letters

Adolescent Pregnancy and Incest

The issue of incest as addressed in the article "Adolescent Pregnancy and Incest: The Nurse's Role as Counselor" (*JOGNN* March/April 1987) was good to see. I would like to see more on this topic in future issues.

There are several comments I want to make about the article. The authors state that incest includes sexual contact from an *adult* to a child. Often, however, the incest offender is an adolescent uncle or brother. Some incest victims have been sexually abused by *younger* siblings.

The statement that the minor is "often a consenting, sometimes willing, participant" is misleading. Indeed, consent is not possible where incest is concerned.[1,2] Often the incest has been going on since the adolescent was a young child. By the time the adolescent is a teenager, she has no concept of how to stop the incestuous relationship. What *appears* to be willingness is really submission out of a sense of powerlessness.

The authors state in the case presentation that the "immediate problem of incest was resolved." I presume they mean that sexual activity was halted. The "problem of incest" takes years to resolve, and in fact, remains a core issue in the victim's life *forever.* Victims of incest often need follow-up at intervals throughout their lives as developmental milestones such as pregnancy, marriage, and job promotions trigger incest issues anew.[3,4] The article does not address the prevalence of eating disorders and other self-destructive behaviors such as suicide attempts. Often these disorders and behaviors are cries for help from the incest victim.

There are so many overwhelming issues in treating a victim of incest, that I would suggest the nurse *must* enlist the aid of other professionals, not "may," as the authors suggest. Usually the entire family needs help. This is too big a problem for one person to cope with alone.

Finally, another area the nurse can help with is in locating and referring the victim to support groups for incest survivors. Although support groups are hard to find, they *do* exist. Local rape crisis centers can often put you in touch with these support groups. The victim feels such a sense of relief to know that she is not alone in experiencing this trauma.

Because nurses (often incest victims themselves) are also part of the community that "looks the other way" when incest is suspected, I commend the authors for bringing this issue out in the open. It is a problem that must not be ignored any longer.

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Authors' Reply

In our article "Adolescent Pregnancy and Incest: The Nurse's Role as Counselor," (*JOGNN* March/April 1987) we highlighted one type of incest, father-daughter—the most common type of incest. In doing so, other examples of incest were not included. The literature is replete with all possible versions of incestual abuse and we suggest that readers review the references listed with our article for a more indepth understanding of the problem as well as the effects on the victim, the family, the community, and the culture at large.

Our statement about the minor as a consenting participant was purposeful. Nurses should be aware that *acting-out* behaviors of adolescents may appear as willingness. Nurses must extend beyond personal value systems to consider what *willing* behavior really represents—fear, depression, and/or security in a father-daughter incest dyad. With this awareness, carrying out the legal and therapeutic processes becomes less of an ambivalent experience for the nurse when faced with seemingly willing behaviors of the young woman victim.

While we concur with the reader's statements about the long-term effects on incest victims, research findings are mixed. Simply, some incest victims achieve healthy resolutions of their experiences with abuse, whereas others experience the problems alluded to by Beard. Whatever accounts for these differences warrants further study. Since many incest victims are also children of alcoholics, interactional effects must be considered.

We stated that nurses *may* want to enlist the aid of other professionals, to demonstrate support of advanced nurse specialists and nurse scientists who have tradi-

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CONCLUSION

Although evidence suggests that the prenatal period is not an optimal time for learning about the postpartal period and infant care, women who choose early discharge may be more open to learning prenatally because they recognize the limited time available for professionally directed learning in the hospital. A unit of content which reviews newborn behavior and characteristics in addition to infant care and feeding skills should be included in prenatal education curricula.

Suggestions for further research into the outcomes of early discharge include replication of the study with populations of women at risk due to inadequate social support, unavailability of prenatal or parenting classes, and unusual emotional or physiologic needs (e.g., adolescents, low-income groups, and single parent families).

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tionally provided the supportive care to such clients. Again, the frontline nurse has a real role to play in the detection of abuse, and when further professional assistance is needed this nurse should consider first consulting with nurse experts within the profession.

Our thanks to this reader for her thoughtful response. Such critiques will foster nursings' role in the area of women's health.

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