

The experiences of primary caregivers whose children/grandchildren were exposed to paternal incest

MF Saloojee

23290242

Dissertation submitted in fulfillment of the requirements for the
degree *Magister Artium* in Psychology at the Potchefstroom
Campus of the North-West University

Supervisor: Dr C. van Wyk

Co-Supervisor: Prof V. Roos

May 2014

I dedicate this study to my late mother,

BETTIE CRAWFORD

Your love, support and belief in me encouraged me to shine.

ACKNOWLEDGEMENTS

Thank you, Lord, for carrying me, so that I could reach this place.

I would also like to thank

Dr Carlien van Wyk, my study leader, who guided, encouraged and supported me to believe I could achieve my goal. A special thanks for always being available.

Prof Vera Roos and **Dr Shingarai Chigeza** from North-West University, for your insight and supportive feedback.

My language editor, **Alette de Beer**, for your insight and constructive recommendations.

All the **primary caregivers** who so willingly took part in this study. Your stories will live on in this work as an encouragement of your amazing ability to survive your pain.

Mrs R. de Jager, Mrs Heleen Louw and **all my peers** at TygerBear. You inspire me to continue the work.

My **friends, Roshin, Tracey and Shani**, who encouraged and helped me along the way. A very special thanks to **Shani** for your assistance with Afrikaans translations.

My **sister, Jaci**, for helping me to find perspective when things became stressful and for believing in me.

My **father, Lennie Crawford**, for your quiet, calming presence in my life and for the sacrifices you made for me.

My **husband, Haroon**, and **my children, Reza, Riyaadh, Nadia, Aadil** and **Muhammad Hamza**, for your tolerance of me and all the many hours I spent away from you. Thank you for understanding when I needed space and supporting me to reach my goals.

SUMMARY

Paternal incest is the intimate sexual contact between biological, step or foster fathers and their children. These father-figures include the live-in partners of the non-offending mother. The actual incidence of paternal incest in South Africa is not known; however, the South African Police Services report the incidence of incest in the Western Cape for 2011/2012 to be the second highest in South Africa. When children reveal the incest to any person, this is called disclosure. After disclosure and with the removal of the paternal figure from the family unit, the mother or grandmother is responsible for the sole care of the child-victim and becomes the primary caregiver. However, in the South African context it is traditionally accepted that the grandmother assumes the role of primary caregiver of the child where the child's mother and/or father are unable to fulfil their parental role adequately. Therefore in this study, "primary caregivers" refers to mothers and maternal grandmothers.

In the South African context, limited studies have been done that explore the experiences of primary caregivers whose children or grandchildren were exposed to paternal incest. There is also a lack of information on how to support these primary caregivers in the abovementioned context. The aim of this study was firstly to explore the experiences of primary caregivers whose children or grandchildren were exposed to paternal incest and secondly to use these experiences to suggest guidelines that may be utilised by practitioners (such as social workers and registered counsellors) to develop support programmes for these caregivers.

The research was conducted at a non-profit organisation in the Western Cape Province of South Africa, that provides psychosocial services and where cases of paternal incest are referred for intervention. A qualitative, phenomenological research design was applied in this study to obtain rich data. Six primary caregivers were chosen through purposive sampling, on the basis that their children or grandchildren were exposed to paternal incest within the last five years. Of these, four were mothers and two were maternal grandmothers who were responsible for the children. Data was collected through in-depth interviews and was analysed thematically.

Two main themes emerged from the study. The first theme involved reactions to the disclosure and its aftermath, which encompassed emotional, cognitive and physiological reactions that are similar to secondary traumatisation. The second theme was coping strategies that emerged to deal with the disclosure and its aftermath, which encompassed effective coping strategies (behavioural coping strategies to actively solve problems and the presence of social support), unhealthy or negative coping strategies (behavioural coping strategies of avoidance) and threats to coping (a lack of social support). The contribution of this study lies in the suggestion of guidelines for the support of primary caregivers whose children or grandchildren were

exposed to paternal incest. These guidelines include the provision of emotional support, multidisciplinary practitioner support and educational support programmes.

Key words: Paternal incest, secondary traumatisation, primary caregivers, emotional support, multidisciplinary practitioner support, educational support programmes

OPSOMMING

Paterne bloedskande is die intieme seksuele kontak tussen biologiese, stief- of pleegvaders en hul kinders. Hierdie vaderfigure sluit inwonende lewensmaats van die nie-oortredende moeder in. Die presiese aantal voorvalle van paternale bloedskande in Suid-Afrika is nie bekend nie, maar 'n verslag van die Suid-Afrikaanse Polisie dui aan dat die voorvalle van bloedskande in die Wes-Kaap die tweede hoogste in Suid-Afrika was vir die 2011/2012-jare. As 'n kind die bloedskande aan enige persoon bekend maak, word dit "onthulling" genoem. Na die onthulling en met die verwydering van die vaderfiguur uit die familie-eenheid word die moeder of materne ouma alleenlik verantwoordelik vir die versorging van die kind-slagoffer en word sy die primêre versorger. In die Suid-Afrikaanse konteks word tradisioneel aanvaar dat die ouma die rol van primêre versorger van die kind oorneem wanneer die kind se moeder en/of vader nie in staat is om hul plig as ouers te vervul nie. Daarom verwys "primêre versorgers" in hierdie studie na moeders en materne oumas.

In die Suid-Afrikaanse konteks is daar tot dusver beperkte studies gedoen wat die ervaringe van primêre versorgers wie se kinders of kleinkinders aan paterne bloedskande blootgestel is, ondersoek. Daar is ook 'n tekort aan inligting oor hoe om die primêre versorgers te ondersteun in die bogenoemde konteks. Die doel van hierdie studie was eerstens om die ervaringe van primêre versorgers wie se kinders of kleinkinders aan paterne bloedskande blootgestel is, te verken en tweedens om op grond van hierdie ervaringe riglyne voor te stel waarvolgens praktisyns (soos maatskaplike werkers en geregistreerde beraders) ondersteuningsprogramme vir hierdie versorgers kan ontwikkel.

Die navorsing is uitgevoer by 'n nie-winsgewende organisasie in die Wes-Kaap Provinsie van Suid-Afrika wat psigo-maatskaplike dienste verskaf en waarheen gevalle van paterne bloedskande vir intervensie verwys word. 'n Kwalitatiewe fenomenologiese navorsingsontwerp is in hierdie studie toegepas om ryk data te bekom. Ses primêre versorgers is gekies deur 'n proses van doelbewuste steekproefneming, op grond daarvan dat hul kinders of kleinkinders in die afgelope vyf jaar aan paterne bloedskande blootgestel is. Hierdie versorgers bestaan uit vier moeders en twee materne oumas wat vir die kinders verantwoordelik was. Die data is verkry deur in-diepte onderhoude en is tematies geanaliseer.

Twee hoofemas het in die studie na vore gekom. Die eerste tema behels reaksies op die onthulling en die naloop daarvan, wat emosionele, kognitiewe en fisiologiese reaksies soortgelyk aan sekondêre traumatisering omvat. Die tweede tema is hanteringstrategieë wat na vore kom om die onthulling en die naloop te hanteer. Dit omvat effektiewe hanteringstrategieë (gedrags-hanteringstrategieë vir aktiewe probleemoplossing en die teenwoordigheid van

maatskaplike ondersteuning) ongesonde of negatiewe hanteringstrategieë (gedrags-hanteringstrategieë van vermyding) en bedreigings vir hantering ('n gebrek aan maatskaplike ondersteuning). Die bydrae van die studie lê in die voorstel van riglyne vir ondersteuning van primêre versorgers wie se kinders of kleinkinders aan paterne bloedskande blootgestel is. Hierdie riglyne sluit die verskaffing van emosionele ondersteuning, multidissiplinêre praktisyn-ondersteuning en opvoedkundige ondersteuningsprogramme in.

Sleutelwoorde: Paterne bloedskande, sekondêre traumatisering, primêre versorgers, emosionele ondersteuning, multidissiplinêre praktisyn-ondersteuning, opvoedkundige ondersteunings-programme

PREFACE

We, the supervisor and co-supervisor, hereby declare that the input and the effort of Melanie Fiona Saloojee in writing this article reflects research done by her on this topic. We hereby grant permission that she may submit this article for examination in fulfilment of the requirements for the degree Magister Artium in Psychology.

- The dissertation is presented in article format as indicated in Rule A.5.4.2.7 of the North-West University Potchefstroom Campus Yearbook.
- The dissertation consists of Section 1: Background to the study, Section 2: The Article and Section 3: Critical reflections on the study.
- The article is intended to be submitted to the journal ***Child Abuse Research in South Africa (CARSA)***.
- In Section 2, which comprises the article, the researcher has followed the Harvard Method of referencing as well as the guidelines of the article format stipulated by CARSA (provided in Appendix B); this includes no numbering of sections.
- Sections 1 and 3 have been referenced according the Harvard Method as stipulated in the North-West University's referencing manual.

A CD accompanies this dissertation, which contains a summary of the background and experiences of the participants, as well as the findings of the study in tabular form (themes, subthemes and categories with appropriate quotes).



Dr Carlien van Wyk



Prof Vera Roos

DECLARATION BY RESEARCHER

I hereby declare that this research, **The experiences of primary caregivers whose children/grandchildren were exposed to paternal incest**, is my own input and effort and that all the sources have been fully referenced and acknowledged.



Ms Melanie Fiona Saloojee

23290242

DECLARATION BY THE LANGUAGE EDITOR

Hereby I declare that I have language edited and proofread the thesis: **The experiences of primary caregivers whose children/grandchildren were exposed to paternal incest** by Melanie Fiona Saloojee for the degree Magister Artium in Psychology.

I am a freelance language practitioner after a career in public relations, with degrees in languages as well as translation and professional writing from the University of Pretoria.

Alette de Beer
BA Languages (Journalism) (UP)
BA (Hons) Translation and Professional Writing (UP)

November 2013

TABLE OF CONTENTS

ACKNOWLEDGEMENTS	i
SUMMARY	iii
OPSOMMING	v
PREFACE	vii
DECLARATION BY RESEARCHER	viii
DECLARATION BY THE LANGUAGE EDITOR	ix

SECTION 1: BACKGROUND TO THE STUDY

1. INTRODUCTION	2
2. LITERATURE ORIENTATION	2
2.1 Incest.....	2
2.2 Paternal incest.....	2
2.3 Family types in which paternal incest can occur	3
2.3.1 <i>The chaotic family</i>	3
2.3.2 <i>The normal-appearing family</i>	3
2.3.3 <i>The emotionally isolated family</i>	3
2.3.4 <i>The patriarchal, authoritarian family</i>	4
2.3.5 <i>The matriarchal, authoritarian family</i>	4
2.3.6 <i>The abused family</i>	4
2.3.7 <i>An overview of the paternally incestuous family types</i>	4
2.4 Implications of paternal incest	5
2.5 Non-offending mothers or grandmothers as primary caregivers	5
2.6 Phenomenology	7
3. THE PROBLEM STATEMENT	8
4. STRUCTURE OF THE RESEARCH REPORT	9
REFERENCES.....	10

SECTION 2: ARTICLE

THE EXPERIENCES OF PRIMARY CAREGIVERS WHOSE CHILDREN/GRANDCHILDREN WERE EXPOSED TO PATERNAL INCEST

Abstract.....	17
INTRODUCTION	18
THEORETICAL FRAMEWORK	19
PROBLEM FORMULATION.....	20

RESEARCH METHODOLOGY	21
RESEARCH CONTEXT	21
PARTICIPANTS	22
ETHICAL GUIDELINES	23
DATA COLLECTION	23
DATA ANALYSIS	24
TRUSTWORTHINESS	24
DISCUSSION OF FINDINGS	26
THEME 1: REACTIONS TO THE DISCLOSURE AND ITS AFTERMATH	27
THEME 2: COPING STRATEGIES THAT EMERGED TO DEAL WITH THE DISCLOSURE AND ITS AFTERMATH	32
IMPLICATIONS OF THE FINDINGS	38
SUGGESTED GUIDELINES	40
LIMITATIONS OF THE STUDY	41
RECOMMENDATIONS FOR FURTHER STUDY	41
CONCLUSION	41
REFERENCES	42

SECTION 3:CRITICAL REFLECTIONS ON THE STUDY

1. CRITICAL REFLECTIONS ON THE STUDY	47
1.1 Emotional support programmes	48
1.2 Multidisciplinary practitioner support	49
1.3 Educational support programmes	49
2. PERSONAL REFLECTIONS OF THE RESEARCHER	49
3. CONCLUSION	50
REFERENCES	51

LIST OF APPENDICES:

APPENDIX A: CONSENT FORM	53
APPENDIX B: JOURNAL GUIDELINES FOR ARTICLE (CARSA)	54

LIST OF TABLES:

Table 1: A summary of the participants' information	22
Table 2: An outline of the steps followed for trustworthiness	24
Table 3: Identified themes and subthemes	26

SECTION 1

BACKGROUND TO THE STUDY

1. INTRODUCTION

In this section the most important concepts of this study will be discussed in the literature orientation. Thereafter the problem statement and structure of the research report will also be outlined.

2. LITERATURE ORIENTATION

2.1 Incest

Incest may be defined as “any kind of exploitative sexual contact or attempted contact that occurs between relatives, no matter how distant the relationship” (Russell, 1999:41). According to Courtois (2010:44-45), there are three categories of incest, namely consanguinal incest (sexual contact between blood relatives), affinal incest (involving relatives by marriage or adoption) and quasi-relative incest (involving members who assume a family role, like a foster parent or live-in lover).

The South African Police Services (2011/2012) places incest in the category of *other sexual offences* (which excludes rape and sexual assault) and has reported 2 872 sexual offences in South Africa during 2011/2012. Of this number, 714 cases have been reported in Gauteng, which is the highest, and 513 cases in the Western Cape Province, the second highest in the country. According to Shields (2010:1), one third of the total number of cases of sexual offences against children are attributed to incest.

2.2 Paternal incest

In an analysis done of data from a South African clinic that provides services to children who have been exposed to sexual offences, Higson-Smith and Thacker (2003) found that out of a sample of 306 children, 25% experienced sexual contact by their biological father or mother’s partner, as opposed to 1.9% by their mothers. The sexual contact between fathers (biological or other) and their children is called paternal incest and may be categorised as consanguinal, affinal or quasi-relative, according to the type of relationship between the father and the child (Courtois, 2010:45;97). Fathers may sexually abuse their daughters as well as their sons. Although boys may be subjected to sexual abuse by their fathers, the overwhelming majority of victims are female (Courtois, 2010:93; Herman, 1981:76; Vogelmann, 1990:3).

2.3 Family types in which paternal incest can occur

Several family types in which paternal incest can occur were identified by Courtois (2010:119-120), Kempe and Kempe (1984), Spies (2006:3-20) and Vogelmann (1990:2) and will be discussed in this section.

2.3.1 The chaotic family

This family type is characterised by recurring generational problems involving low socioeconomic status, family members exposed to ongoing community violence, substance abuse, lawlessness, state assistance, erratic community contact, poor education, underachievement at work, unstable intimate serial relationships and the mixing of children from these relationships. In this type of family, sexual involvement with one another is common and the children born from these relationships are raised in the family, resulting in the blurring of paternity and generations (Courtois, 2010:82-83; Kempe & Kempe, 1984).

2.3.2 The normal-appearing family

According to Courtois (2010:83) and Kempe and Kempe (1984) this family type appears to be functioning normally to the outside world. The parents are usually in a monogamous relationship and are financially and socially stable. On the inside, however, the parents may not provide emotional nurturance to each other or their children. Busy work and social schedules developed by either of the parents may encourage emotional and sexual distance. Their relationship thus deteriorates and the parents may become unavailable to one another. This unavailability may lead to the parents turning to their children to fulfil their needs instead of embarking on extra-marital affairs, which may cause family disintegration. Spies (2006:3) argues that incest is used as a coping mechanism whereby the father, who lacks self-regulation skills to control impulses for sexual gratification, fulfils his needs within the family system. Sholevar (2003:695) contends that although its practice causes the integrity of the family system to be violated, incest is tolerated by its members so that the family would not disintegrate.

2.3.3 The emotionally isolated family

This family type is characterised by secrecy and dependence on one another. Members are not allowed to venture outside of the family system. Force may be used by the father to prevent the family from interacting with outsiders and therefore isolates the family emotionally. Feelings of the family members are not acknowledged by one another. Family problems are kept within this

closed system and talking out is considered to be taboo (Krause, 2010:2; Spies, 2006:12-13; Vogelman, 1990:2).

2.3.4 The patriarchal, authoritarian family

In such families, the father as the head demands respect and obedience. He dominates and views his wife and children as his property. Despite this dominance within the home, he may be inadequate when it comes to social relationships involving adults. The father commonly withdraws and prefers to have relationships with dependent, submissive women or children, within the home, who seem to be less of a threat to him (Krause, 2010:3; Spies, 2006:12;16; Townsend & Dawes, 2004:63-64; Vogelman, 1990:2). The wives in this family type are passive, dependent and emotionally immature and as such become deeply enmeshed in their relationship with their husbands (Hules, 2005:15; Vogelman, 1990:2).

2.3.5 The matriarchal, authoritarian family

In these families, the mother is the dominant figure and the father is dependent on her. The wife fulfils a motherly role for the husband and treats him as one of the children. The husband withdraws from the wife and develops a relationship with the daughter, who fills the emotional void created by this withdrawal. The daughter eventually takes on the mother's role as wife (Spies, 2006:16).

2.3.6 The abused family

In this family type, both husband and wife come from incestuous or physically abusive backgrounds with unmet needs for affection. When the couple are unable to meet these needs in each other, they turn to their children for comfort and sexual gratification (Spies, 2006:18), in this way transferring the abuse across generations. Literature by Cooper and Cormier (1982:231-235) and Courtois (2010:85) explain that the father with a history of his own incestuous victimisation may repeat this in his own family. Likewise, the mother with an unresolved history of incest with her own father may be unable to prevent incest from occurring between her husband and children.

2.3.7 An overview of the paternally incestuous family types

In the preceding exposé of paternally incestuous family types, it is evident that family members have difficulty negotiating their basic needs for emotional nurturance, sexuality, affection and trust within the family unit, thus giving rise to unacceptable social ways to attain them, in the

form of incest. The aim of this behaviour seems to be that of preventing family disintegration or abandonment by some of its members (Spies, 2006:20). Paternal incest has a great potential for harm due to the biological and relational bonds between a father and his children. Breaking of these bonds is a betrayal of the parents' responsibility as primary caregivers and their role as protectors and nurturers (Courtois, 2010:93). The implications of paternal incest are outlined below.

2.4 Implications of paternal incest

Since paternal incest has a repetitive nature and may be accompanied by violence, the child may be harmed physically, psychologically and emotionally (Grogan, 2011:3;19; Vogelman, 1990:2). It is considered to be the most disturbing type of incest and has a heightened potential for traumatisation (Courtois, 2010:93).

No matter the age of the child, the effects are shocking and damaging to the child-victim. Studies (Finkelhor & Browne, 1985:530; Richter & Higson-Smith, 2004:25-26; Spies, 2006:44) about survivors of paternal incest outline testimonies of scars left by this scourge. Trauma experts Finkelhor and Browne (1985:530) describe the following effects of paternal incest on children: traumatic sexualisation, stigmatisation, betrayal of trust and powerlessness. Other authors (Bailey, 2005:144; James, 1989:21-38; Strand, 2000:17; Van der Merwe, 2009:25) add self-blame, loss, fragmentation of bodily experience, eroticisation, destructiveness, dissociation and attachment disorder to these effects. Another aspect mentioned by Roos (2005:23) and Spies (2006:53) is that child-victims lose their innocence and their childhood.

The effects of paternal incest in a family are not solely experienced by the child-victim. The whole family experience the emotional distress, physiological and psychological symptoms that affect the way they live and the family structure (Cwik, 1996:95-116; Morrison, Quadara & Boyd, 2007:6-9). Although the whole family may be affected (Bailey, 2005:139), in the context of this study, the focus is on the non-offending mothers or grandmothers of the children or grandchildren, who become solely responsible for their care as a result of the father or child-victim being removed from the home.

2.5 Non-offending mothers or grandmothers as primary caregivers

Primary caregivers in this study are non-offending mothers or grandmothers. These primary caregivers become aware of the paternal incest of their children or grandchildren in various ways. Some of the child-victims tell the primary caregivers about the incestuous acts, others tell someone they trust (perhaps a teacher or friend) and in the case of younger children, physical

harm or behavioural signs of incest are noticed by the primary or other caregivers (Higson-Smith & Lamprecht, 2004:344). Telling someone about a secret such as paternal incest is called disclosure (Allnock, 2010:1; Rober, Walravens & Versteijnen, 2011:7). Merely from the disclosure of the incestuous acts, the primary caregivers form visual images of what the child-victim endured, which causes them to become traumatised (Willingham, 2007:4).

The children's direct exposure to paternal incest makes them the primary victims of the resultant trauma and their parents and other family members, who are indirectly impacted by the trauma, are secondary victims (Shah, Garland & Katz, 2007:59). Strand (2000:17) and Morrison *et al.* (2007:6-9) confirm that the effects of incest trauma on the child-victims may be transferred to the primary caregivers so that they become secondary victims of the trauma. Only recently have researchers begun to view the primary caregiver as a secondary victim of the paternal incest of their children (Strand, 2000:17), as discussed above. Earlier literature viewed the primary caregiver as non-protective and collusive (Jacobs, 1990:502; Justice & Justice, 1979:96-97; Weinberg, 1955). Contrary to earlier views, some current authors state that most mothers act supportively and protectively (Heriot, 1996:181-194; Strand, 2000:72;9; Willingham, 2007:13) and through their supportive actions, the degree of traumatisation in secondary victims may be as severe as those experienced by primary victims (Headington Institute, 2011).

Furthermore, Mbokazi (2005:103) even declares that the primary care-giving mother is a primary trauma victim of the paternal incest of the child due to the loss of her relationship with her partner. Other literature (Appleyard & Osofsky, 2003:115) states that the primary caregivers who have been exposed to their children's trauma display similar symptoms to their children. Their parenting of the children as well as their own daily functioning may be affected. These researchers go on to say that the primary caregivers' traumatic response to the trauma endured by the child may create a complex system that may maintain or contribute to the dysfunction of both the primary caregiver and the child. Willingham (2007:3) agrees that this complex system is made up of the compounding effects or symptoms of the combined trauma experienced by both the caregiver and the child.

Primary caregivers are not a homogenous group. Their experiences and subsequent reactions to paternal incest trauma may vary, as found by Mbokazi (2005:42) and Myer (1985:47-58). Other researchers (Howard, 1993:176; Willingham, 2007:1-2) believe that differences in personality styles, personal histories, levels of intelligence, stages of identity development, financial situations and personal support systems will cause primary caregivers' experiences of the paternal incest in their families to vary. Strand (2000:16) adds that the experiences of these effects may be compounded if the primary caregiver is a victim of her own childhood experiences of incest trauma. Appleyard and Osofsky (2003:113-114) confirm that primary

caregivers could revisit past trauma of their own due to emotional or situational triggers that are similar to these past experiences. In addition to the differences in background and trauma experiences mentioned above, primary caregivers may be either mothers or grandmothers as it is a reality and common practice in South Africa for grandmothers to be the sole carers of their grandchildren in situations where mothers or fathers are unable to fulfil this role. Traditionally, grandmothers are considered to be the most appropriate alternate caregivers for children and are believed to share the same amount of interest and affection that parents would have for their children (Safman, 2004:11;19). Sometimes the role of grandmothers as primary caregivers is not freely chosen, but rather adopted because of family expectations, cultural norms and situations where parents are unable to care for their children, due to poverty, sexual and other forms of abuse and even death (Mudavanhu, Puleng & Fourie, 2008:78; Winston, 2006:91;100).

Primary caregivers' experiences can therefore only be understood according to the meaning that they ascribe to them. This study is therefore based on the phenomenology (Fouché & Schurink, 2011:316; Henning, van Rensburg & Smit, 2004:34) of these primary caregivers where their experiences, deeply held beliefs, feelings or worldviews may be expressed in their own language by their own voices. Working in a phenomenological way allows for the exploration of personal experiences within the contexts of their lived world, as the one aspect may only be understood in relation to the other (Fouché & Schurink, 2011:316; Lindegger, 2006:463).

2.6 Phenomenology

Phenomenology, according to Creswell (2009:13) seeks to describe the essence of basic lived experience by looking at its *lived-through quality*, as well as the *meaning of the expressions* of this lived experience. In the process of utilising phenomenology as both a philosophy and a research method, the researcher works from the assumption that the meaning of lived experience is hidden within the research participants' expression of their experiences. These hidden aspects will be allowed to show itself when the participants name and describe their experiences. It is therefore imperative that the researcher's own experiences be set aside and that descriptions of the participants' experiences be from the participants' own perspectives and not that of the researcher.

According to van Manen (1990:9) phenomenology further aims to gain a deeper understanding of the lived experiences of participants, as it was presented to them from their own consciousness (deliberate, intentional awareness). Van Manen adds that anything that presents itself to consciousness may be real or imagined, measurable or subjectively felt and is

worth exploring, as the significance attached to it would be their own, and this is what is desired in this type of theoretical framework.

3. THE PROBLEM STATEMENT

Most of the literature on paternal incest focuses on its effects on adolescent girls (Morrow & Sorrel, 1989:677-678; Spies, 2006:55-59) and adult women (Brand & Alexander, 2003:285-293; Newman & Peterson, 1996:463-473). Other studies have explained the effects of paternal incest on the mother-daughter relationship (Bolen & Lamb, 2002:265-276; Mbokazi, 2005; Plummer & Eastin, 2007:1053-1071; Tjersland, Gulbrandsen, Juuhl, Jensen, Mossige & Reichelt, 2008:243-257). In the past, studies concerning the non-offending primary care-giving mother in paternally incestuous families showed that negative reactions to paternal incest disclosure were displayed and furthermore, the mother was accused of being collusive, rejecting, disbelieving, unaware and non-protective (Justice & Justice, 1979:96-97; Plummer & Eastin, 2007:1053-1055; Weinberg, 1955). More recent studies explained that primary caregivers were secondary victims of their children's traumatic experiences (Appleyard & Osofsky, 2003:115; Mbokazi, 2005:69; Morrison *et al.*, 2007:6-9; Strand, 2000:17). A small number of studies focused on non-offending primary care-giving mothers' marital role, parenting role, domestic violence exposure and the evaluation of interventions that were drawn up (Willingham, 2007:7). Researchers (Kleijn, 2010; Pretorius, Chauke & Morgan, 2011) have found that most studies have focused on the experiences of child-victims and the perpetrator; therefore there is limited research that has been done on the experiences of primary caregivers.

Current studies conducted in a South African context have explored the effects of paternal incest on the mother-child relationship (Mbokazi, 2005). Another study by Smit (2007) explored the reactions of mothers to the disclosure of paternal incest as experienced by their adolescent daughters. Pretorius *et al.* (2011) conducted a study about the experiences of non-offending primary care-giving mothers whose children were exposed to paternal incest, and focused solely on their emotional reactions to the trauma. These studies have mainly focused on the mother-child relationship and the caregivers' emotional reactions in their attempts to support the child-victim. The support needs of these primary caregivers have not been fully explored; that is what motivated this research study. This is confirmed by Stitt and Gibbs (2007:13) who state that there are limited guidelines available on how to support these caregivers after the secondary trauma they had experienced. This study therefore attempts to research the experiences of primary caregivers (both mothers and grandmothers) from their own perspectives and to utilise these experiences to suggest guidelines of support for them. Practitioners (social workers and registered counsellors) could draw on the findings of this study

to develop programmes of support and provide psychosocial education surrounding the outcomes of the study.

The aim of the study is thus firstly to explore the experiences of primary caregivers whose children or grandchildren were exposed to paternal incest and secondly to use these experiences to suggest guidelines that may be used by practitioners to develop programmes to support them.

4. STRUCTURE OF THE RESEARCH REPORT

In Section 1, a background to the study was provided where the most important concepts underpinning this study were discussed; this led to the formulation of the aim of the study. In Section 2, the research report is presented in article format. An introduction is provided that outlines paternal incest in families, the disclosure thereof, the resultant care of the child, the primary caregiver and secondary trauma. These elements lead to the formulation of the problem and the research question for this study. A general outline is given of the research process, which comprises the aim, research design, the methodology followed and the findings. In the findings, primary caregivers' experiences are discussed and guidelines are suggested for their support. In Section 3, critical reflections on the study as well as personal reflections are discussed.

REFERENCES

- Allnock, D. 2010. Children and young people disclosing sexual abuse: an introduction to the research. <http://www.nspcc.org.uk/inform> Date of access: 10 Oct. 2012.
- Appleyard, K. & Osofsky, J.D. 2003. Parenting after trauma: supporting parents and caregivers in the treatment of children impacted by violence. *Infant mental health journal*, 24(2):111-125.
- Bailey, C.E. 2005. Children in therapy: using family as a resource. New York: W.W Norton & Company.
- Bolen, R.M. & Lamb, J.L. 2002. Guardian support of sexually abused children: a study of its predictors. *Child maltreatment*, 7(3):265-276.
- Brand, B.L. & Alexander, P.C. 2003. Coping with incest: the relationship between recollections of childhood coping and adult functioning in female survivors of incest. *Journal of traumatic stress*, 16(3):285-293.
- Cooper, I. & Cormier, M. 1982. Intergenerational transmission of incest. *Canadian journal of psychiatry*, 278:231-235.
- Courtois, C.A. 2010. Healing the incest wound. Adult survivors in therapy. 2nd ed. New York: W.W. Norton & Company.
- Creswell, J.W. 2009. Research design: qualitative, quantitative and mixed methods approaches. USA: Sage.
- Cwik, M.S. 1996. The many effects of rape: the victim, her family, and suggestions for family therapy. *Family therapy*, 23(2):95-116.
- Finkelhor, D. & Browne, A. 1985. The traumatic impact of child sexual abuse. A conceptualisation. *American journal of orthopsychiatry*, 55(4):530-541.
- Fouché, C.B. & Schurink, W. 2011. Qualitative research designs. (In De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L., eds. Research at grass roots: for the social sciences and human service professions. Pretoria: Van Schaik. p.307-327.)
- Grogan, C.L. 2011. The wound and the voiceless: The insidious trauma of father-daughter incest in six American texts. Tampa, FL: University of South Florida. (Dissertation – PhD).

Headington Institute. 2011. Understanding and coping with traumatic stress. <http://www.headington-institute.org/Default.aspx?tabid=2182> Date of access: 9 May 2013.

Henning, E., van Rensburg, W. & Smit, B. 2004. Finding your way in qualitative research. Pretoria: Van Schaik.

Heriot, J. 1996. Maternal protectiveness following the disclosure of intra-familial child sexual abuse. *Journal of interpersonal violence*, 11:181-194.

Herman, J.L. 1981. Father-daughter incest. Cambridge, MA: Harvard University Press.

Higson-Smith, C. & Lamprecht, L. 2004. Access to specialist services and the criminal justice system: data from the Teddy Bear Clinic. (In Richter, L., Dawes, A. & Higson-Smith, C., eds. Sexual abuse of young children in South Africa. Cape Town: HSRC Press. p.335-355.)

Higson-Smith, C. & Thacker, M. 2003. Summative and formative evaluation of the Teddy Bear Clinic. Research report. Johannesburg: Psych-Action (unpublished).

Hules, J.A. 2005. The traditional values of sex offenders and their victims: what the research shows. http://www.hules.us/CS_ch02.pdf Date of access: 15 Oct. 2012.

Jacobs, J.L. 1990. Reassessing mother blame in incest. *Journal of women in culture and society*, 15(3):500-514.

James, B. 1989. Treating traumatized children. New insights and creative interventions. New York: The Free Press.

Justice, B. & Justice, R. 1979. The broken taboo: Sex in the family. New York: Human Sciences.

Kempe, R. & Kempe, H. 1984. The common secret. New York: Freeman.

Kleijn, A.A. 2010. The demographic profile and psychosocial history of a group of convicted perpetrators of the rape of children under the age of three years. <http://www.wiredspace.wits.ac.za/bitstream/handle/10539/8574/vol1.pdf> Date of access: 4 Jun. 2012.

Krause, E. 2010. The effect of incest on interpersonal relationships of young adult females seen at a private clinic in Pretoria: A preliminary investigation. Ga-Rankuwa: University of Limpopo - Medunsa. (Dissertation – MA).

Lindegger, G. 2006. Research methods in clinical research. (*In* Terre Blanche, M., Durrheim, K. & Painter, D., eds. *Research in practice: Applied methods for the social sciences*. Cape Town: University of Cape Town Press. p. 456-475.)

Mbokazi, F.M. 2005. The impact of father-daughter incest on the mother-daughter relationship. Johannesburg: WITS. (Dissertation – MA).

Morrow, K.B. & Sorell, G.T. 1989. Factors affecting self-esteem, depression and negative behaviours in sexually abused female adolescents. *Journal of marriage and family*, 51(3):677-686.

Morrison, Z., Quadara, A. & Boyd, C. 2007. "Ripple Effects" of sexual assault. *Australian Institute of Family Studies*. <http://www.aifs.gov.au/acssa/pubs/issue/i7.html> Date of access: 20 Aug. 2012.

Mudavanhu, D., Puleng, S. & Fourie, E. 2008. Grandmothers caring for their grandchildren orphaned by HIV and AIDS. *New voices in psychology*, 4(1):76-96.

Myer, M.H. 1985. A new look at mothers of incest victims. *Journal of social work and human sexuality*, 3(2-3):47-58.

Newman, A.L. & Peterson, C. 1996. Anger of women incest survivors. *Sex roles*, 34(7/8):463-473.

Plummer, C.A. & Eastin, J. 2007. The effect of child sexual abuse allegations/ investigations on the mother-child relationship. *Violence against women*, 2007, 7:1053-1071.

Pretorius, G., Chauke, A.P. & Morgan, B. 2011. The lived experiences of mothers whose children were sexually abused by their intimate male partners. *Indo-Pacific journal of phenomenology*, 11(1):1-14.

Richter, L. & Higson-Smith, C. 2004. The many kinds of sexual abuse of young children. (*In* Richter, L., Dawes, A. & Higson-Smith, C., eds. *Sexual abuse of young children in South Africa*. Cape Town: HSRC Press. p.21-35.)

Rober, P., Walravens, G. & Versteijnen, L. 2011. "In search of a tale they can live with": About loss, family secrets, and selective disclosure. *Journal of marital and family therapy*, 38(3):1-13.

Roos, N. 2005. *Praatdaaroor: 'n Handleiding vir seksueel-gemolesteerde vroue*. Pretoria: Lapa.

Russel, D.E.H. 1999. *The secret trauma: incest in the lives of girls and women*. 2nd ed. New York: Basic Books.

Safman, R.M. 2004. Assessing the impact of orphanhood on Thai children affected by AIDS and their caregivers. *AIDS CARE*, 16(1):11-19.

Shah, S.A., Garland E. & Katz C. 2007. Secondary traumatic stress: prevalence in humanitarian aid workers in India. *Traumatology*, 3(1):59-70.

Shields, R. 2010. South Africa's shame: the rise of child rape.

<http://www.independent.co.uk/news/world/africa/south-africas-shame-the-rise-of-child-rape-1974578.html> Date of access: 9 May 2013.

Sholevar, M.D. 2003. *Textbook of family and couple therapy: clinical applications*. London: American Psychiatric Publishing.

Smit, H.A. 2007. *Adolescents' experiences of parental reactions to the disclosure of child sexual abuse*. Pretoria: UP. (Dissertation – MSD).

South African Police Service. 2011/2012. *An analysis of the national crime statistics*.

Addendum to the Annual Report 2011/2012.

http://www.saps.gov.za/saps_profile/strategic_framework/annual_report/2011_2012/saps_crime_stats_report_%202011-12.pdf Date of access: 15 Jan. 2013.

Spies, G.M. 2006. *Sexual abuse: dynamics, assessment and healing*. Pretoria: Van Schaik.

Stitt, S. & Gibbs, B. 2007. Non-offending mothers of sexually abused children: the hidden victims. *Institute of Technology Blanchardstown journal*, 15:13-37.

Strand, V.C. 2000. *Treating secondary victims: intervention with the non-offending mother in the incest family*. California: Sage.

Tjersland, O.A., Gulbrandsen, W., Juuhl-Langseth, M., Jensen, T., Mossige, S. & Reichelt, S. 2008. From betrayal to support: a case history of support. *Journal of family psychotherapy*, 19(3):242-258.

Townsend, L. & Dawes, A. 2004. Individual and contextual factors associated with the sexual abuse of children under 12: a review of recent literature. (In Richter, L., Dawes, A. & Higson-Smith, C., eds. *Sexual abuse of young children in South Africa*. Cape Town: HSRC Press. p.55-94)

Van der Merwe, M. 2009. Traumagenic dynamics as fundamental constructs in sexual trauma intervention: Beyond Finkelhor and Browne. *Journal of child abuse research in South Africa*, 2(10):25-40.

Van Manen, M. 1990. *Researching lived experience. Human science for an action sensitive pedagogy*. Canada: Althouse Press.

Vogelman, L. 1990. Debunking some myths of the "sex monster" syndrome. Centre for the study of violence and reconciliation. <http://www.csvr.org.za/wits/articles/artvoqe3.htm> Date of access: 24 Jun. 2011.

Weinberg, S.K. 1955. *Incest behaviour*. New York: Citadel.

Willingham, E.U. 2007. *Maternal perceptions and responses to child sexual abuse*. Atlanta: Georgia State University. (Dissertation).

Winston, A.C. 2006. African American grandmothers parenting AIDS orphans: grieving and coping. *Qualitative social work*,5(1):33-43.

SECTION 2

ARTICLE

**THE EXPERIENCES OF PRIMARY CAREGIVERS WHOSE CHILDREN/GRANDCHILDREN
WERE EXPOSED TO PATERNAL INCEST**

The experiences of primary caregivers whose children/grandchildren were exposed to paternal incest

M.F.Saloojee

149 Wallace Street

Goodwood

7460

Email: fiona.synchro@gmail.com

Dr C. Van Wyk*

Institute of Child, Youth and Family Studies

North-West University

Wellington

Email: Carlien.VanWyk@nwu.ac.za

Prof V. Roos

School of Psychosocial Behavioural Sciences

Psychology

North-West University

Potchefstroom

E-mail: Vera.Roos@nwu.ac.za

*To whom correspondence should be addressed

The experiences of primary caregivers whose children/grandchildren were exposed to paternal incest

Fiona Saloojee

Carlien van Wyk

Vera Roos

North-West University, Potchefstroom

Abstract

Paternal incest is traumatic for the child-victim and has the potential to be harmful to the rest of the family members, particularly the primary caregivers (mothers and grandmothers), who therefore need to be supported. The aim of this study was firstly to explore the experiences of primary caregivers whose children or grandchildren were exposed to paternal incest and secondly to use these experiences to suggest guidelines for practitioners on how to support these caregivers. A qualitative, phenomenological design was used in the study. In-depth interviews were conducted with six primary caregivers (four mothers and two maternal grandmothers) from the coloured population group, aged between 25 and 60, from the Western Cape Province of South Africa. Data was analysed thematically. Two main themes emerged from the study. The first theme entailed reactions to the disclosure and its aftermath, which encompassed emotional, cognitive and physiological reactions that were similar to secondary traumatisation. The second theme was coping strategies that emerged to deal with the disclosure and its aftermath, which encompassed effective coping strategies (behavioural coping strategies to actively solve problems and the presence of social support), unhealthy or negative coping strategies (behavioural coping strategies of avoidance) and threats to coping (a lack of social support). Guidelines are suggested for emotional support, multidisciplinary practitioner support and educational support programmes.

Keywords: paternal incest, primary caregivers, secondary traumatisation, reactions, coping strategies, emotional support, multidisciplinary practitioner support, educational support programmes.

INTRODUCTION

Incest may be described as the sexual contact between a child and a close relative, or someone perceived to be related (Spies 2009:17). The South African Police Services (2011/2012:16), who class incest under a general category of *other contact sexual offences*, had 2 872 reported cases for the whole of South Africa and 513 in the Western Cape, the second highest number in the country, in 2011-2012. The highest was in Gauteng with 714 reported cases.

There are different types of incest, namely paternal; maternal; sibling incest and incest involving extended family members (Vogelman 1990:1; Spies 2006:5-10). Of these different types, paternal incest is considered to be the most prevalent (Higson-Smith & Thacker 2003) and occurs when a father-figure violates his child sexually. This type of incest may be classified according to the nature of the relations between the father and the child. These are consanguinal (where they are blood relatives), affinal (involving relations by marriage or adoption) and quasi-relative (involves the father as a foster parent or live-in lover). Fathers may commit incest with their daughters and/or sons (Courtois 2010:44-45). Father-daughter incest is the most documented (Spies 2006:4) and father-son incest is the least reported and therefore the least documented form of incest (Courtois 2010:118).

Paternal incest disclosure and the resultant care of the child

Revealing the secret acts of paternal incest is called disclosure (Spies 2006:48). Mothers or grandmothers are sometimes the first to whom children disclose the incest. Children may also tell other family members or their teachers. In other instances where the child does not disclose, signs of bodily harm due to the incestuous acts may be noticed by the primary and/or other caregivers (Higson-Smith & Lamprecht 2004:344). With disclosure, the perpetrating father may be removed from the family (Wickham & West 2002:25) and the family may disintegrate (Spies 2006:48). The non-offending mother then becomes the primary caregiver of the child-victim, as she is now solely responsible for the child's care (Swanepoel 2003:3). In instances where the child is removed from the family or where the mother is unable to care for the child, the child may be cared for by the maternal grandmother. The grandmother thus becomes the primary caregiver. In the South African context, grandmothers are often chosen as alternative primary caregivers for their grandchildren in circumstances where the parents of the children are not able to care for them (Mudavanhu, Puleng & Fourie 2008:78; Winston 2006:91;100). Since the father is also considered to be the primary caregiver of the child, the mothers and grandmothers will henceforth be referred to as caregivers in the context of this study.

The caregiver and secondary trauma

The paternal incest of the child affects the whole family, but the focus will specifically be on the caregiver. In recounting the story of the abuse, the caregiver is exposed to secondary trauma. The mere hearing of this story creates thoughts and images of it in the mind of these caregivers, causing them to identify with the pain and suffering of the child-victim (Morrison, Quadara & Boyd 2007:2; Willingham 2007:4). The caregivers' continued exposure to the child's trauma is stressful and they are often unable to support themselves to heal (Appleyard & Osofsky 2003:113-115; Willingham 2007:2-3; Womack, Miller & Lassiter 2000:23). Some researchers (Morrison *et al.*, 2007:6-9; Shah, Garland & Katz 2007:59; Strand 2000:16-17), state that in cases where there is no direct exposure to the trauma, the knowledge of it and resultant effects indicate that secondary victimisation and therefore secondary traumatisation occurs. In some instances where caregivers and their children or grandchildren have been exposed to paternal incest, the caregiver experiences the trauma of paternal incest of the child to the same degree that the child experiences it (Headington Institute, 2011). The very nature of the relationship between the caregiver and the child may compound the effects of the trauma in both of them (Willingham 2007:2-3).

Mbokazi (2005:69) goes further and states that caregivers are primary victims of paternal incest trauma in their children due to their relationship with the perpetrator. The primary care-giving mother is directly exposed to the break in trust of the perpetrator, her intimate partner. Whether these carers are primary or secondary victims to the trauma of the incident or not, the aftermath of the reporting process and the ensuing judicial process further distresses the caregiver, who is exposed to repetitive trauma by having to relive it (Bailey 2005:143; Willingham 2007:2-3).

The caregivers are not a homogenous group and may have different lived experiences according to Mbokazi (2005:42). Differences in their personalities, personal contexts, financial status, support structures, level of intelligence and family roles (mother or grandmother), to name a few, are factors that may cause their experiences to vary (Howard 1993:176). Based on this, it is imperative that caregivers in this study be given a voice so as to express their own experiences freely.

THEORETICAL FRAMEWORK

In this study Phenomenology was used both as the theoretical framework, and research method. For the purposes of the discussion in this section, the focus will be on phenomenology as the theoretical framework used. According to Husserl (2001) and Smith (2013:1-4), phenomenology is the study of structures of experiences as they appear and the meanings

given to these experiences from the first-person point of view. These structures of experiences are also conscious, may be passive or active and encompass perception, imagination, thought, emotion, desire, volition and action. The aforementioned theorists further explain that experiences are conscious when they are placed into awareness while living through or performing them.

Phenomenology in the context of this study, afforded the caregivers an opportunity to bring into awareness their conscious experiences. By utilising phenomenology (Lindegger 2006:463), the researcher was able to explore the personal, lived experiences of the caregivers within their life worlds, as told in their own words. When people recount stories of their life worlds, they infuse meaning into their experiences of events (Tuval-Mashiach, Freedman, Bargai, Boker, Hadar & Shalev 2004:281). Based on the aforementioned explanations, phenomenology thus describes the quality of the lived-through experience, as well as the meaning of the expressions of the lived experience (Van Manen 1990:25). Van Manen so aptly describes phenomenology as a “poetizing activity that tries an incantive, evocative speaking, a primal telling, wherein the aim is to involve the voice in an original singing of the world” (Van Manen 1990:13) – the song being the lived experience. In describing the lived experiences of the caregivers in the context of this study, the researcher attempts to make their song known, and thus the sense they make of phenomena in their life worlds, as explained by Van Manen (1990:27).

PROBLEM FORMULATION

Past literature on paternal incest has focused on its effects on adolescent girls (Morrow & Sorrel 1989:677-678), women who disclosed during adulthood (Newman & Peterson 1996:463-473) and the mother-daughter relationship (Bolen & Lamb 2002:265-276; Plummer & Eastin 2007:1053-1071). Other literature pertaining to the non-offending primary care-giving mother in families where paternal incest was prevalent (Justice & Justice 1979:96-97; Weinberg 1955), accused these mothers of being collusive and non-protective. Later, Feminist literature refuted this viewpoint, regarding these primary caregivers not as collusive, but rather as victims of a patriarchal system (Howard 1993:178). According to Stitt and Gibbs (2007:13), until this shift came about, the plight of the primary care-giving mother was overlooked. More recent studies have found that primary caregivers are secondary victims of their children’s experiences of paternal incest trauma (Appleyard & Osofsky 2003:115; Morrison *et al.*, 2007:6-9; Strand 2000:17). Having been identified as victims, these caregivers now needed support, and studies by Womack *et al.* (2000) and Willingham (2007) focused on supporting them in order to support the child.

Stitt and Gibbs (2007:13) confirm that primary caregivers in paternally incestuous families are victims in their own right, with unique needs, and that limited scientific discourse exists regarding these caregivers' needs and the support that should be provided to them. These authors add that past studies have not focused on supporting the primary caregiver for their own trauma and future well-being. Furthermore, these studies were conducted in American patriarchal contexts and may not be generalisable to our South African society.

Current studies conducted in a South African context have explored the effects of paternal incest on the mother-child relationship (Mbokazi, 2005). Smit (2007) explored mothers' reactions to the disclosure of paternal incest as experienced by their adolescent daughters and Pretorius, Chauke and Morgan (2011), explored the experiences of non-offending primary caregiving mothers whose children were exposed to paternal incest and focused solely on the mothers' emotional reactions to the trauma. Although the aforementioned studies have explored some aspects of the primary caregivers' experiences with regards to paternal incest, these experiences focused on supporting the caregiver in order to support the child-victim and not supporting the caregiver as such.

From the research and literature discussed above, it is evident that the primary caregivers whose children or grandchildren were exposed to paternal incest are not a homogenous group, may have experienced secondary trauma and are therefore victims in their own right who need to be supported. Pretorius *et al.* (2011:1) confirm that in South Africa, very few studies have been conducted about primary caregivers in the context of support for their own trauma. A gap therefore exists in the area of support for primary caregivers in this context.

The research question is therefore as follows:

What are the experiences of primary caregivers whose children or grandchildren were exposed to paternal incest?

The aim of the study is firstly to explore primary caregivers' experiences and secondly to use these experiences to suggest guidelines that can assist practitioners in drawing up support programmes for them.

RESEARCH METHODOLOGY

A qualitative, phenomenological approach was used in this study. This manner of exploration facilitates the gathering of rich data (Creswell 2009:64). This rich data is made up of the personal experiences of the participants' lived world, which may only be understood according

to the meaning that they assign to this lived world (Lindegger 2006:463; Fouché & Schurink 2011:316). The participants, in the context of this study, are the primary caregivers whose children or grandchildren were exposed to paternal incest.

RESEARCH CONTEXT

The research was conducted at a non-profit organisation in Cape Town, in the Western Cape Province of South Africa. This organisation provides a psychosocial and care service to survivors and their families who have been exposed to sexual abuse, rape and other types of trauma. It was opened in 2008 and arose due to an alarming increase in children’s trauma. Some of the sexual abuse trauma dealt with results from incest and some of these cases are specifically related to paternal incest.

PARTICIPANTS

The organisation at which this study was conducted, is situated in the northern suburbs of Cape Town; therefore its catchment area consists mostly of coloured people. Although it services all races, a large number of people that are referred to this facility are from the coloured population group and therefore all the participants of this study are from this population group. The participants, primary caregivers (non-offending mothers and maternal grandmothers) were selected by purposive sampling (Strydom 2011:232) for their knowledge and experience of their own trauma, as well as their availability to be interviewed. The criterion for this sampling was that their children or grandchildren must have been exposed to paternal incest within the last five years. A summary of the participants’ information is outlined in Table 1.

Table 1: A summary of the participants’ information

PRIMARY CAREGIVERS	AGE	CULTURAL GROUP
Primary Caregiver 1 (<i>Mother</i>)	43	Coloured
Primary Caregiver 2 (<i>Mother</i>)	39	Coloured
Primary Caregiver 3 (<i>Mother</i>)	39	Coloured

Primary Caregiver 4 (<i>Mother</i>)	25	Coloured
Primary Caregiver 5 (<i>Grandmother</i>)	50	Coloured
Primary Caregiver 6 (<i>Grandmother</i>)	60	Coloured

The participants are regarded as a vulnerable group and specific ethical considerations pertaining to them will be discussed under ethical guidelines.

ETHICAL GUIDELINES

Ethical approval (NWU-00060-12-A1) was obtained from the North-West University and permission to conduct the research was obtained from the founder/chairperson and management of the organisation where the study was to take place. The participants were invited to participate in the research by social workers from the aforementioned organisation. The researcher's contact details were provided to them so that they could make contact if they were interested in participating in the research. Six participants contacted the researcher. It was explained to them individually that the research would contribute towards exploring their experiences, with the aim of developing guidelines for support programmes. The researcher met with them and explained the aim of the study, so that the participants could make an informed decision to participate or not. The researcher has an ethical obligation to respect and protect the participants from harm (Creswell 2009:90-91) and did so by ensuring and informing them that their participation was voluntary, that they could withdraw from it at any time without being questioned, and that the information they supplied would be confidential and their identities kept anonymous. Due to the sensitivity of the topic, the researcher anticipated that emotions could surface during the interviews and took care not to explore aspects that were too painful for the participants to talk about. After the data gathering process, counselling of participants was arranged with the organisation utilised in the study. All the participants were referred for emotional support, which they could take up if the need arose.

DATA COLLECTION

Data was collected through in-depth interviews (Greef 2011:348) that were conducted with six participants and took place in a private room at the organisation utilised for the study. This type of interviewing created a deeper understanding of the experiences of the participants and the meaning they made of their experiences. During the interviews, one open-ended question was used: *What was your experience as a primary caregiver whose child or grandchild was exposed*

to paternal incest? There was one interview of approximately two hours in length with each participant, a feedback session, which the participants requested be done in a group, and telephonic interviews with two participants to verify the data collected. The interviews were recorded onto a digital voice recorder. The researcher also obtained permission from the participants to utilise the group feedback session for member checking, where the transcribed data and findings were presented to them for perusal. This gave the participants the opportunity to check the accuracy of the data and also mention if any additions should be made.

DATA ANALYSIS

The interviews were transcribed and analysed according to Braun and Clarke’s (2006:87) method of thematic analysis. Phase 1 entailed transcribing the data and identifying initial ideas. In Phase 2, initial ideas were gathered into codes. During Phase 3, themes were searched for within the gathered codes. Then, in Phase 4, themes and sub-themes were reviewed and checked to create a thematic map. Phase 5 entailed defining, naming and continuous refining of themes into categories and sub-categories. In Phase 6, a final analysis was made, relevant quotes were extracted and related to the analysis, research question and literature. A scientific report was written up in article format.

TRUSTWORTHINESS

To ensure trustworthiness of the study, the criteria for excellent qualitative research by Tracey (2010:840) was used and is outlined in table 2:

Table 2: An outline of the steps followed for trustworthiness

The eight criteria that needed to be followed to ensure trustworthiness	Various means, practices and methods used to achieve trustworthiness
1. Worthy topic	The topic is worthy as it is relevant to exploring the experiences of primary caregivers in this context. Few studies have been done to explore their experiences and suggest guidelines for their support.

<p>2. Rich rigor</p>	<p>Rich rigor is determined by the quality of the data analysis. The researcher attempted to attain this by conducting six in-depth interviews, a group feedback session and telephonic interviews with two participants to verify data. The group feedback session (with the participants' permission), was also used for member checking.</p>
<p>3. Sincerity</p>	<p>Sincerity was achieved through self-reflexivity. The researcher kept a journal of feelings, opinions and thoughts throughout the research process to ensure that a constant awareness of biases could be maintained.</p>
<p>4. Credibility</p>	<p>Member checking was done by the participants who read the transcribed data and analysed themes, verified it and added other data to it. This ensured reliability of data and findings.</p>
<p>5. Resonance</p>	<p>Resonance was attained by reporting of the participants' experiences as accurately and objectively as possible. The researcher strove to achieve objectivity through consistent self-reflection and accuracy through meticulous data analysis, reflexivity, debriefing and member checking.</p>
<p>6. Significant contribution</p>	<p>A contribution was made by suggesting guidelines of support to primary caregivers whose children or grandchildren were exposed to paternal incest, which is the gap in literature that needed to be filled.</p>
<p>7. Ethical practices</p>	<p>The following ethical practices were adhered to: obtaining permission from the relevant institutions for the study to be conducted, informed consent, confidentiality, anonymity and further support - counselling.</p>
<p>8. Meaningful coherence</p>	<p>The study was coherent and grounded in literature. The study also achieved its aim, which was firstly to explore the participants' experiences and secondly to suggest guidelines for their support.</p>

DISCUSSION OF FINDINGS

Table 3 shows the main themes and subthemes that emerged from the study. Thereafter, these themes and subthemes are discussed and supported with verbatim quotes.

Table 3: Identified themes and subthemes

Themes	Subthemes		
Theme 1: Reactions to the disclosure and its aftermath	i. Emotional ii. Cognitive iii. Physiological		
Theme 2: Coping strategies that emerged to deal with the disclosure and its aftermath	i. Effective coping strategies	ii. Unhealthy or negative coping strategies	iii. Threats to coping
	Behavioural coping strategies that actively solve problems Social support	Behavioural coping strategies of avoidance	Lack of social support

According to literature on trauma by the NSW Institute of Psychiatry (2007), and Raphael, Wooding, Burns and Stevens (2012), people’s reactions to traumatic events may be classified into three phases, namely Impact Phase; Immediate Post-Impact (Disaster) Phase and Recovery Phase. These phases could be applied to the context of this study as follows: the disclosure of the paternal incest may be viewed as the Impact Phase; the aftermath and associated losses these caregivers endured as consequences of the disclosure could fit into the Immediate Post-Impact Phase and the prolonged period of adjustment or return to equilibrium may be seen as the Recovery Phase. Since the data was collected 3-4 years after the incidents of abuse, some of the caregivers’ experiences occurred at different time periods within this time frame. Their progression through the different phases may thus have varied. Possible time periods and/or phases will be indicated in the sections to follow.

THEME 1: REACTIONS TO THE DISCLOSURE AND ITS AFTERMATH

Primary caregivers experienced emotional, cognitive and physiological reactions to the disclosure of the paternal incest of their children and during its aftermath.

i. Emotional reactions

A variety of emotional reactions described the severity of the experiences for the caregivers and indicated that their children's trauma was also traumatic for them. Emotional reactions were experienced at different phases during the trauma. On disclosure (mainly during Impact Phase, possible progression to later phases) they experienced shock and disbelief; fear and ambivalent feelings. As the reality of the incidents became clear after the disclosure (Immediate Post-Impact and Recovery Phases), emotional reactions of confusion; trying to make sense of the incident; anger, loss, helplessness and shame were experienced.

Shock and disbelief

Shock and disbelief was an initial reaction to the disclosure. The following quotes provide evidence of this:

"... I went into a shock ... I couldn't believe it ..." (Caregiver 1)

"I was shocked ... I am still shocked. I still can't believe it." (Caregiver 3)

"I was shocked ... I couldn't believe he did this to the children." (Caregiver 6)

Most of the shock reactions were linked to the caregivers' inability to believe that their partners could commit these incestuous acts with their children. Willingham (2007:9;49) and Pretorius *et al.* (2011:4-5), state that shock and disbelief is an initial response to paternal incest disclosure.

Fear

On disclosure (Impact Phase), some of the caregivers expressed fears of retaliation by the fathers of the children, who were already experienced as physically abusive towards them: *"I'm gonna confront him [about the abuse] then maybe he can kill us all."* (Caregiver 1) Caregiver 6 feared reporting the abuse of her granddaughters as their mother's partner would turn his anger towards them. According to Willingham (2007:54), all the caregivers in her study experienced some type of fear, including fear of the perpetrator.

Other fears that were experienced by caregivers after disclosure (Immediate Post-Impact Phase), were also expressed: *"She [the sergeant] didn't let me know if he is out on bail ..."*

because I was scared ... he threatened that he would kill me many times.” (Caregiver 3) Caregiver 5 reported fearing the re-victimisation of her granddaughter when she stayed with the school caretaker: *“I felt that I couldn’t breathe! I was so scared that he would hurt her ...”* In Willingham’s (2007:54-55) study, fears of re-victimisation of the children were also evident in caregivers. All the caregivers feared leaving their children with people they mistrusted. Three of them lost their jobs from following the court processes and an inability to cope with the trauma. They opted to care for the children themselves. The remaining three, who were employed, left the children in the care of trusted family. Willingham’s (2007:55) findings confirmed this fear of caregivers of leaving children with others and Wickham and West (2002:71) also note that caregivers may be hyper-vigilant and overprotective of their children’s safety.

Ambivalent feelings

The study showed that caregivers experienced ambivalent feelings in relation to their partners, children and themselves. Ambivalent feelings occur when someone simultaneously experiences strong positive and strong negative feelings or thoughts about an object or occurrence (Bolen & Lamb 2007:192; Thompson, Zanna & Griffin 1995:361-386) or when the push and pull of opposing feelings causes inner conflict and two-mindedness (Bolen & Lamb 2004:188; Weingardt 2000:298). Ambivalent feelings related to the child and partner were experienced mainly during Impact and Immediate Post-Impact Phases, whereas those related to the self were expressed in Immediate Post-Impact and Recovery Phases.

Ambivalent feelings in relation to partner fosters conflicting feelings towards the child

Caregiver 3 reported putting aside the pity she felt for her partner in order to make a choice to protect her child: *“... I feel sorry for him ... then I don’t feel sorry for him ... this is my husband and this is my child and I choose my child.”* These ambivalent feelings towards the partner foster conflicting feelings within the non-offending caregiver, who questions her loyalties, as she loves both the child and the partner-perpetrator. Her desire to protect both is strong, however there is no option to do so. Bolen and Lamb (2004:186;194), confirm that ambivalence in primary caregivers occurs when the bonds between the caregiver, child and partner are equally strong and conflict arises as a choice has to be made between the perpetrator and the child. Caregiver 2 reported experiencing ambivalent feelings about her partner going to jail: *“I feel sorry for him because he is my husband. I believe my daughter. But for me as a person it’s not nice to put someone in jail.”* Bolen and Lamb (2004:194) state that ambivalence in this regard occurs when the caregiver has a close relationship with the perpetrator.

Ambivalent feelings in relation to self

Caregiver 6 reported experiencing ambivalent feelings about stepping in to protect her granddaughters: *"I questioned myself ... did I do the right thing ... didn't I do the right thing ..."* Caregiver 4: *"There's a time that I wanted to live and there was a time I didn't want to live ..."* The inner conflict and two-mindedness in caregivers referred to by Bolen and Lamb (2004:188), is evident in the quotes above.

Helplessness

After disclosure (Immediate Post-Impact Phase), the caregivers experienced helplessness due to losses and other situational stressors. Caregiver 5 reported helplessness when she lost her house and job: *"... there was nothing I could do ..."* Caregiver 6 felt that there was no solution to her struggles: *"I left everything just like that ... I don't know what I am going to do."* Caregiver 4 expressed helplessness when she could not convince the prosecutor to take her child's case to court: *"The doors are closed ... I didn't go any further with the case. ... because I am helpless."*

As seen from the above quotations, helplessness was expressed by the caregivers as a loss of power (Strand 2000:17-18) and being overwhelmed by the new demands and challenges in the aftermath of the disclosure of paternal incest (Plummer & Eastin 2007:1060).

Anger

Anger was another emotion felt by the caregivers after disclosure (Immediate Post-Impact Phase). All of them expressed anger towards the perpetrators:

"... and sometimes when I walk past there [the perpetrator's house] then the anger comes up ..." (Caregiver 4)

"... when I sit and struggle so ... because if he didn't do this stupid thing ... he'd help me ... I get so angry." (Caregiver 3)

"... that she [my daughter] stands by him ... I get so angry." (Caregiver 6)

Wickham and West (2002:71) and Pretorius *et al.* (2011:7-8), confirm that the anger felt by caregivers in their studies were also directed at their partners.

Confusion

Some of the caregivers reported experiencing confusion after disclosure (Immediate Post-Impact Phase). The National Child Traumatic Stress Network Organisation (2009:1) writes that caregivers whose children have been exposed to intra-familial sexual abuse, like paternal incest, are stressed and can experience intense feelings of confusion. These were expressed as follows:

“I don’t know, everyone makes me confused ... Sometimes I wonder what made me marry that man?” (Caregiver 2)

“I don’t know how a mother feels, if I as grandmother feel this way. How must a mother feel? I am now fully confused.” (Caregiver 6)

“...my mind spinning and things going through my mind.” (Caregiver 1)

Trying to make sense of the incident

Caregivers in the study reported questioning the perpetrator and God after the disclosure (Immediate Post-Impact and Recovery Phase) in an effort to make sense of their traumatic experiences.

Caregivers questioned the perpetrator’s intentions that led to his actions as follows:

“Why must he do this to my child? ... I will just question that over and over.” (Caregiver 3)

“This is what is so difficult for me that I can’t understand why he did it.” (Caregiver 2)

Caregiver 4 questioned God: *“There are lots of times that I question the Lord ... why this and why that ... Why did this happen to my daughter?”*

Silver and Updegraff (2008:9) state that trauma causes people to make sense of the experience by a “mental reviewing process” as seen in the quotes above.

Loss

Different losses were endured by the caregivers after the disclosure (Immediate Post-Impact Phase). Some caregivers reported loss of employment due to the incident and following the court processes: *“I lost my job ... I had to go to court ... my boss didn’t understand.”* (Caregiver 4) Others expressed the loss of their partners who were incarcerated: *“I miss my husband ... I feel so alone.”* (Caregiver 2) With the aforementioned loss of employment coupled with the loss of their partners, these caregivers experienced loss of financial support: *“He [her husband]*

paid the rent, he paid the shops ... now it's just the little that I get ... things are tough." (Caregiver 3) Caregivers 5 and 6 felt the loss of their daughters who distanced themselves in the aftermath of the incestuous incidents: *"I ... just had to accept that... she [her daughter] walked out on us ... her family, her child ..."* (Caregiver 5)

Literature (Willingham 2007:17; Pretorius *et al.* 2011:2) confirms that caregivers whose children have been sexually abused by their partners experience many losses.

Shame

After the disclosure (Immediate Post-Impact Phase) and during the Recovery Phase, shame was experienced by most of the caregivers, except one, and it manifested on the level of the community as well as the child-victim.

Caregiver 6 expressed her shame as follows: *"Yes, I was ashamed ... I thought what's the community going to say?"* Caregiver 4 withdrew from the community in shame: *"The people [from the community] laughed at me ... I withdrew myself from people."* Caregiver 2 described her inability to face her child and her family from the shame felt for her partner's incestuous actions. Willingham (2007:56) found that primary caregivers in her study described an enormous amount of shame as they felt blamed and judged by the people in their surroundings. However, Caregiver 3 said that *"I can't say I felt shame because I wasn't a negligent mother."*

ii. Cognitive reactions

Most of the caregivers reported experiencing intrusive, recurrent thoughts of the trauma after disclosure (Immediate Post-Impact Phase), as illustrated below:

"I keep thinking about all of these things." (Caregiver 5)

"I thought I was going mad ... This is what went on in my head ... over and over." (Caregiver 3)

Caregiver 1 explained that her mind was spinning from all the thoughts going through it. Naparstek (2006:81) confirms that typical cognitive difficulties following trauma involve recurring, intrusive thoughts.

iii. Physiological reactions

After the disclosure (Immediate Post-Impact Phase) and the Recovery Phase, the caregivers reported that their bodies reacted in different physiological ways, which (according to Scott 2008:5-33) is common in people who have experienced trauma. According to Bloom (1999:5-

10), physiological reactions to traumas such as sexual abuse are short-term responses, which if prolonged, may develop into post-traumatic stress disorder. Narratives of these physiological reactions are:

“I felt like I couldn’t breathe ... the doctor said it was an anxiety attack.” (Caregiver 5)

“I have high blood ... every time when I stress so about the children and the court case.”
(Caregiver 6)

“I had no appetite at all. I couldn’t sleep. I was like a robot, I couldn’t move. I couldn’t talk.”
(Caregiver 1)

“I had a breakdown already ... this keeps me from moving forward.” (Caregiver4)

Literature from various authors confirm that the physiological reactions expressed by the caregivers above are associated with traumatic experiences: Scott (2008:6), confirms that recurring memories after trauma causes anxiety and panic attacks and Van der Kolk (1994:3), confirms that sounds, images and thoughts of the trauma trigger autonomic responses to do with heart rate and blood pressure in the individuals exposed to it. According to Naparstek (2006:37;69), some sufferers of trauma are seriously incapacitated by disabling symptoms as well as sleep disturbances and eating disorders.

THEME 2: COPING STRATEGIES THAT EMERGED TO DEAL WITH THE DISCLOSURE AND ITS AFTERMATH

From the impact of the disclosure and its aftermath, strategies emerged that facilitated effective coping, such as behavioural coping strategies aimed at solving problems and social support; those that facilitated unhealthy or negative coping strategies, such as avoidance of problems and threats to coping, such as a lack of social support. Aldwin and Yancura (2004:6-7), Lazarus and Folkman (1984:150-155) and Taylor (1998:1) all confirm that problem-focused and avoidant coping as well as support are coping strategies employed by people to cope with their trauma. Strategies that facilitated coping are outlined below.

i. Effective coping strategies

These entail behavioural coping strategies to solve problems, and social support.

Behavioural coping strategies to solve problems

According to Zeidner and Endler (1996:258), coping involves behavioural efforts to carry on in spite of the pain of the trauma. Some of the caregivers reported engaging in problem-solving

behavioural strategies in order to cope with situational demands in all of the phases. Behavioural coping strategies aimed at solving problems on different levels were:

Behavioural coping strategies in relation to others (Immediate Post-Impact Phase):

"I went to fetch my sister ... to stay with me ... so that I wouldn't be alone in that house."
(Caregiver 3)

Behavioural coping strategies that were spiritual in nature, occurred after disclosure (Immediate Post-Impact to Recovery Phase):

"I read my Bible and I pray ... and they [her daughter and nephew] go with me to church on Sundays." (Caregiver 4)

Behavioural coping strategies in relation to the child, involving protection, that occurred at different time periods (indicated in brackets after the quote):

"He [the child] said: Mummy ... Dada hurt me ... then I phoned the police and the police came."
(Caregiver 3: Impact Phase)

"... out from under my eyes I can't let you go ... just be here where I can see you." (Caregiver 2: Immediate Post-Impact to Recovery Phase)

"... everywhere he went I walked behind him ... I watched him ... I told my husband to watch him ... he mustn't go near my grandchild." (Caregiver 5: Immediate Post-Impact Phase)

The behavioural coping strategies displayed in the quotes above show that caregivers in this study took direct action to improve their situations. Brewin and Holmes (2003:363) define safety behaviours as active attempts to prevent or minimise trauma-related outcomes.

Social support

The caregivers reported receiving family, professional, police, community and financial support in the different phases. According to Aldwin and Yancura (2004:29-30) and Lazarus and Folkman (1984:179), support from others helps to buffer or mediate traumatic effects.

Family support

Caregivers reported receiving family support during the Immediate Post-Impact Phase:

"I am staying now with my mother." (Caregiver 1)

"She [her daughter] ... didn't even want to walk near to the Wendy House. So my brother suggested that we move into the house at the back for a while." (Caregiver 2)

“My aunty and them are very supportive.” (Caregiver 3)

According to Appleyard and Osofsky (2003:122), caregivers fare better when they build up a system of support. Micheel and Levy-Peck (2012:76) state that families can be an important source of support, as illustrated above.

Professional support

Caregivers reported receiving some professional support for themselves and their children from social workers, registered counsellors, doctors and nurses on disclosure (Impact Phase to Immediate Post-Impact Phase), such as arranging for accommodation in places of safety, grant applications and reporting of the abusive incidents. At the time of the interviews (Recovery Phase) only two of the children were receiving counselling support from the organisations concerned, whereas all the other children’s cases were closed. Hodas (2006:15) confirms that caregivers and their families need access to healthcare and social services, as this access is both supportive and protective. Examples of this type of support were reported:

“Miss J [the social worker] said that I should go to the child protection unit and then I should state my case to them ...” (Caregiver 6)

“I had a bond to pay ...C [social work and counselling institution] ... help for me ... they help me a lot.” (Caregiver 1)

“The doctor examined him ... and said Mummy you must be strong ... The sister at the hospital came to speak to me ... and prayed with me.” (Caregiver 3)

Police support

Almost all the caregivers reported being supported by the police on disclosure (Impact Phase) and during the Immediate Post-Impact Phase, until their cases reached the court or had been closed. Caregiver 4, however, reported that she was disappointed in the police: *“The case was incorrectly handled by the police ... they were supposed to take her [her child] to the hospital that night and they didn’t ...”* Loffel (2004:252) contends that the police is responsible for formal child protective services, and are an essential part of society’s response to child sexual abuse. Police support was experienced as follows:

“The police listen to my story.” (Caregiver 1)

“I was at work ... they say my daughter was raped ... The policeman is so good ... he brought me to the station ...” (Caregiver 2)

“The lady at B [social work institution] then called child protective services ...” (Caregiver 5)

Community support

Kammerer and Mazelis (2006:5-6) emphasise the importance of community peer support after the experience of trauma, and state that this support is usually well received by trauma-affected individuals. All the caregivers reported being supported by the community in various ways after the disclosure (Immediate Post-Impact Phase):

“Lots of people came to my house ... lots of mothers ... told me that the same thing happened to their children.” (Caregiver 4)

“I need the money ... so I make stuff to sell and the people that work nearby support me.”
(Caregiver 5)

“The Lord put people by my side ... the dressmaker ... my friend support me, then I didn’t feel so alone.” (Caregiver 1)

Financial support

According to Howard (1993:180), caregivers of newly disclosed incest victims may find themselves with a husband in jail, homeless or in a new home and no financial support for the family other than state welfare. Most of the caregivers reported receiving financial support after the disclosure (Immediate Post-Impact Phase) either from the state or their families:

“The children do get a grant ... now when my children get money then I pay the rent ...”
(Caregiver 3)

“The family helps with money sometimes, this is how we get by and my husband has the odd job here or there.” (Caregiver 5)

“Now my family supports me ... because I am not working ...” (Caregiver 4)

Caregivers 3 and 6 expressed feeling helpless and alone for not being able to cope with their financial struggles, however being employed helped them to survive. Caregivers 2, 3 and 6 were employed, whilst the other caregivers were not. Bolen and Lamb (2004:181-194) confirms that a lack of resources causes mothers in situations like these, to feel stressed and alone.

ii. Unhealthy or negative coping strategies

These types of behavioural coping strategies entailed avoidance of problems.

Behavioural coping strategies of avoidance

Most of the caregivers reported avoidance strategies, such as withdrawal, self-blame and blaming of others on disclosure (Impact Phase), after disclosure (Immediate Post-Impact Phase) as well as in the Recovery Phase. These are discussed below and illustrated with quotes.

Withdrawal

Some caregivers experienced withdrawal from the community during all the phases. This is an example of an avoidant form of coping which is an initial buffer for trauma, but with prolonged use may be a psychological risk factor associated with poorer healing outcomes (Holahan & Moos 1987:3-13). The following quotes are examples of incidences of withdrawal:

"I withdrew myself from people ... people were talking about me" (Caregiver 4: Immediate Post-Impact Phase)

"I just don't feel ready to go [to church after the incident] ... I always think people is looking at me." (Caregiver 5: Immediate Post-Impact to Recovery Phase)

Another form of withdrawal from the community is silence, which entails abstaining from verbal interaction with its members:

"I didn't confront the man, I never spoke to him, I was like someone that is silent." (Caregiver 1: Impact Phase)

"I just kept silent, I never went further with the case." (Caregiver 4: Immediate Post-Impact Phase)

Withdrawal in the form of silence was another way to avoid dealing with the child's trauma, as reported by Caregiver 5: *"When my granddaughter came out with this whole thing ... I didn't know how to handle it. I didn't know what to say to her ... then I would just keep quiet ... then she also stops talking."* (Impact Phase)

Van Loon and Kralik (2005:80) identify silence as a strategy used to suppress memories, forget the incident, disengage or disassociate, isolate the self from it or try to please everyone.

Self-blame and blaming of others

Victorson, Farmer, Burnett, Ouellette and Barocos (2005:408) identify self-blame and attribution of blame to others as coping strategies used to minimise traumatic distress. However, Aldwin and Yancura (2004:13) explain that these are avoidant forms of coping associated with poorer

outcomes. In the study, this form of avoidant coping occurred after disclosure (Immediate Post-Impact Phase) and is illustrated below:

Caregiver 1 said: *"I really blame myself. I wasn't a good mother to my daughter."* Caregiver 2 blamed herself for not being there to protect her daughter. Caregiver 4 noted that *"...there's a time that I blamed myself ... because I let her go ... I pushed her into it."*

Four of the caregivers blamed their partners for their current predicaments. Caregiver 1 expressed her blame for her partner as follows: *"This is all because of what that man put me through. It's because of my husband I am in this situation."*

Caregiver 4 and 5 blamed their daughters for their struggles. Caregiver 4 said: *"My mother said to me ... you can't blame your child for this."*

Van Loon and Kralik (2005:99) state that self-blame is a destructive form of coping that encourages self-sabotage and also mention that blaming others discourages people from taking responsibility for their own healing, as they are unable to take the lesson from their experiences.

iii. Threats to coping

Lack of social support

The caregivers experienced a lack of social support when there was blaming by others and a lack of emotional support on disclosure (Impact Phase) and thereafter (Immediate Post-Impact and Recovery Phases)

Blaming by others

Five of the caregivers described feeling blamed by others for reporting the incestuous acts of the perpetrators. Plummer and Eastin (2007:1061-1062) confirm that caregivers feel blamed by others, either subtly or outright, for the children's abuse and their reactions to it. Caregiver 3 felt blamed by the perpetrator's family: *"... they are blaming me... because it's through me that her child [son] is now in jail."* Caregiver 4 reported feeling blamed by the community for publicising the incest as her community favoured silence in situations like these. Caregiver 6 reported that: *"My daughter told everyone at my old work that it's my fault ... because I wanted the children."*

Lack of emotional support from others

According to Willingham (2007:73), support and validation are critical components to addressing traumatic stress and assisting in coping with this stress. The caregivers all expressed the need to be supported emotionally on disclosure (Impact Phase) and thereafter (Immediate Post-Impact and Recovery Phases):

All the caregivers stated that the research interview was the first opportunity they had to express their own feelings about their experiences since the incidents and that they felt relieved for being able to do this. Poor emotional support from others was expressed:

“Everything is so difficult really... I am alone ... perhaps I will feel better if I talk about this with someone like you.” (Caregiver 3)

“I can’t speak to my mother and them ... like I am now talking to you ... when I talk to them then they shout or say something negative.” (Caregiver 2)

“There were a lot that came and say ... I will support you ... then they turn their backs.”
(Caregiver 1)

According to Herman (1992:61), trauma survivors are often afraid to be alone and crave the presence of a sympathetic person. A supportive response from other people softens the impact of the event. The caregivers in this study clearly experienced a lack of emotional support from people in their environments as well as a lack of ongoing emotional counselling support. Appleyard and Osofsky (2003:122) state that therapeutic services are essential for the emotional support of caregivers who have experienced trauma.

IMPLICATIONS OF THE FINDINGS

This study utilised phenomenology to explore the experiences of primary caregivers whose children or grandchildren were exposed to paternal incest, in order to suggest guidelines of support for them. Although it was limited to a small group of caregivers, their voices were heard, their experiences related, and their needs communicated. It was clear that the caregivers, already in a challenging environment, were further challenged by their children or grandchildren’s disclosures of abuse. Their reactions to the disclosures and the consequences thereafter showed that they were traumatised by it and went through different phases of trauma. Since the caregivers were not a homogenous group, each of the phases presented different challenges to them, towards which they reacted in different ways. A brief exposé will be given outlining their experiences of their trauma within the different phases, as well as their emotional reactions and coping strategies. The phases of traumatic stress reactions as espoused by the

NSW Institute of Psychiatry (2007) and Raphael *et al.* (2012) briefly mentioned in the findings, will be utilised as a template for this outline.

During the Impact Phase (NSW Institute of Psychiatry 2007; Raphael *et al.*, 2012:21-27), on disclosure of the abusive incident, the caregivers found themselves in a situation that demanded actions of basic safety and survival. Avoidant coping strategies (silence, withdrawal and blaming) were utilised by some of the caregivers on disclosure, to cope with the initial overwhelming emotional reactions to the abuse. Avoidant coping strategies are a necessary initial buffer to the trauma (Holahan & Moos 1987:3-13; Lazarus & Folkman, 1984:150-155) and in some instances helped the caregivers to survive. Many of the caregivers had the sole responsibility for caring for the children and therefore their coping was important. Effective behavioural coping entailed reporting the incidents of abuse (to promote the safety of the children) and seeking various forms of social support (which ensured their own and their children or grandchildren's survival).

At the time of the interviews, although a number of years had passed since the disclosure, the participants gave rather detailed expressions of diverse emotions, indicating how severely they experienced the impact. Possible explanations could include that this research was the first opportunity they had to reflect on their experiences; it also confirms literature that disclosure of paternal incest is traumatic for caregivers. Trauma impacts on people in different ways, but it seems as if this group of caregivers experienced secondary trauma due to exposure to their children or grandchildren's trauma as described by Morrison, Quadara and Boyd (2007:6-9) and Strand (2000:17).

The Immediate Post-Impact Phase, the time period following the disclosure, was characterised by rescue and recoil (NSW Institute of Psychiatry 2007; Raphael *et al.*, 2012:87-107). The task of rescuing was two-fold. The caregivers needed to care for the children who were harmed; and in turn, the caregivers needed to be cared for due to the many losses they had endured. With these losses came changes and disruptions to their daily lives. A range of cognitive, physiological and emotional reactions (different to those of the Impact Phase) were experienced as a result of having to deal with their losses. Professional, family and financial support assisted the caregivers to cope until they could fend for themselves and their children again. The recoil (withdrawal) mentioned above, could be seen as an avoidant coping strategy that, if carried over to the recovery phase, may contribute to poor healing outcomes, as it is an unhealthy or negative behavioural coping strategy. Effective behavioural coping that solved problems entailed finding employment and fending for themselves and their children.

The Recovery Phase (NSW Institute of Psychiatry 2007; Raphael *et al.*, 2012:24), after the disclosure and its aftermath, was characterised by a return to equilibrium, a prolonged period of

adjustment, whereby lives and activities were brought back to some form of normality. Social support discussed in the findings was instrumental in assisting the caregivers to reach this phase. However, a prolonged dependency by some of the caregivers on some forms of support, such as financial support, may have contributed to these caregivers feeling dependent and disempowered. It is during this phase that caregivers became more aware of their emotional needs and may now be ready to work through their reactions to the trauma and rebuild their shattered life worlds. The situational demands for the preceding two phases required that caregivers shelve these needs, to be dealt with at a more appropriate time.

The trauma experienced by the caregivers indicated a need for different forms of support throughout the different phases discussed above. Guidelines for this are suggested below.

SUGGESTED GUIDELINES

Emotional support could be beneficial and may be undertaken by social workers, registered counsellors, counselling and clinical psychologists (within their scopes of practice) as well as caring peers. The emotional support referred to above could take the form of a caring attitude, a listening ear and seeing to practical needs in the Impact and Immediate Post-Impact Phase; and individual counselling (Womack *et al.* 2000:28) later in the aftermath. The aim of this counselling would be to assist caregivers to work through their emotional reactions and address ambivalence and secondary traumatisation outlined in the findings, as such improving their relationships with their children, past or future partners and their communities. Support groups (Stitt & Gibbs 2007:29; Womack *et al.*, 2000:27) and group counselling (Stitt & Gibbs 2007:29), may also be effective tools to utilise, especially since these caregivers expressed a need to learn coping skills from others who had similar experiences. Emotional support could be ongoing, thus assisting them to make a smooth transition from one phase to another by employing more active problem-solving behavioural coping strategies.

A systematic network of support services (Stitt & Gibbs 2007:34-35), would be beneficial in providing a range of support to the caregiver during the Immediate Post-Impact Phase to address specific needs, for instance, removal of the child or application for financial assistance from the state. The value in utilising the support of a multidisciplinary team of practitioners (Willingham 2007:42), consisting of nurses, doctors, social workers, registered counsellors, psychologists and psychiatrists should not be under-estimated, as referrals for specialised support may be necessary.

The development of educational programmes with a focus on empowering (Womack *et al.*, 2000:27) caregivers in the Immediate Post-Impact Phase are suggested to develop skills that

assist in problem-focused coping, which may alleviate feelings of helplessness and dependency. Information about the steps to take when faced with situations like these could assist caregivers to take the necessary action confidently. Psychosocial educational programmes could be helpful and personally empowering (Stitt & Gibbs 2007:22; Willingham, 2007:21-22).

LIMITATIONS OF THE STUDY

The biggest challenge in this study was the availability of participants that fitted the criteria, due to the sensitivity surrounding the topic. The amount of time that had lapsed between the disclosure and the research interview might have influenced the experiences of the caregivers.

RECOMMENDATIONS FOR FURTHER STUDY

Due to the situation in South Africa, where grandmothers often are primary caregivers of their sexually abused grandchildren, further studies should be undertaken in order to determine their specific needs. Future studies could include a more diverse cultural representation of participants and also incorporate a larger number of participants. Other suggestions for further research entail drawing up intervention programmes of support and studying their effectiveness.

CONCLUSION

The study highlighted that caregivers were traumatised by their children or grandchildren's disclosures of paternal incest and reacted to the trauma in phases. Each phase had different situational demands that the caregivers coped with in two ways: either by solving the problems or avoiding them. Solving their problems was empowering, whereas avoiding them gave rise to poorer healing outcomes. Guidelines were suggested for caregiver support.

REFERENCES

- Aldwin, CM & Yancura, LA. 2004. Coping and health: A comparison of the stress and trauma literature. (In Schnurr, PP & Green, BL., eds. *Trauma and health: physical health consequences of exposure to extreme stress*. Washington, DC: American Psychological Association Press. p.99-125)
- Appleyard, K & Osofsky, JD. 2003. Parenting after trauma: Supporting parents and caregivers in the treatment of children impacted by violence. *Infant Mental Health Journal*, 24(2):111-125.
- Bailey, CE. 2005. *Children in therapy: using family as a resource*. New York: W.W Norton & Company.
- Bloom, SL. 1999. *Trauma theory abbreviated*. Philadelphia: Community Works®.
- Bolen, RM & Lamb, JL. 2002. Guardian support of sexually abused children: a study of its predictors. *Child Maltreatment*, 7(3):265-276.
- Bolen, RM & Lamb, JL. 2004. Ambivalence of non-offending guardians after child sexual abuse disclosure. *Journal of Interpersonal Violence*, 19:185-211.
- Bolen, RM & Lamb, JL. 2007. Can non-offending mothers of sexually abused children be both ambivalent and supportive? *Child Maltreatment*, 12:191-197.
- Braun, V & Clarke, V. 2006. Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3:77-101.
- Brewin, CR & Holmes, EA. 2003. Psychological theories of posttraumatic stress disorder. *Clinical Psychology Review*, 23:339-376.
- Courtois, CA. 2010. *Healing the incest wound. Adult survivors in therapy*. 2nd ed. New York: W.W. Norton & Company.
- Creswell, JW. 2009. *Research design: qualitative, quantitative and mixed methods approaches*. USA: Sage.
- Fouché, CB & Schurink, W. 2011. Qualitative research designs. (In De Vos, AS, Strydom, H, Fouché, CB & Delpont, CSL., eds. *Research at grass roots: for the social sciences and human service professions*. Pretoria: Van Schaik. p.307-327.)
- Greeff, M. 2011. Information collection: interviewing. (In De Vos, AS, Strydom, H, Fouché, CB & Delpont, CSL., eds. *Research at grass roots: for the social sciences and human service professions*. Pretoria: Van Schaik. p.341-374.)
- Headington Institute. 2011. *Understanding and coping with traumatic stress*. Available from: <http://www.headington-institute.org/Default.aspx?tabid=2182> (Accessed: 9 May 2013).
- Herman, JL. 1992. *Trauma and recovery*. New York: Basic Books.
- Higson-Smith, C & Lamprecht, L. 2004. Access to specialist services and the criminal justice system: data from the Teddy Bear Clinic. (In Richter, L, Dawes, A & Higson-Smith, C., eds. *Sexual abuse of young children in Southern Africa*. Cape Town: HSRC Press. p.335-355)

- Higson-Smith, C & Thacker, M. 2003. *Summative and formative evaluation of the Teddy Bear Clinic*. Johannesburg: Psych-Action. (Unpublished research report).
- Hodas, GR. 2006. *Responding to childhood trauma: the promise and practice of trauma informed care*. Pennsylvania Office of mental health and substance abuse services. Available from: http://www.dpw.state.pa.us/ucmprd/groups/public/documents/manual/s_001585.pdf (Accessed: 10 May 2012).
- Holahan, CJ & Moos, RH. 1987. Risk, resistance, and psychological distress: a longitudinal analysis with adults and children. *Journal of Abnormal Psychology*, 96:3-13.
- Howard, CA. 1993. Factors influencing a mother's response to her child's disclosure of incest. *Professional Psychology: Research and Practice*, 24(2):176-181.
- Husserl, E. 2001. *The shorter logical investigations*. New York: Routledge.
- Justice, B & Justice, R. 1979. *The broken taboo: sex in the family*. New York: Human Sciences.
- Kammerer, N & Mazelis, R. 2006. *After the crisis: Healing from trauma after disasters*. Bethesda: SAMHSA.
- Lazarus, RS & Folkman, S. 1984. *Psychological stress and the coping process*. New York. NY: Springer.
- Lindegger, G. 2006. Research methods in clinical research. (In Terre Blanche, M, Durrheim, K & Painter, D., eds. *Research in practice: Applied methods for the social sciences*. Cape Town: University of Cape Town Press. p.456-475.)
- Loffel, J. 2004. Policy responses to child sexual abuse in South Africa. (In Richter, L, Dawes, A & Higson-Smith, C., eds. *Sexual abuse of young children in Southern Africa*. Cape Town: HSRC Press: p.250-275.)
- Mbokazi, FM. 2005. *The impact of father-daughter incest on the mother-daughter relationship*. Johannesburg: WITS. (Dissertation – MA)
- Micheel, L & Levy-Peck, JY. 2012. *Parent Support Group Guide. A guide to psycho-educational support groups for non-offending parents and caregivers of children who have been sexually abused*. Washington, DC: WCSAP.
- Morrison, Z, Quadara, A & Boyd, C. 2007. *"Ripple Effects" of sexual assault*. Australian Institute of Family Studies. Available from: <http://www.aifs.gov.au/acssa/pubs/issue/i7.html> (Accessed 20 August 2012).
- Morrow, KB & Sorell, GT. 1989. Factors affecting self-esteem, depression and negative behaviours in sexually abused female adolescents. *Journal of Marriage and Family*, 51(3):677-686.
- Mudavanhu, D, Puleng, S & Fourie, E. 2008. Grandmothers caring for their grandchildren orphaned by HIV and AIDS. *New Voices in Psychology*, 4(1):76-96.
- Naparstek, B. 2006. *Post-traumatic stress disorder. Reduce and overcome the symptoms of PTSD*. Great Britain: PIATKUS.

- Newman, AL & Peterson, C. 1996. Anger of Women Incest Survivors. *Sex roles*, 34(7/8):463-473.
- NSW Institute of Psychiatry. 2007. *Phases of traumatic stress reactions in a disaster*. Available from: <http://www.ptsd.va.gov/professional/pages/phases-trauma-reactions.asp> (Accessed 10 October 2013).
- Plummer, CA & Eastin, J. 2007. The effect of child sexual abuse allegations/investigations on the mother-child relationship. *Violence Against Women*, 7:1053-1071.
- Pretorius, G, Chauke, AP & Morgan, B. 2011. The lived experiences of mothers whose children were sexually abused by their intimate male partners. *Indo-Pacific Journal of Phenomenology*, 11(1):1-14.
- Raphael, B, Wooding, S, Burns P & Stevens G. 2012. *NSW Health: Disaster mental health manual*. Sydney: University of Western Sydney.
- Scott, MJ. 2008. *Moving on after trauma*. East Sussex: Routledge.
- Shah, SA, Garland, E & Katz, C. 2007. Secondary traumatic stress: prevalence in humanitarian aid workers in India. *Traumatology*, 3(1):59-70.
- Silver, RC & Updegraff, JA. 2008. Searching for and finding meaning following personal and collective traumas. (In Markman, K, Proulx, T & Lindberg, M., eds. *Psychology of meaning*. Washington: American Psychological Association. p.1-29)
- Smit, HA. 2007. *Adolescents' experiences of parental reactions to the disclosure of child sexual abuse*. Pretoria: University of Pretoria.
- Smith, DW. 2013. Phenomenology. Available from: <http://plato.stanford.edu/entries/phenomenology/> (Accessed 10 October 2013).
- South African Police Service. 2011/2012. *An analysis of the national crime statistics. Addendum to the Annual Report 2011/2012*. Available from: http://www.saps.gov.za/saps_profile/strategic_framework/annual_report/2011_2012/saps_crime_stats_report_%202011-12.pdf (Accessed 12 April 2013).
- Spies, GM. 2006. *Sexual abuse: dynamics, assessment and healing*. Pretoria: Van Schaik.
- Spies, GM. 2009. Restorative justice: a way to support the healing process of a child exposed to incest. *Acta Criminologica*, 22(1):15-24.
- Stitt, S & Gibbs, B. 2007. Non-offending mothers of sexually abused children: the hidden victims. *Institute of Technology Blanchardstown Journal*, 15:13-37.
- Strand, VC. 2000. *Treating secondary victims: intervention with the non-offending mother in the incest family*. California: Sage.
- Strydom, H. 2011. Sampling in the quantitative paradigm. (In De Vos, AS, Strydom, H, Fouché, CB & Delport, CSL., eds. *Research at grass roots: for the social sciences and human service professions*. Pretoria: VanSchaik. p.222-235.)

- Swanepoel, Y. 2003. Primary caregivers' experiences of raising children with autism. A phenomenological perspective. Available from: <http://eprints.ru.ac.za/164/1/swanepoel-ma.pdf> (Accessed 21 February 2013).
- Taylor, S. 1998. *Coping strategies*. Available from: <http://www.macses.ucsf.edu/research/psychosocial/coping.php> (Accessed 15 March 2013).
- Thompson, MM, Zanna, MP & Griffin, DW. 1995. Let's not be indifferent about attitudinal ambivalence. (In Petty, RE & Krosnik, JA., eds. *Attitude strength antecedents and consequences*. Mahwah, NJ: Lawrence Earlbaum. p.361-386)
- Tracey, SJ. 2010. Qualitative quality: Eight "big-tent" criteria for excellent qualitative research. *Qualitative Inquiry*, 16(10):837-851.
- Tuval-Mashiach, RT, Freedman, S, Bargai, N, Boker, R, Hadar, H & Shalev, Y. 2004. Coping with trauma: narrative and cognitive perspectives. *Psychiatry*, 67(3):280-293.
- Van der Kolk, B. 1994. The body keeps the score: memory and the evolving psychobiology of post-traumatic stress. *Trauma information page*, 1-21.
- Van Loon, AM & Kralik, D. 2005. *Reclaiming myself after child sexual abuse*. South Australia: RDNS Research Unit.
- Van Manen, M. 1990. *Researching lived experience. Human science for an action sensitive pedagogy*. Canada: Althouse Press.
- Victorson, D, Farmer, L, Burnett, K, Oullette, A & Barocas, J. 2005. Maladaptive coping strategies and injury-related distress following traumatic physical injury. *Rehabilitation Psychology*, 50(4):408-415.
- Vogelman, L. 1990. *Debunking some myths of the "sex monster" syndrome*. Centre for the study of violence and reconciliation. Available from:<http://www.csvr.org.za/wits/articles/artvoege3.htm> (Accessed 24 June 2011).
- Weinberg, SK. 1955. *Incest behaviour*. New York: Citadel.
- Weingardt, KR. 2000. Viewing ambivalence from a sociological perspective: Implications for psychotherapists. *Psychotherapy*, 37(4):298-304.
- Wickham, RA & West, J. 2002. *Therapeutic work with sexually abused children*. New Delhi: Sage.
- Willingham, EU. 2007. *Maternal perceptions and responses to child sexual abuse*. Atlanta: Georgia State University.
- Winston, AC. 2006. African American grandmothers parenting AIDS orphans: Grieving and coping. *Qualitative Social Work*, 5(1), 33-43.
- Womack, ME, Miller, G & Lassiter, MS. 2000. Helping mothers in incestuous families. *Women and Therapy*, 22(4):17-34.
- Zeidner, M & Endler, NS. 1996. *Handbook of coping: theory, research and applications*. Canada: John Wiley & Sons.

SECTION 3

CRITICAL REFLECTIONS ON THE STUDY

1. CRITICAL REFLECTIONS ON THE STUDY

Previous studies with primary caregivers whose children or grandchildren were exposed to paternal incest were conducted with the aim to discover how to support the primary caregiver in order to support the child-victim (Mbokazi, 2005; Pretorius *et al.*, 2011; Smit, 2007; Stitt & Gibbs, 2007). Stitt and Gibbs (2007:1) wrote that in the past, the primary caregivers' needs for support were not a priority as they were not acknowledged by practitioners to be in need of support in their own right. These researchers refer to these caregivers as "hidden victims" and confirm that in the past, even fewer studies had been done to determine the kind of support that the caregivers needed.

The aim of this study was firstly to explore the experiences of the primary caregivers whose children or grandchildren had been exposed to paternal incest and secondly to use these experiences to suggest guidelines that may be utilised by practitioners to develop support programmes for them.

The findings of the study showed that primary caregivers experienced secondary trauma, as described by Morrison, Quadara and Boyd (2007:6-9) and Strand (2000:17), which resulted from the caregivers' exposure to their child or grandchild's disclosures of incestuous trauma and its aftermath. The trauma was evident in the primary caregivers' descriptions of their experiences in terms of emotional, cognitive and physiological reactions and was seen to occur in different phases. These phases were based on the following phases of traumatic reactions, identified by the NSW Institute of Psychiatry (2007) and Raphael, Wooding, Burns and Stevens (2012): on disclosure of the abuse (Impact Phase), after the disclosure (Immediate Post-Impact Phase) and a Recovery Phase.

The two themes that emerged from the interviews with caregivers are summarised below.

Theme 1: Reactions to the disclosure and its aftermath

Emotional reactions of shock and disbelief; fear; ambivalent feelings; helplessness; anger; confusion; questioning in order to make sense of the incident; loss and shame were experienced by the caregivers. The first four emotional reactions were characteristic of the Impact Phase and the rest were characteristic of the Immediate Post-Impact Phase. Cognitive reactions such as recurrent, intrusive thoughts and the physiological reactions reported in the Immediate Post-Impact to Recovery Phase were related to stress symptoms commonly experienced after a trauma. Some of these symptoms were anxiety attacks, blood pressure problems, loss of appetite, sleeplessness, and disabling symptoms.

Theme 2: Coping strategies that emerged to deal with the disclosure and its aftermath

This theme entailed coping with the impact of the disclosure and its aftermath, which entailed effective coping strategies (behavioural coping strategies to actively solve problems and the presence of social support), unhealthy or negative coping strategies (behavioural coping strategies of avoidance) and threats to coping (a lack of social support). The caregivers utilised these coping strategies in the various phases of trauma to assist them in progressing from one phase to the next.

Behavioural coping strategies that facilitated effective coping occurred when the caregivers took action to solve their problems, which could be seen as the problem-focused coping strategies described by Aldwin and Yancura (2004:5) and Lazarus and Folkman (1984:150-155). The caregivers also received family, community, professional, police and financial support, which they experienced as positive and which also facilitated effective coping. Effective coping assisted the caregivers to reach the Recovery phase sooner than if they avoided their problems.

Behavioural coping strategies reported by the caregivers that were avoidant in nature could be seen as unhealthy or negative forms of coping. The caregivers used these avoidant coping strategies (Lazarus & Folkman, 1984:150-155), to avoid the problems that resulted from the trauma. These were withdrawal, self-blame and blaming of others. Withdrawal limited the caregivers' interaction with others and they tended to feel isolated and alone. Caregivers also experienced a lack of social support in the form of a lack of emotional support from others, they expressed a need to be heard by caring people, and not to be blamed, as people in their surroundings did not understand what they were going through. A lack of support was a threat to coping and kept the caregivers stuck in the Post-Impact Phase thus delaying recovery.

From the discussion above it may be seen that the trauma experienced by the caregivers indicated a need for different forms of support throughout the different phases mentioned. Guidelines for this are suggested below.

1.1 Emotional support programmes

Emotional support during the initial phases of the trauma could take the form of a caring, listening attitude and assistance to accomplish practical tasks, to name a few. The situational demands of safety and survival, during the initial phases of the trauma, may not demand intervention such as counselling. Individual counselling, group counselling and support groups (Stitt & Gibbs, 2007:29; Womack, Miller & Lassiter, 2000:27-28) are suggested once the immediate needs of the caregivers have been met. The primary caregivers in the study (who

were in the Recovery Phase) expressed a need to interact with peers in groups as they needed to identify with or connect with others who had been through similar experiences. Counselling could be ongoing until recovery is complete, to ensure that primary caregivers develop a strengthened sense of self by working through the emotional, cognitive and physiological reactions that were identified in the themes. Various practitioners' skills, like those of registered counsellors, psychologists and psychiatrists (within their scopes of practice) could be useful in supporting primary caregivers in situations like these.

1.2 Multidisciplinary practitioner support

With the paternal incest trauma of the children and after the disclosure thereof (during the Post-impact Phase), the primary caregivers experienced many changes like losing their homes and jobs; they were furthermore required to follow the court process for the children or apply for state financial assistance. A multidisciplinary team of practitioners would be able to provide a range of this kind of support to the carers in these situations (Stitt & Gibbs, 2007:34-35; Willingham, 2007:42). Practitioners need to operate within various scopes of practice that cover their expertise and their disciplines. A team such as this would have systemic support systems in place to be able to channel the primary caregivers in a direction that ensures they receive the necessary support.

1.3 Educational support programmes

Educational programmes (Womack, *et al.*, 2000:27-28) during the Post-impact and Recovery Phases are necessary as they assist primary caregivers to develop skills for coping better with their situations. Programmes such as these could promote empowerment in these caregivers. Particular emphasis in these programmes could be on encouraging these caregivers to solve their problems, which may lessen their dependency on others. Psychosocial educational programmes (Stitt & Gibbs 2007:22; Willingham, 2007:21-22) may also provide valuable support, as most of the primary caregivers in this study explained that they felt helpless due to a lack of knowledge of what to do and whom to approach for assistance when their children or grandchildren were exposed to the paternal incest.

2. PERSONAL REFLECTIONS OF RESEARCHER

I was encouraged by the eagerness with which the primary caregivers participated in the study. The gratitude they expressed for being afforded the opportunity to tell their stories was humbling. Their resilience emerged in their capacity to move on, no matter their pain.

At first the interviews were emotionally disturbing to me, as most of the participants went into great detail describing their experiences. It was challenging for me to stay steady and not be affected by the sadness of their pain. I remained consistently aware that their experiences were part of their own life's journey and that my purpose was to record the information. I am of the opinion that I tried my best to remain objective due to a consistent self-reflective process after each interview. A journal was utilised in which my feelings, opinions and thoughts throughout the research process were recorded to ensure that a constant awareness of biases could be maintained by me. Discussions held with supportive peers at the institution where the study took place assisted me to keep the necessary perspective to stay focused on the task at hand and my role in the process. As the study progressed, with the assistance of the supervisors, it became easier for me to determine the meaning that primary caregivers ascribed to their own experiences and recognise that this was indeed an enlightening experience for me.

I felt honoured to be entrusted with the primary caregivers' deep feelings of pain. Having heard their struggles and witnessing their gratitude for simply receiving feedback about their interviews gave me a sense of advocacy, almost as if the study was a validation of their struggle to conquer amidst grave difficulty. Throughout my experience with them, I researcher realised that my own struggles were small in comparison and that judging mothers in this position would be unfair to them. I have become aware of my own socially constructed biases and will be eternally indebted to the primary caregivers for teaching me these lessons.

3. CONCLUSION

Findings of the study showed that primary caregivers whose children or grandchildren were exposed to paternal incest are victims of their children's trauma. They experience emotional, cognitive, physiological reactions which indicate that they had experienced secondary trauma which occurred in different phases. This study was an opportunity for their voices to be heard so that they would be able to communicate their needs. The study also highlighted their strategies of coping with the impact of the disclosure and its aftermath, which was seen in the behavioural coping strategies that were employed by them, that either facilitated effective coping, were unhealthy or negative coping forms or threats to coping. Due to the trauma they experienced they need various forms of support. Guidelines for this support were provided, and could assist practitioners to draw up intervention programmes for them.

REFERENCES

- Aldwin, C.M. & Yancura, L.A. 2004. Coping and health: a comparison of the stress and trauma literature. (*In Schnurr, P.P. & Green, B.L., eds. Trauma and health: physical health consequences of exposure to extreme stress. Washington, DC: American Psychological Association Press. p.99-125*)
- Lazarus, R.S. & Folkman, S. 1984. *Psychological stress and the coping process*. New York, NY: Springer.
- Mbokazi, F.M. 2005. The impact of father-daughter incest on the mother-daughter relationship. Johannesburg: WITS. (Dissertation – MA).
- Morrison, Z., Quadara, A. & Boyd, C. 2007. “Ripple effects” of sexual assault. *Australian Institute of Family Studies*. <http://www.aifs.gov.au/acssa/pubs/issue/i7.html> Date of access: 20 Aug. 2012.
- NSW Institute of Psychiatry. 2007. Phases of traumatic stress reactions in a disaster. <http://www.ptsd.va.gov/professional/pages/phases-trauma-reactions.asp> Date of access: 10 Oct. 2013).
- Pretorius, G., Chauke, A.P. & Morgan, B. 2011. The lived experiences of mothers whose children were sexually abused by their intimate male partners. *Indo-Pacific journal of phenomenology*, 11(1):1-14.
- Raphael, B., Wooding, S., Burns, P.& Stevens, G. 2012. NSW Health: Disaster mental health manual. Sydney: University of Western Sydney.
- Smit, H.A. 2007. Adolescents’ experiences of parental reactions to the disclosure of child sexual abuse. Pretoria: UP. (Dissertation–MSD).
- Stitt, S & Gibbs, B. 2007. Non-offending mothers of sexually abused children: the hidden victims. *Institute of Technology Blanchardstown Journal*, 15:13-37.
- Strand, V.C. 2000. Treating secondary victims: intervention with the non-offending mother in the incest family. California: Sage.

Willingham, E.U. 2007. Maternal perceptions and responses to child sexual abuse. Atlanta: Georgia State University.

Womack, M.E., Miller., G & Lassiter, M.S. 2000. Helping mothers in incestuous families. *Women and Therapy*, 22(4):17-3

APPENDIX A
CONSENT FORM

Dear Participant,

I would like to invite you to participate in a research study that I am undertaking as a Masters student of North-West University. My study aims to explore the experiences of primary caregivers whose children/grandchildren were exposed to paternal incest. Your experience will assist social workers and counsellors to develop support programmes for primary caregivers who have experienced this kind of trauma.

A single interview will be conducted in order to obtain the abovementioned data and a group feedback session, which will be used for member checking as well, will be arranged after the data has been analysed to confirm accuracy. Since the topic is a sensitive one, effort will be made to minimise discomfort throughout the interview and if you feel that you are not able to commence with it, your decision to withdraw from the interview at any stage will be respected without question. In the event of a need for counselling support, I (the researcher) will refer you to the organisation that referred you to me for this study.

All the information collected in this study will be kept strictly confidential. In the event of the publication of a scientific paper, all names will be changed to preserve anonymity. The interviews will be recorded and transcribed and will not be made public. These recordings will be kept in a safe place and will only be heard by me. If you have any questions pertaining to the study, you may contact me, Fiona Saloojee (on 082 564 9126) or my supervisor, Dr Carlien van Wyk (on 082 940 6690). After the research has been completed a copy of the research report will be provided to you.

I understand what the research study is about and voluntarily agree to participate.

Signature of participant

Date

Signature of researcher

Date

APPENDIX B: Guidelines for article

CARSA - CHILD ABUSE RESEARCH A SOUTH AFRICAN JOURNAL PUBLISHING POLICY

Child Abuse Research a South African Journal (CARSA) has been published biannually in April and October since 2000. It was SAPSE accredited in 2003 for articles published in the journal from 2004 onwards. This means that CARSA is a peer reviewed, fully accredited, professional journal and academics at higher education institutions receive credits if their articles are published in CARSA.

Publishing policy

CARSA is a national journal that promotes academic and professional discourse amongst professionals involved in child-care work. It publishes high quality, peer-evaluated, applied, multidisciplinary articles focusing on the theoretical, empirical and methodological issues related to child abuse in the light of the current political, cultural and intellectual topics in South Africa. Authors of articles submitted for review will remain anonymous. The comments of the reviewers and peer evaluators should be constructive and helpful and designed to aid the authors to produce articles that can be published. The authors may then use these comments to revise their articles. However, the final decision on whether or not to publish an article rests with the editor. There should be an interval of at least two issues between articles published by the same author.

Preparing articles for submission

The submitted articles should always conform to CARSA's house style. As the journal develops, it is envisaged that it will contain full-length articles, shorter debates, book reviews and software reviews. The following information is provided regarding the length of articles:

Full-length articles should not exceed a word count of 8000 (tables excluded).

Shorter articles (in the form of shorter debates) should not exceed a word count of 3000 (tables excluded)

Book reviews should not exceed a word count of 1000.

Software reviews should not exceed a word count of 3000.

Tables, figures, illustrations and references are excluded from the word count. Book reviews and software reviews will be initiated by the editor and review editors. They will commission individuals to do the reviews. Prospective authors are expected to abide by language guidelines regarding issues of gender and race and disability.

Empirical research should adhere to acceptable standards of descriptive and inferential statistics and empirical data should be manipulated statistically using an acceptable statistical program such as the Statistical Package for the Social Sciences (SPSS) or SAS. The inferences regarding qualitative analysis should also be accompanied by an explanation of the techniques used or should utilise statistical packages such as SQR.NUD.IST which are recognised for this type of analysis.

Copyright policy and author's rights

Once an article has been accepted for publication, the author automatically agrees to the following conditions. All work published in CARSA is subject to copyright and may not be reproduced, in whole or in part, in any manner or in any medium without the written consent of the editor, unless no charge is made for the copy containing the work, and provided the author's name and place of first publication appears in the work. Authors assign copyright to CARSA. Non-exclusive rights for contributions to debates and comments to articles are requested so that these may also appear in CARSA. The moral right of the author to his or her work remains with the author. Where applicable, contributors should indicate sources of funding. It is the duty of the author to clear copyright on empirical, visual or oral data. Simultaneous submission to other electronic or printed journals is not allowed.

Notes for contributors

Articles that appear in CARSA are subject to the usual academic process of anonymous peer reviewing. The articles that are written by the editorial staff will be refereed by independent referees. Electronic submission of articles by E-mail should be done in MS Windows, Word. Authors should submit their work to the editor, Prof Michele Ovens at: ovensm@unisa.ac.za Before submission, articles should have been corrected for errors, edited and should be accurate.

It is the responsibility of the author that articles should be language and technically edited, before submission. Formal conversation is required that the final accepted article has been edited for language proficiency.

Style

Main headings should be typed in upper case and begin at the left margin. No indentation is allowed. Dates should be written as follows:

9 January, 2000. Bold, italics and underscore should be formatted as such in the original document. The recommended style for reference purposes is the abbreviated Harvard

technique, for example, "Child abuse is rising (Author 1999:10)" OR "According to Author (1999:10), child abuse is rising". In the case of legal articles, footnotes will be allowed.

To work toward uniformity in the alphabetical bibliography at the end of an article, the following examples of format are given:

Books:

Kuehnle, K. 1996. *Assessing allegations of child sexual abuse*. Sarasota: Professional Resource Press.

Articles:

Collings, SJ & Payne, MF. 1991. Attribution of causal and moral responsibility to victims of father-daughter incest: an exploratory examination of five factors. *Child Abuse and Neglect* (15)4:513-521.

Where applicable, contributors should indicate sources of funding. It is the duty of the author to clear copyright on empirical, visual or written data. Simultaneous submission to other electronic or printed journals is not allowed.

Non-sexist language

Gender specific nouns and pronouns should not be used to refer to people of both sexes. The guidelines on sexist, racist and other discriminatory language should be observed. The following is intended to assist contributors to refrain from sexist language by suggesting non-sexist alternatives.

Sexist: Each respondent was asked whether he wanted to participate. The child should have enough time to familiarise himself with the test.

Non-sexist: Respondents were asked whether they wished to participate. Enough time should be allowed for the child to become familiar with the test.

THE FINDINGS OF THE STUDY IN TABULAR FORM (THEMES, SUBTHEMES AND CATEGORIES WITH APPROPRIATE QUOTES)

RESEARCH QUESTION: WHAT ARE THE EXPERIENCES OF PRIMARY CAREGIVERS WHOSE CHILDREN/GRANDCHILDREN WERE EXPOSED TO PATERNAL INCEST?

THEMES	SUBTHEMES	CATEGORIES	QUOTES
<p>Reactions to the disclosure and its aftermath</p>	<p>Emotional Reactions</p>	<p>Shock and disbelief</p>	<p>PCG 1: ... I went into a shock ... To tell you the honest truth, if you have met my husband you would never have say he would have done such a thing. I couldn't believe it.</p> <p>PCG 2: So she said no they think my daughter was abused. Yo! ... hesitant [shocked look on face] ... I ... gave the phone to M ... [her manager] ... I told him he must talk to the people because they say my child was raped. [silence] ... I went outside and I went to smoke. They were like daughter and father. I don't believe it. Can a person do something like this to a person's own child?</p> <p>PCG 3: I was shocked ... I am still shocked. I still can't believe it.</p> <p>PCG 4: I couldn't even think of that ... [shock in her</p>

		<p>Fear</p>	<p>face] ...if she didn't say that then we would not have known... But she kept on saying it... Then it must have happened.</p> <p>PCG 5: ... I was shocked and I believed her when she told me about it, because it happened to my grandmother, my mother, to me and my daughter. I believed her when she told me about it.</p> <p>PCG 6: I was shocked ... I couldn't believe he did this to the children.</p> <p>PCG 1: " I'm gonna confront him [about the abuse] then maybe he can kill us all ...</p> <p>PCG 2: I am afraid that when he gets out of jail then he's going to take revenge.</p> <p>PCG 3: "She [the sergeant] didn't let me know if he is out on bail ... because I was scared ... he threatened that he would kill me many times."</p> <p>PCG 4: I am scared of him.</p> <p>PCG 5: He said that ... umm ... if I tell my mother what he did he would kill my mother in front of me and then kill me. [Fears that granddaughter will be re-victimised because it happened to her] another quote: "I couldn't get there fast enough ... I felt that I</p>
--	--	--------------------	--

		<p>Ambivalent Feelings</p>	<p><i>couldn't breathe! I was so scared that he [the caretaker] would hurt her."</i></p> <p>PCG 6: <i>Then he again began to hit me. I shot him with a gas gun in his eyes and then I also ran away. I was scared if I report it then he's going to hurt them.</i></p> <p>Ambivalent feelings in relation to children</p> <p>PCG 1: <i>I want to protect [the child] ... and I want to protect my husband. I love my child and I love my husband.</i></p> <p>PCG 5: <i>I should hate my daughter ... but I don't. I don't feel that I don't ... I don't feel that I do.</i></p> <p>PCG 2: <i>Is C... [the child] lying to me or is C ...[the partner] telling the truth.</i></p> <p>Ambivalent feelings in relation to partner</p> <p>PCG 3: <i>... I feel sorry for him ... then I don't feel sorry for him. Then he must go and serve time for what he has done. ... this is my husband and this is my child and I choose my child.</i></p> <p>PCG 2: <i>I feel sorry for him because he is my</i></p>
--	--	-----------------------------------	--

		<p>Helplessness</p>	<p><i>husband. I believe my daughter. But for me as a person it's not nice to put someone in jail.</i></p> <p>PCG 1: <i>I don't know why I was so in love with that man ... the one moment you feel hatred, the next moment you feel love ...</i></p> <p>Ambivalent feelings in relation to self</p> <p>PCG 2: <i>He hit me a lot.. but I still love him.</i></p> <p>PCG 4: <i>I don't want to stand in court tomorrow and then I am the whole joke in the whole thing [justice versus embarrassment]. There's a time that I wanted to live and there was a time I didn't want to live ...</i></p> <p>PCG 6: <i>I questioned myself ... did I do the right thing ... didn't I do the right thing ... My daughter told the magistrate that I interfered in her life and that I wanted to take her children.</i></p> <p>PCG 1: <i>I thought maybe I wasn't a good mother for D [my daughter]... but according to me I was a good mother ...</i></p> <p>PCG 1: <i>She [her mother] ...is rude really. She don't</i></p>
--	--	----------------------------	---

			<p><i>care what she tell you. It's her house, you must just keep quiet. I can do nothing ... I have nowhere to go.</i></p> <p>PCG 2: <i>They say my daughter was raped ... and I struggle and I struggle to get home ... everything took too long for me. Supervisor, phoned the police ... I said to him ... please, my child is at the police station ... my child was raped ... can he please take me out there ...</i> Another quote: <i>This is how my mother is, it's almost as if she wants to control me. I can't make my own decisions.</i></p> <p>PCG 3: <i>Because it's now through me that her child is now in jail ... I don't have power ... they all say they blame me. I don't have power ... honestly ...</i></p> <p>PCG 4: <i>The doors are closed. I put everyone off, I did nothing I just went silent. I didn't go any further with the case. ... because I am helpless.</i></p> <p>PCG 5: <i>I must still provide for her child also. I must still look after her child also because she couldn't. I must still protect her child because she couldn't. [powerlessness]. I lost my house, I lost my job, everything because of that whole thing ... there was</i></p>
--	--	--	--

		Anger	<p><i>nothing I could do.</i></p> <p>PCG 6: <i>I left everything just like that ... I don't know what I am going to do.</i></p> <p>PCG 1: <i>I was cross ... I was disappointed, you go through different emotions man ...</i></p> <p>PCG 2: <i>He sent a letter. Then he writes a lot of nice things in. He loves me and the children, he misses me, us. He should have thought about this before he caught on these things with my daughter. He can't want to miss me now [angry].</i></p> <p>PCG 3: <i>I blame him when I sit and struggle so ... because if he didn't do this stupid thing, he'd help me ... I get so angry.</i></p> <p>PCG 4: <i>My family was also angry with them, because my father is a lawyer, he said that we mustn't fight with them. " ... and sometimes when I walk past there [the perpetrator's house] then the anger comes up ..."</i></p> <p>PCG 5: <i>It just makes me angry. I should hate my daughter because of the type of people she brought into our lives ... I lost my house, I lost my job, everything because of that whole thing</i></p>
--	--	--------------	--

<p>Coping strategies that emerged to deal with the disclosure and its aftermath</p>	<p>Effective coping strategies</p>	<p>Behavioural strategies to solve problems</p>	<p><i>stress so about the children and the court case.</i></p> <p>PCG 1: <i>I had no appetite at all. I couldn't sleep. I was like a robot, I couldn't move. I couldn't talk. I thought I'm a have a heart attack ... but maybe it was the Spirit of the Lord that carry me down that stairs that I didn't collapse, it was such a shock for me ...</i></p> <p>PCG 4: <i>I had a breakdown already ... this keeps me from moving forward. I couldn't walk ... I was in hospital.</i></p> <p>PCG 3: <i>I went to fetch my sister ... to stay with me ... so that I wouldn't be alone in that house. He [the child] said: Mummy ... Dada hurt me ... then I phoned the police and the police came.</i></p> <p>PCG 4: <i>I read my Bible and I pray ... and they [her daughter and nephew] go with me to church on Sundays.</i></p> <p>PCG 1: <i>I must learn to accept it, I must accept it to make them happy.</i></p>
--	---	--	--

			<p>Protective action:</p> <p>PCG 1: ... so I leave my child by my mother.</p> <p>PCG 2: ... out from under my eyes I can't let you go ... just be here where I can see you.</p> <p>PCG 3: ... he is now in G ... [home town] because my husband's family lives here and I didn't want them to catch on nonsense and question him and so ...</p> <p>PCG 5: ... everywhere he went I walked behind him ... I watched him ... I told my husband to watch him ... he mustn't go near my grandchild. I don't want anything to happen to her ... I wait for her after school and walk her home.</p> <p>PCG 6: I am going to speak to the social worker Miss J ... Granny is going to try to stop the abuse. I can't trust her because she abducted my grandchild. I called the police.</p> <p>PCG 4: ... when there's males then I get so scared for her ... I now keep my eyes open ... I hold her tight.</p>
--	--	--	---

		Social support	Family support PCG 1: <i>I am staying now with my mother.</i> PCG 2: <i>She [her daughter] ... didn't even want to walk near to the Wendy House. So my brother suggested that we move into the house at the back for a while.</i> PCG 3: <i>My aunty and them are very supportive.</i> PCG 4: <i>My family is not fed up with me they support me a lot. My mother is scared I will throw myself under a train behind my house.</i> PCG 5: <i>The family helps with money sometimes this is how we get by.</i> PCG 6: <i>But that husband, I must say he gave me everything.</i> Professional support PCG 6: <i>Miss J [the social worker] said that I should go to the child protection unit and then I should state my case to them ...</i> PCG 1: <i>I had a bond to pay ... C [social work and counselling institution] ... help for me ... they help</i>
--	--	-----------------------	---

			<p>me a lot.</p> <p>PCG 3: <i>The doctor examined him ... and said Mummy you must be strong ... The sister at the hospital came to speak to me ... and prayed with me.</i></p> <p>PCG 2: <i>My child comes for counselling here</i></p> <p>PCG 4: <i>... She referred me to this hospital for counselling for S ... [my daughter].</i></p> <p>PCG 5: <i>I mean for that two years she had five different social workers.</i></p> <p>Police support</p> <p>PCG 1: <i>The police listen to my story. FCS ... they have a way with working with children.</i></p> <p>PCG 2: <i>I was at work ... they say my daughter was raped ... The policeman is so good ... he brought me to the station ...</i></p> <p>PCG 5: <i>The lady at B [social work institution] then called child protective services ...</i></p> <p>PCG 3: <i>I phoned the police and the police came and we went to the police station.</i></p>
--	--	--	--

			<p>PCG 4: <i>Sunday I phoned the police ... because I know they must help me. The police came and told me I must get her to a doctor. That Sunday when they came they were supposed to help me. The case was incorrectly handled by the police ... they were supposed to take her [her child] to the hospital that night and they didn't ...</i></p> <p>PCG 6: <i>We went to the police station ... they opened up a case and they placed S ... [her granddaughter] in my care.</i></p> <p>Community support</p> <p>PCG 4: <i>Lots of people came to my house ... lots of mothers ... told me that the same thing happened to their children.</i></p> <p>PCG 5: <i>I need the money ... so I make stuff to sell and the people that work nearby support me.</i></p> <p>PCG 1: <i>The Lord put people by my side ... the dressmaker ... my friend support me, then I didn't feel so alone.</i></p> <p>PCG 2: <i>... Sergeant M ... [name] ... organised for a petition to be drawn up ... he got five hundred</i></p>
--	--	--	---

		<p><i>names of people that requested for him [my husband] to not get bail. They say they stand behind me 100%.</i></p> <p>PCG 3: <i>M ...[work colleague] ... is a pastor. He talks a lot to me. The sister at the hospital came to speak to me a lot and prayed with me and there were lots of people at the hospital ... we will talk so nicely.</i></p> <p>PCG 6: <i>The people at work support me. I work at a children's home.</i></p> <p>Financial support</p> <p>PCG 3: <i>The children do get a grant ... now when my children get money then I pay the rent ...</i></p> <p>PCG 5: <i>The family helps with money sometimes this is how we get by and my husband has the odd job here or there.</i></p> <p>PCG 4: <i>Now my family supports me ... because I am not working ...</i></p> <p>PCG 1: <i>I get a disability grant.</i></p> <p>PCG 2: <i>I work for my children. My older boy gets maintenance from his father, but this goes to my</i></p>
--	--	--

	<p>Threats to coping</p>	<p>Behavioural strategies of avoidance</p>	<p><i>mother.</i></p> <p>PCG 6: <i>But that husband, I must say he gave me everything. I went to apply for their money that I now receive.</i></p> <p>Withdrawal</p> <p>PCG 4: <i>I withdrew myself from people ... people were talking about me.</i></p> <p>PCG 5: <i>I just don't feel ready to go [to church after the incident] ... I always think people is looking at me .</i></p> <p>PCG 6: <i>I did nothing about it, but the whole time it bothered me. I don't know what to do ... there's no-one to help me ...</i></p> <p>PCG 3: <i>But when people ask me about it ... then it becomes too much for me ... I want to try to forget it.</i></p> <p>PCG 1: <i>I cannot tell you ... sometimes you know there is a problem but you don't want to admit there's a problem.</i></p> <p>PCG 2: <i>My mother and them don't know what I really went through ... I just keep quiet.</i></p>
--	---------------------------------	---	--

			<p>Silence as a form of withdrawal</p> <p>PCG 1: <i>I didn't confront the man, I never spoke to him, I was like someone that is silent.</i></p> <p>PCG 5: <i>"When my granddaughter came out with this whole thing. I didn't know how to handle it. I didn't know what to say to her ... then I would just keep quiet ... then she also stops talking.</i></p> <p>PCG 4: <i>I just kept silent, I never went further with the case.</i></p> <p>PCG 3: <i>But with them I never, the three years that I was married to this man, I never phoned and said anything about the abuse. I only told them when they heard that he was in the hospital. I must fight my own battles.</i></p> <p>PCG 6: <i>I kept quiet because I didn't want the children to be teased.</i></p> <p>PCG 1:<i>... you want to protect mos your marriage ... that's why we prefer to keep quiet"...</i></p>
--	--	--	---

			<p>Self-blame</p> <p>PCG 1: <i>I really blame myself. I wasn't a good mother to my daughter.</i></p> <p>PCG 2: <i>I wasn't there.</i></p> <p>PCG 4: <i>There's a time that I blamed myself ... because I let her go ... I pushed her into it.</i></p> <p>PCG 5: <i>I did not blame myself because she wasn't in my care when it happened, but I did blame myself for the abuse that happened to me.</i></p> <p>PCG 3: <i>God is punishing me because I did it [had an extra-marital affair]. God is punishing me by using the child. I must open my eyes a little ... that it was wrong to have an affair.</i></p> <p>PCG 6: <i>I blamed myself because my daughter told the magistrate that I meddled in her life and that I told the children to say those things because I wanted her children.</i></p> <p>Blaming others</p> <p>PCG 1: <i>This is all because of what that man put</i></p>
--	--	--	---

		<p>Lack of social support</p>	<p><i>me through. It's because of my husband I am in this situation.</i></p> <p>PCG 4: <i>My mother said to me ... you can't blame your child for this.</i></p> <p>PCG 5: <i>I should hate my daughter because of the type of people she brought into our lives ... She [my daughter] ... brought me down and I can't seem to climb the ladder again</i></p> <p>PCG 2: <i>I didn't put him in jail. He put himself there.</i></p> <p>PCG 6: <i>When she met her mother she said to her: "Mommy didn't hurt you, its daddy."</i></p> <p>Blaming by others</p> <p>PCG 3: <i>... they are blaming me... because it's through me that her child [son] is now in jail.</i></p> <p>PCG 4: <i>Any newspaper won't take a story without having the facts ... His mother said she was going to sue me. She told the people that I said he did it and not that the child said so ... The people laughed at me ... they said I am mad in my head.</i></p> <p>PCG 6: <i>My daughter told everyone at my old work that it's my fault ... because I wanted the children.</i></p> <p>PCG 1: <i>But I just want to tell you my grandma and</i></p>
--	--	--------------------------------------	---

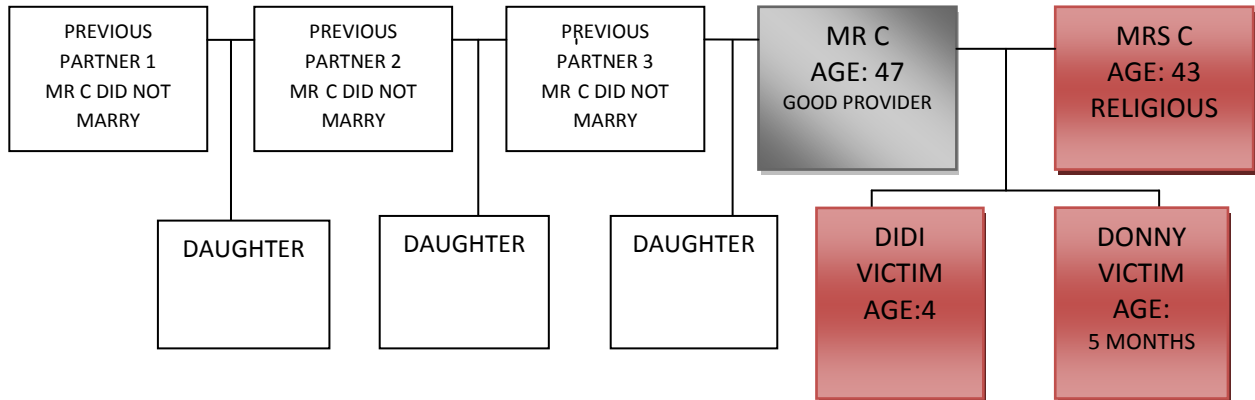
		<p><i>... and them ... they are all making you [Primary caregiver 1]... the bad person.</i></p> <p>PCG 2: <i>Now I'm the pig in the story. They are standing by him.</i></p> <p>PCG 4: <i>But she [partner's mother] doesn't say that the child said, she said I said ... he did this to his child.</i></p> <p>PCG 5: <i>My mother blamed me for her husband abusing me. My mother resents my grandchild for what her mother did.</i></p> <p>Lack of emotional support from others</p> <p>PCG 3: <i>Everything is so difficult really... I am alone ... Perhaps I will feel better if I talk about this with someone like you.</i></p> <p>PCG 2: <i>I can't speak to my mother and them ... like I am now talking to you ... when I talk to them then they shout or say something negative.</i></p> <p>PCG 1: <i>There were a lot that came and say ... I will support you ... then they turn their backs.</i></p> <p>PCG 5: <i>Because I know what it is going through that ... you just never forget ... people have told me</i></p>
--	--	--

			<p><i>to, I just feel I can't. My mother is supposed to be there for me ...</i></p> <p>PCG 4: <i>She can't grow because I am helpless. This is the first time I am talking about them. To tell you the truth I feel better now that I have spoken about it.</i></p> <p>PCG 2: <i>I will never be the same ... that's why I am glad I could talk about it because this is the first time since the incident that I am talking about it.</i></p> <p>PCG 6: <i>Its all the problems and the children that is why I need help ... [crying] ...I can't anymore ...</i></p>
--	--	--	--

SUMMARY OF CAREGIVERS' EXPERIENCES (All names have been changed to ensure the anonymity of participants and their families)

SUMMARY 1 : Caregiver 1: A mother's experience

Family Background and Family Members



Family Functioning

Mr and Mrs C were both employed. They lived comfortably and purchased a house together. Mrs C worked mostly at night and Mr C and Mrs C's mother cared for Didi during the day. Mrs C described her partner to be a "hands-on father". Mr C was a drinker and often became verbally and physically abusive towards Mrs C. Many incidents of violence caused Mrs C to take out a protection order against him, which she did not use. Once, Mr C attacked her with a knife. Mrs C feared for her life.

Incidents with children

Mr C had a desire for certain sex acts that Mrs C was not open to. Didi was 4 years old when she disclosed that her father expected her to perform oral sex with him. Mr C threatened to kill Didi if she disclosed to her mother. Mr C silenced her with bribes of money. Mrs C was both afraid and weary of Mr C's potential for violence. Mrs C did not want to lose her home as Mr C's financial contribution to the bond was valuable, so she kept silent. Mrs C declared that she would not have made a case against Mr C if she was not informed that she would be charged as an accomplice to the abuse. After the first disclosure, Mr C convinced Mrs C to sabotage the case by failing to appear in court. Mr C resolved to seek counselling and the couple reconciled. During the pregnancy of their son, Mr C's sexual abuse of Didi had resumed. Five months after Donny's birth, he also fell victim to the abuse. Mrs C again made a case against Mr C, this time determined to follow

through as he was not willing to reform. Mr C was convicted of rape and sentenced to 15 years of imprisonment.

Emotional Reactions

Mrs C felt betrayed by the sexual abuse of the children. At first Mrs C was shocked and denied the abuse due to an inability to believe that he could commit such acts with their daughter. The disappointment and broken trust was devastating and she was initially paralysed into inaction. Mr C's violence instilled fear and anxiety in her. The disgust for his actions and her powerlessness to make a difference caused helplessness, guilt and shame. Mrs C struggled with ambivalent feelings of anger and love for her husband. She acknowledged that despite her longing for her husband, she could not live with his actions and blamed herself for the inadequate protection of the children. The guilt Mrs C carried, drove her to suicidal thoughts and more guilt as this posed a religious dilemma for her, as following through with these thoughts meant punishment of "hell".

Behavioural Reactions

Mrs C was torn between taking action and losing the home they lived in. Mr C's parents sided with him and covered-up his behaviour. Mrs C was forced to rent out her home for an income. Mrs C and the children stayed in a shelter, in crowded conditions at her mother for some time and moved around from place to place, exposing themselves to environments of drug abuse, criminals and filth. The children were re-traumatised. With the children's willingness to endure their maternal grandmother's verbal abuse, they moved back in with her. This family have lost their home, their financial status, their support and their idea of family. Furthermore, Mrs C has lost her companion, her health, her job, her trust in men and her children have lost their father-figure.

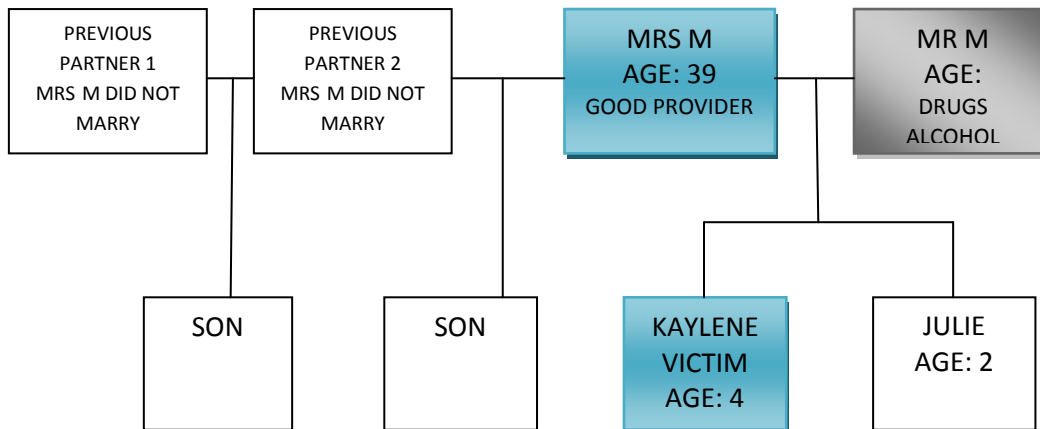
Social Reactions

Mrs C's family and parents-in-law were not supportive. The parents-in-law blamed Mrs C for their son's incarceration. They rejected their grandchildren. The parents-in-law spread rumours about Mrs C among other family members, friends and neighbours, damaging her reputation. As such Mrs C was ashamed to interact with them. Mrs C was fortunate to have a church community and a relationship with her creator, that supported her. Mrs C and her daughter mistrust men. Due to fears of recurrence of abuse, Mrs C minimised her own and Didi's interaction with men and the community in general. She left her job to care for the

children. Mrs C believed her children were now stigmatized. After the abuse, Didi showed sexualised behaviour towards her brother. Mrs C was grateful for the counselling that Didi received (which helped to alleviate this behaviour) and other support her family received from the social justice system. Now unemployed, Mrs C relies on government grants to be able to survive. Although she appreciates the support, this has caused her to feel dependent and unable to do much for herself.

SUMMARY 2 : Caregiver 2: A mother's experience

Family Background and Family Members



Family Functioning

Mr M physically abused Mrs M. Mrs M did not lay charges and returned to him every time. Inaction became her pattern. Her justification was that he was the children's father and her husband. She was the sole breadwinner for a time and he was dependent on her for his needs. He sold his wedding ring and her cell phone to buy drugs. The family lived in a wooden Wendy House (which Mrs M erected and paid for) at the back of her mother's yard. Mrs M's mother supported them financially when they were unemployed. Mr M was the dominant one in the relationship. Mrs M feared him and was subservient. She described that Mr M worshipped Kaylene and they trusted him. She was expecting another baby at the time of the abuse.

Incident with child

Shortly before the incidents of abuse, Mr and Mrs M found employment and worked different shifts. Mrs M worked at night. While Mrs M was at work, Mr M sexually abused Kaylene. Mrs M's sister usually took care of Kaylene during the day and discovered that Kaylene's underwear was bloody. Kaylene disclosed to her aunt and older brother that her father hurt her vagina. They took her to the police station and reported the incident. At the time Mr M was not at home. On being informed of the incident Mrs M was in shock and later followed the necessary procedures for making a case against Mr M. He was arrested and the case is ongoing. Mrs M blamed him for what they had to endure as a result of his actions.

Emotional Reactions

Shock and disbelief were her initial reactions. She later became angry and felt betrayed. He broke her trust. Mr M denied the charges. Mrs M believed Kaylene over him. Mrs M was ashamed of her husband's actions and she could not face her daughter and her family. She was unable to live with this shame, that she terminated her pregnancy. Mrs M was conflicted and confused by her ambivalent feelings of anger, pity and love for her husband. She was sad for having lost her partner, her companion and felt guilty for terminating her pregnancy. At present, Mrs M believes her mother and sisters control her and mistrust her decisions. Mrs M does not confide in them and feels judged.

Behavioural Reactions

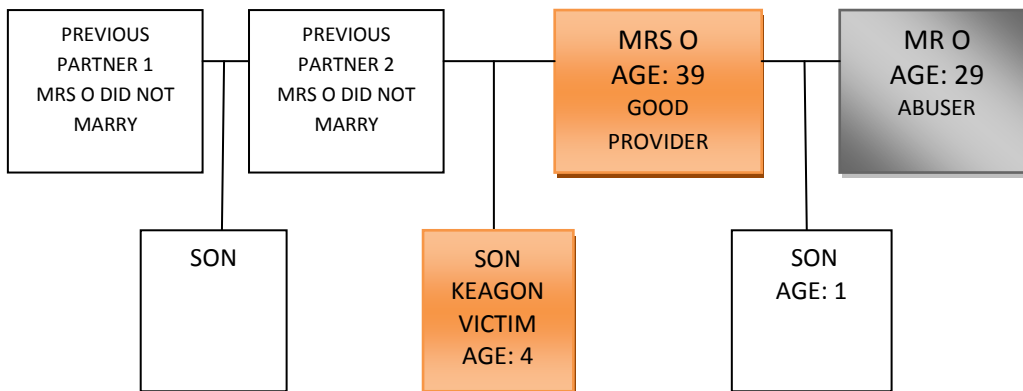
Mrs M blamed herself for her decision to marry her partner and for not protecting her daughter adequately. According to Mrs M, the incident of incestuous abuse confirmed their misgivings about her choices in men and his potential for abuse. Mrs M's family were aware that she covered up for her husband in the past. They mistrusted her as a result and she alienated herself from them, by withdrawing. Due to Mrs M's own feelings of mistrust, she did not let Kaylene out of her sight for fear that she would be kidnapped and re-victimised. Her fears have impacted on Kaylene who stays indoors all the time. Mrs M fears that her partner will be back to hurt them.

Social Reactions

The community's reactions were one of pity. Mrs M did not want their pity. Mrs M was defensive and was determined to rise up, strong enough to work through the trauma. Kaylene received counselling support from the counsellors at the social work unit. Her experience has been positive. Mrs M had withdrawn from people. She longs for her family to support her in all aspects of her life and to trust her decisions. Mrs M appreciated the supportive actions of the police and their assistance in ensuring that the necessary procedures be followed regarding the case against her husband. Her job and the independence it gave her, helped her not to depend on her family for financial support during her daughter's abuse and its aftermath. She received no financial support from the government.

SUMMARY 3: Caregiver 3: A mother's experience

Family Background and Family Members



Family Functioning

Mrs O described the beginning of her marriage to Mr O, as blissful. Mrs O had two children out of wedlock, before she married Mr O. One of the children was cared for by family in her hometown and the other, Keagon, lived with them. Also at the beginning of the relationship, both Mr and Mrs O drank alcohol on a small scale over weekends. This gradually became more frequent for Mr O and it began to affect their family life. Mr O became verbally and physically abusive towards Mrs O. At first, Mrs O was unemployed and Mr O was the sole provider. Mrs O complained that her mother-in-law meddled in their lives. Mr O regularly confided in his mother about their problems. His mother would also verbally abuse and put Mrs O down in public. Much of their arguments were about money. Mrs O discovered that Mr O was having an extra-marital affair. They fought frequently. The physical, verbal and alcohol abuse created distance between them. Mrs O planned to leave Mr O.

Incident with child

Keagon was 4 years old when he disclosed that Mr O had had anal sex with him. Mrs O went to the nearby shop and was out for approximately 10 minutes and returned home sooner than Mr O had expected. Mrs O was surprised to find that the fridge had been pushed up against the front door and she became suspicious when she could not open the door. She feared that something was amiss and panicked when she heard her child's frantic cries for her to help him. Mrs O reported that Keagon heard her knocking on the door. Mr O opened the door and she ran inside to attend to Keagon. Keagon immediately disclosed the abuse to her. Mr O denied the act and blamed it on someone else. Mrs O phoned the police, who came out immediately and the necessary procedures were followed in order to

make a case against Mr O. Keagon was traumatised both emotionally and physically and was hospitalised for a month.

Emotional Reactions

Mrs O was in denial and shock. She could not believe that her husband, whom she loved had hurt her child. She kept questioning ... "Why?" Mrs O felt betrayed as she and her son trusted him. Mr O and her son, had a very close relationship. Mrs O had much conflict spurned by ambivalent feelings of wanting to kill him versus feeling sorry that he had to go to jail. This was compounded by her dilemma of love and hate for him. Mrs O felt powerless during the incident, when she could not reach her son, when he needed her. The thoughts of her child being hurt was torturous. Mrs O expressed a lack of power and helplessness throughout the interview. She also feared that Mr O would take revenge when he was released from jail. Mrs O's loss of financial support and partner (although abusive) caused her to feel stressed as she now struggles to make ends meet. Much of her anxiety is about paying the debts incurred in order to care for the basic needs of her family. Mrs O was angry that she did not have her husband's financial support anymore.

Behavioural Reactions

Mrs O blamed her husband for placing her in an unsupported situation. There was no self-blame as she did not believe that she was negligent towards her child. Mr O's family blamed Mrs O for his incarceration. Despite the dilemma of ambivalent feelings, Mrs O emphatically chose to protect and side with her son and sometimes thought of revenge. Mrs O requested for her younger sister to come to live with her as the loneliness she felt, was unbearable. Mrs O preferred not to discuss the incident with others and would rather forget it happened. The reality is that she is unable to forget, as her surroundings (the Wendy House) are a constant reminder of the abusive acts. Her silence about her own abuse at the hands of her husband caused her to feel unsupported by her family. She felt shame for her own and her child's abuse and this caused her to withdraw from the people in her community where she lives.

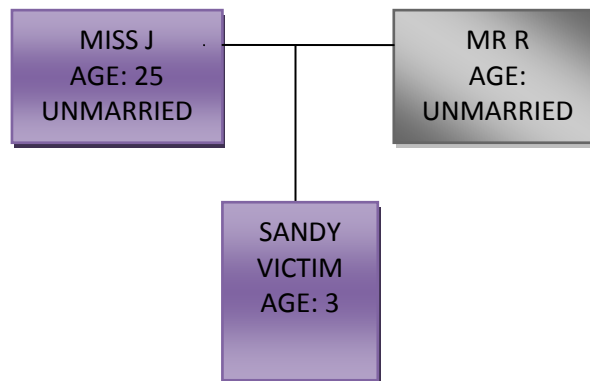
Social Reactions

Mrs O felt supported by the police, social workers and doctors. Their reactions were supportive and reassuring. Mrs O mistrusted everyone in her space after the incident. The support received renewed her hope in people. However, Mrs O mistrusted the people in her

neighbourhood and recently moved away in order to feel safer. Mrs O protected her son from interrogation and intimidation from Mr O's family and the neighbours, by sending him away to live with her sister for a while. She felt that the neighbours were not trustworthy, believed that they were into her business and also broke into her Wendy House to steal her possessions. Mrs O received child care grants from the government which helped to alleviate some of the financial pressure. Her job helped her to fend for her family and she is not dependent on her family for financial support.

SUMMARY 4: Caregiver 4: A mother's experience

Family Background and Family Members



Family Functioning

Mr R and Miss J have a 3 year old daughter, named Sandy. The couple were seeing one another since Miss J was in Grade 10 at school. As the years went by, Miss J minimised her involvement with Mr R because he abused drugs, could not hold a job, stopped financial support of Sandy and was physically abusive towards Miss J. She had an interdict against him. Miss J took him to court several times and he was fined for his behaviour. Miss J was employed at the time of the abuse and Sandy was taken care of by her maternal great grandmother during the day. Mr R and his parents lived opposite Sandy's maternal great grandmother's home.

Incident with child

It was normal for Sandy to run across the road to visit her father. Her father was very fond of her. It was after one of these visits to her father, that Sandy became withdrawn, cried profusely, wet herself and slept for longer than usual. The next day, Sandy disclosed that her father had digital sex with her. Miss J reported the incident to the police. She was insufficiently supported by them. Incorrect procedures were followed for evidence collection. The case was provisionally closed.

Emotional Reactions

Miss J was overcome with shock and disbelief of her child's sexual abuse by her father. She felt intimidated and victimised by threats on her life by Mr R and his mother, after reporting it. Miss J feared Mr R's reaction. She was angry and disappointed that justice was not served.

Miss J experienced her daughter's abuse as a stigma. She perceived that the community saw this abusive act as a joke and was embarrassed and ashamed. Miss J was angry, hurt and blamed herself and Mr R for her situation. She lost her job, due to being absent from work in order to follow the judicial process for the case. Miss J felt powerless as she was unable to follow through with the court case due to the incorrect gathering of evidence by the police. Her daughter's young age also prevented her from testifying.

Behavioural Reactions

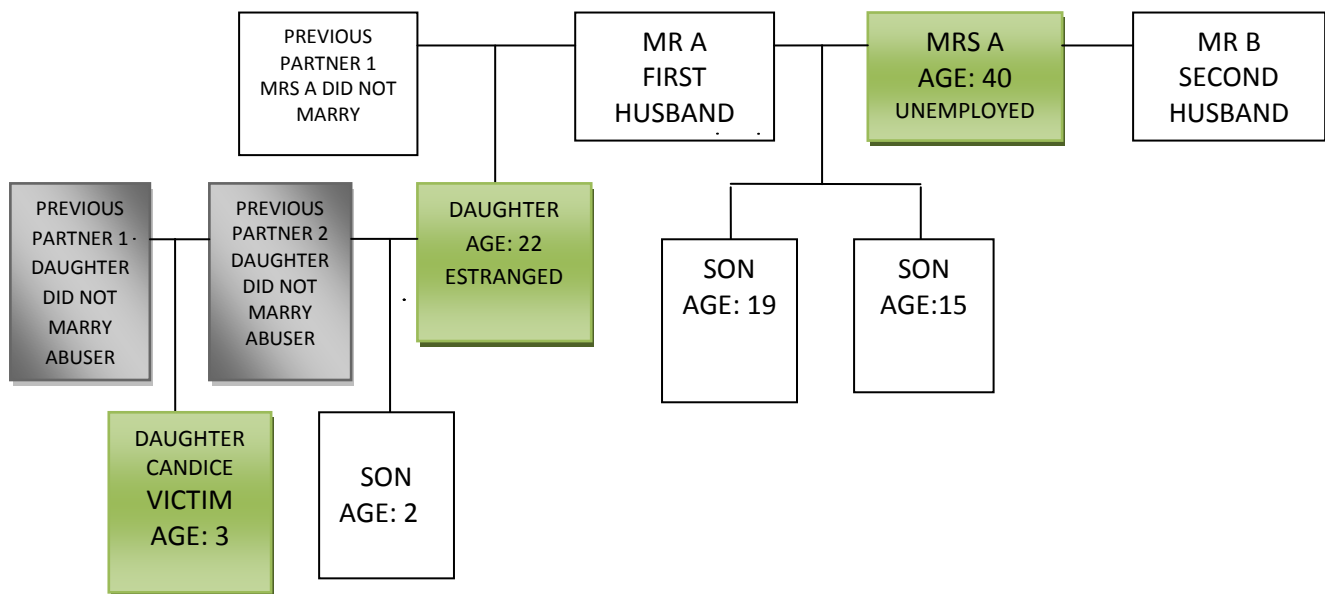
In an effort for justice Miss J wanted Sandy's voice to be heard, she approached the local newspaper to print an article to tell her story. She felt that this helped her to restore some sort of justice. Miss J wanted the community to know her daughter's truth and not only hear the perspective of Mr J's family. The disillusionment and inability to effect change in the justice system caused Miss J to have a nervous breakdown, which reportedly caused her to experience disabling symptoms of temporary paralysis. She believed this to be a manifestation of her stress and was hospitalised. Miss J blamed herself for inadequate care of Sandy. At times Miss J blamed Sandy for her distress and rejected her. Suicidal thoughts often crossed her mind. Miss J mistrusted herself and everyone around her.

Social Reactions

Miss J withdrew from social interactions with people. Her daughter's sexual abuse by her father caused her to feel shame. She also mistrusted the men in her family and those in the community. Miss J wanted to change the community's expectation that silence be upheld when incest happens in the family. A few people commended her efforts to challenge the status quo, however her actions were met with criticism and blame from the community. Miss J avoided interactions with her partner and his family in order to avoid conflict with them. She eventually found solace and strength with her church community. Miss J now holds tightly onto her daughter. Although Miss J is grateful for the counselling support offered to her daughter by the hospital, she has lost faith in the justice system and in her anger therefore, did not take up the offer for the counselling. This experience has left her scared and rejected. Losing her job meant that Miss J and her daughter were completely financially dependent on her mother. This caused her to feel inadequate and despondent as she was unable to find suitable employment. She received no financial grant from the government.

SUMMARY 5: Caregiver 5: A grandmother's experience

Family Background and Family Members



Family Functioning

At 16, Mrs A's daughter gave birth to Candice and abandoned her when she was 9 months old. Mrs A cared for her during this time. Mrs A's daughter took Candice to live with her sometimes, but was however inconsistent in caring for her. The sexual abuse of Candice by her mother's partners at that time, occurred while she was in her mother's care. Her mother's partners abused drugs and alcohol. In order to provide safety for Candice, she was placed in her grandmother's care. As Mrs A recounted her experiences as a grandmother whose daughter and granddaughter were exposed to paternal incest, it triggered memories of Mrs A's own sexual abuse by her stepfather, which she endured for 7 years. Mrs A's functioning was affected by paternal incest in her past. Both Mrs A and Mr B (her current husband) do not have a regular income. Mr B lost his job after a car accident and has been struggling ever since.

Incidents with child

When Candice was 3 years old she disclosed that her father had performed oral sex on her. She was admitted to hospital for 3 days. Mrs A explained that her daughter did not believe Candice. She dismissed her disclosures and told her that she was full of stories. After the hospitalisation Mrs A took up the case. Candice later disclosed that her stepfather also touched her private parts. Due to insufficient evidence and Candice's young age for

testifying, the case was provisionally closed. Mrs A's daughter is no longer in contact with them and her whereabouts are unknown. Mrs A applied to adopt Candice as she wanted to restrict her contact with her father.

Emotional Reactions

Mrs A was angry with her daughter for not keeping Candice safe. She feared that contact with her father could expose Candice to a possible abduction and further abuse. Mrs A has ambivalent feelings towards her daughter for destroying Mrs A's life. She lost her home, her job and her freedom. Candice's father is a gang member who threatened her life and that of her family. He thrashed her home as a message to her to drop the case. Mrs A and her family are in hiding. She believes she should hate her daughter for what they have endured but is unable to. These ambivalent feelings cause her distress. Mrs A is disappointed in her daughter, ashamed of her promiscuous behaviour and involvement with men who have raped and physically abused her.

Behavioural Reactions

Mrs A's immediate reaction was to support and protect Candice, which stems from her own experiences of abuse that she was not protected from. Mrs A was threatened by her stepfather that he would kill her mother in front of her if she disclosed. Mrs A's powerlessness and helplessness in the past kept her silent to save her own mother. According to Mrs A, this is the only way to handle situations she is unable to cope with. Mrs A has anxiety attacks when she is uncertain of Candice's safety. Her mistrust, inability to work and her lack of finances keeps her trapped in a cycle of powerlessness, helplessness and despair. She blames herself for the way her daughter turned out.

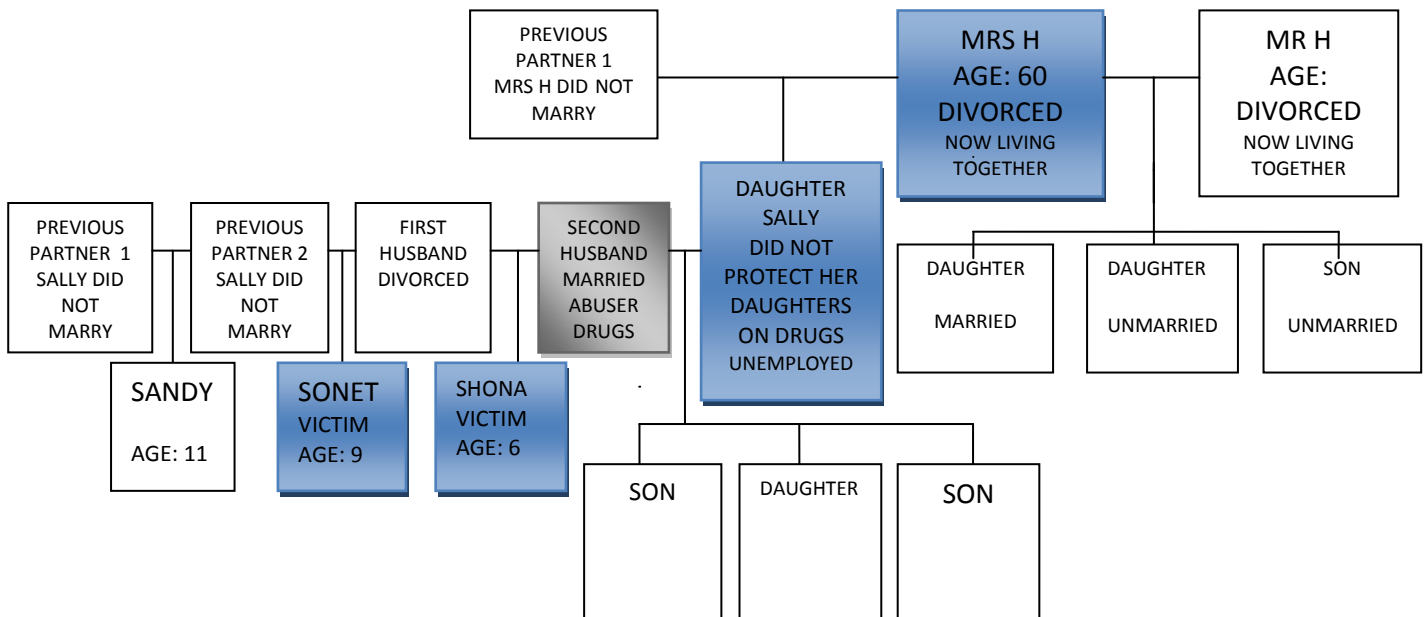
Social Reactions

Mrs A was weary of the community's reaction towards her family. As she was in hiding, her interaction with people was restricted. Her old neighbours gossiped about her daughter's promiscuity and she felt blamed by them. Mrs A was ashamed of her own and her granddaughter's abuse. She restricted Candice's interaction with people as she believed that she was overly friendly and Mrs A was afraid that men would take advantage of her. Mrs A disliked feeling stupid in front of others and stayed away from people who caused her to feel inadequate. Mrs A was disillusioned by the failure of the justice system to assist her in adopting Candice and blamed them for not supporting her in this regard. Despite this, she

was grateful for the counselling support her granddaughter received from the hospital social services. She received no financial grant from the government. Mrs A and her husband struggled to make ends meet and relied solely on odd jobs and family financial support.

SUMMARY 6: Caregiver 6: A grandmother's experience

Family Background and Family Members



Family functioning

Mr and Mrs H are both employed. Mr H was a good provider and Mrs H reconciled with him after the divorce. They never remarried. Sally was a daughter that Mrs H had out of wedlock, before she married Mr H. Sally is now married and living with her second husband who has sexually abused two of her three daughters (from three different fathers before she married her present husband). The three granddaughters, Sandy, Sonet and Shona live with Mrs H by choice. Mrs H sees to their needs. They trust her to protect and care for them. When they lived with their mother they were kept indoors and not allowed to interact with people. Their mother relied on their stepfather for financial support. Their stepfather took drugs, physically abused Sally and sexually abused his two stepdaughters.

Incidents with the children

At ages 9 and 6 respectively, Sonet and Shona disclosed that their stepfather inappropriately touched Sonet and had vaginal and anal sex with Shona. The sisters disclosed this to Mrs H, who met with Sally in order for the them to disclose to her. Sonet claimed that she had disclosed to her mother before. Sally responded with jealous accusations instead of support. As they expected, Sally took no action. With Sally's inaction, Mrs H reported the incidents and a case was made against the stepfather. The case had been ongoing since two years ago. The stepfather was out on bail. Sally abducted Shona from Mrs H's house.

Mrs H contacted the police who immediately went to Sally's home and found her there with the abuser present. He was out on bail. Mrs H believes that her daughter colluded with her husband regarding the sexual abuse of her granddaughters (Mrs H's daughter, currently stands accused as an alleged accomplice to her husband's acts of abuse towards the girls). She also told of Sally's fear of being kicked out onto the streets for fear of not meeting his needs.

Emotional Reactions

At first, Mrs H was shocked and could not believe her son-in-law had sexually abused her granddaughters. She was further angered by Sally's inability to protect her daughters. She was disappointed that Sally had made bad choices in her life. The impact these choices had on Mrs H's life caused her to feel powerless. Choosing to protect the children compelled Mrs H to take financial responsibility for them as well. This placed strain on her as she had planned to retire at 60. Mrs H felt as if she was not in control of her own life. The added financial responsibility forced her to continue to work. Mrs H felt trapped in the despair. Although Sally received maintenance for the girls, she did not consistently assist Mrs H. Mrs H felt blamed and unappreciated. Mrs H had ambivalent feelings as she questioned whether she had done the right thing or not, by reporting the incidents. She feared that the children's stepfather's retaliation would be directed at her daughter, Sally. Mrs H also became estranged from Sally as the reporting caused a rift between them. She was saddened by the loss of her relationship with her daughter.

Behavioural Reactions

Mrs H advocated for her granddaughters' safety, supported them emotionally and provided them with education. She was able to see to their needs as she was employed and had the financial support of her partner. The children had suffered from the trauma of the abuse which reflected in their school work. Mrs H's support and action empowered the girls and their school grades improved markedly. Sally blamed Mrs H and her daughters for her husband's incarceration. She denied their disclosures and caused them to feel guilt for his fate. The daughters rejected their mother when the court asked them where they wanted to be placed until the case was over. They chose to stay with Mrs H. Sally distanced herself from them and minimised contact. The abduction incident was the last contact made. Mrs H mistrusted her now more than ever.

Social Reactions

Mrs H did not experience any adverse reactions from the community, she was however concerned that the community would tease the children and struggled with the shame she felt. She expressed the value of the support she received from the social justice system. Her granddaughters were counselled to work through the trauma. Sonet and Shona thrived in their grandmother's environment as they were able to interact with friends and be free from the abuse. They previously lived in a closed family system with their mother, where social interaction was restricted both with friends and family.