condoning behavior is often evident in the extended family where incest occurs, and even in the community. Often the community will look the other way when family rights and privacy are held as community values.

The nurse must proceed carefully but steadily to challenge such values. This is especially true when the legal repercussions are considered. Incest punishment can range from a moderate fine to a minimal jail sentence in most states. The child involved in such

families may simply close off communication to professionals so that she/he does not have to give up the family of origin.⁹ Thus, while incest is a taboo, sanctions against it are somewhat nebulous.

For such powerful family and community problems, the nurse may consider enlisting the aid of a co-therapist and use the social network therapy approach to enlist the aid of family and friends to break the incest cycle. Through network therapy, the power available for the family is tapped at one time by large networks of people assembled to plan solutions for the family.¹⁶

Nurses play vital roles as counselors and teachers during crisis intervention. With specific knowledge about incest, nurses can identify problems and minimize intervention-induced trauma. A positive relationship with the nurse—an adult—helps the patient develop interactive behaviors necessary to achieve physical and emotional health. Nurses with a special interest in adolescents will find counseling and teaching an exciting challenge. The five approaches recommended by Johnson can be used by nurses in school, public health, pediatric, emergency room, or maternity care

settings to lay foundations for further interactions.

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