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Incest

There are many definitions of incest but this annotation refers mostly to sexual activity between fathers or stepfathers and their daughters, which in Western Europe and North America is probably the commonest form of child sexual abuse. Other forms of incest such as sexual intercourse between brothers and sisters, uncles and nieces, or homosexual relationships between parents and children account for about 20–30% of cases.

Nobody has any exact knowledge of incidence because incest is carefully concealed both by parents and their child victims. This is understandable because detection carries a considerable risk of imprisonment and family disruption. It occurs in all social classes but concealment is most likely to fail among those of low intelligence and as a consequence of pregnancy, family quarrels, or mental illness. Among a group of psychiatric patients 4% gave a history of incest.[1]

Victims

The abuse usually takes place in the context of a loving relationship and only a small minority of children show any physical evidence of force having been used. Many are threatened, to discourage disclosure, and false denial by them is common. Sexual activity continuing over several years is often kept secret.

Incest may occur at any age but it commonly starts during the latency years when arousal of earlier feelings towards the parent may make the child especially vulnerable. As with non-accidental injury, there may be escalating abuse beginning with trivial acts of indecency. Fondling at bath time progresses to more overtly sexual acts such as rubbing the penis between the child's thighs or inducing her to handle her parent's genitalia and this is followed later by further escalation to vaginal penetration. Some children are subjected to orogenital or anogenital activity.[2] Repetition of the abuse until the child leaves home is usual and successive girls in families may become victims.

Parents

Several types of incestuous father have been described.[3] Many are in their mid-30s or older, sexually rejected by their wives, socially isolated, and often unemployed. In some, the beginning of incest is associated with alcohol consumption. A minority are aggressively psychopathic and their children are simply among their several coerced sexual partners. Others are paedophilic and a danger to other children as well as to their own.

Mothers are often aware of the incest and collude by doing nothing about it. They are fearful of the break up of their families and join their husbands in denial and in resisting outside enquiry. The family pattern is one of introversion, and they may move home to avoid investigation and treatment.

Examination

The examination of sexually abused children requires skill, sensitivity, and suitable surroundings. It should not be done by general duty police surgeons in police stations, and in conurbations there is merit in the work being assigned to specially experienced women police surgeons.[4] Some children will come to the attention of paediatricians, and paediatric departments are an appropriate setting for the examination provided that care is taken not only to diagnose and treat but also to record in detail evidence that may be required in any subsequent litigation.

With young victims it should be part of a thorough general examination when evidence of non-genital injury or neglect may be found. On examining the perineum it may be useful to let the child see with a mirror what is happening and to get her to hold the labia separate. The skin should be inspected in a good light for minor abrasions. Perineal injuries are unusual but should be photographed if present.

Swabs should be taken for *Neisseria gonorrhoeae* from the pharynx, urethra, vagina, and anus and sent promptly to the laboratory. These should be repeated until 2 weeks after the last exposure. Serological tests for syphilis should be done and repeated 6–8 weeks after the last possible contact. In girls old enough to become pregant urine tests should be done at similar intervals.

Swabs should also be taken to try to isolate spermatozoa if contact may have occurred within the preceding 72 hours. Fluid is pipetted from the vagina, samples taken of dried semen on the skin or clothes, and swabs taken from behind the molars in an attempt to show spermatozoa. Material for acid phosphatase tests is also required. In postpubertal children pubic hair should be inspected

for lice and a few hairs removed. There is a Home Office examination kit which may be made available in police cases.

Sequelae

Many forms of emotional disturbance have been ascribed to incest, and school failure is prominent among the symptoms.[5] Nevertheless, some children are apparently unaffected and those who have been deprived may welcome the attention and rewards while the incest continues. Detection may not be welcome unless there has been aggression because it brings to the child a feeling of responsibility for the consequences and a fear of loss. Most children do not openly object until they reach adolescence when they may make their complaint known and leave home early. It is later in life that the damage caused by incest becomes most apparent in that it frequently leads to major psychosexual problems. Children who have experienced incest clearly need help to avoid the sequelae and should be referred to a child and adolescent psychiatry service.

In Britain there is a punitive attitude to incest and suspicion is likely to lead automatically to police enquiry. In many areas the ordinary child abuse procedures do not apply to sexual abuse. It is not surprising, therefore, that families are deterred from seeking help and that detection rates are low. Humanistic treatment of father/daughter incest in a manner that is neither permissive nor cruelly punitive has been advocated.[6] Such an approach seems to offer the best hope of prevention in a field where other methods have failed.

Paediatricians have an interest in incest not only in the context of child abuse but also because of the genetic implications of consanguinous pregnancies. Several studies of their outcome have been published.[7–9] It is difficult to define precise risks because of the inherent problems of obtaining satisfactory control groups for comparison but it is quite clear that there is a substantially increased risk of homozygosity for recessive disorders. It is estimated that less than half of the surviving children of incestuous unions are normal. Some have clearly defined genetic conditions but many have non-specific forms of mental subnormality. They are usually of moderate degree and may be associated with epilepsy.

The poor medical and social prognosis has considerable implications for practice. Termination of pregnancy may be considered but pregnancies due to incest are often diagnosed too late. A cautious approach towards adoption and fostering is prudent and placement should not be made without appropriate counselling. In the end the children will need homes but most of them will also have special needs.

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