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

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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 design. 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 authors were 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 incantative, 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 authors attempt 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 the 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 care-giving 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 (*Mother*)	43	Coloured
Primary Caregiver 2 (*Mother*)	39	Coloured
Primary Caregiver 3 (*Mother*)	39	Coloured
Primary Caregiver 4 (*Mother*)	25	Coloured
Primary Caregiver 5 (*Grandmother*)	50	Coloured
Primary Caregiver 6 (*Grandmother*)	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. Contact details were provided to them so that they could make contact if they were interested in participating in the research. Six participants indicated that they were interested. 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 aim of the study was explained, so that the participants could make an informed decision to participate or not. Researchers have 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, it was 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. Permission was obtained 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; 2013: 202-203) 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.
2. Rich rigor	Rich rigor is determined by the quality of the data analysis. The authors 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.
3. Sincerity	Sincerity was achieved through self-reflexivity. A journal of feelings, opinions and thoughts was kept throughout the research process to ensure that a constant awareness of biases could be maintained.
4. Credibility	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.
5. Resonance	Resonance was attained by reporting of the participants' experiences as accurately and objectively as possible. The authors strove to achieve objectivity through consistent self-reflection and accuracy through meticulous data analysis, reflexivity, debriefing and member checking.
6. Significant contribution	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.
7. Ethical practices	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.
8. Meaningful coherence	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.

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

<table>
<tr><th>Themes</th><th colspan="3">Subthemes</th></tr>
<tr><td>Theme 1:
Reactions to the disclosure and its aftermath</td><td colspan="3">i. Emotional
ii. Cognitive
iii. Physiological</td></tr>
<tr><td rowspan="2">Theme 2:
Coping strategies that emerged to deal with the disclosure and its aftermath</td><td>i. Effective coping strategies</td><td>ii. Unhealthy or negative coping strategies</td><td>iii. Threats to coping</td></tr>
<tr><td>Behavioural coping strategies that actively solve problems

Social support</td><td>Behavioural coping strategies of avoidance</td><td>Lack of social support</td></tr>
</table>

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. Fourie and Van der Merwe (2014: 4) also confirm this reaction of caregivers in the case of sexual abuse.

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 to 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." (Caregiver 4)

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. Families can be an important source of support (Micheel & Levy-Peck, 2012: 76) and can have a healing influence on recovery (Goelitz & Steward-Kahn, 2013: 27), 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) as well as Goelitz and Steward-Kahn (2013: 28) confirms that caregivers and their families need access to healthcare and social services, as this access is both supportive and protective, it can also help to establish safety. 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.

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